Children and Young People’s Emotional Wellbeing and Mental Health: Health Needs Assessment

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<td>Author</td>
<td>Siobhan Horsley, Health Improvement Practitioner, CYPF, Sheffield City Council</td>
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<td>Owner (if different)</td>
<td>Dr Sue Greig, Consultant in Public Health, CYPF, Sheffield City Council</td>
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1 Executive Summary

The purpose of this summary is to outline the findings from a Health Needs Assessment exploring the emotional wellbeing and mental health needs of children in Sheffield. The HNA will be used to inform the direction of the Emotional Wellbeing and Mental Health Strategy and future design and commissioning of services.

Content is derived from national and local indicators, informed by the evidence base of protective and risk factors for emotional health and wellbeing. The report also considers service level data and self-reported measures from local surveys and consultations.

1.1 Population

The scope of the HNA is 0-25 year olds, with a particular focus on Early Years and Adolescence as important periods of physical and emotional development.

Preschool years involve children undertaking a number of important developmental tasks relating to their physical development, social and emotional development and language and cognitive development which all have an impact on later childhood.

In regards to adolescence, the widening gap between physical and sexual maturity and adult social and financial independence has been offered as an explanation for growing mental health, and behavioural issues amongst young people. There is a surge of brain development in early adolescence, continuing into early 20s, and this brings with it a great potential for building lifelong wellbeing and resilience.

The table below profiles the Sheffield population of Children and Young People as relates to usual divisions in service provision i.e. Early Years, 5-15s, 16 & 17 year olds, and 18-25 year olds.

<table>
<thead>
<tr>
<th>Age Group</th>
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<th>Female</th>
<th>Total</th>
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<tbody>
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<td>0-4</td>
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<td>16-17</td>
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<td>18-25</td>
<td>45,281</td>
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<td>0-16 Total</td>
<td>55,246</td>
<td>52,518</td>
<td>107,764</td>
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<td>0-19 Total</td>
<td>68,782</td>
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<td>16-25 Total</td>
<td>51,569</td>
<td>50,247</td>
<td>101,816</td>
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1.2 Prevalence of mental disorder and illness

- Mental disorders arise early in the life course and impact on a young person's development and can stop them realising their potential. Furthermore mental disorders often last for a long period of time. It is recognised that 50% of lifetime mental illness (except dementia) arises by age 14 and 40% of young people experience at least one mental disorder by age 16.
- It is estimated that approximately 7000 5-15 year olds in Sheffield have a clinically recognisable mental health disorder.
- Prevalence data for Early Years is less clear but it estimated that approximately 10% of 0-3 year olds could have a mental health problems.
- It should be noted that local estimates of prevalence are based on extrapolated national data, some of which is 10 years old. We have good local data around risk factors and protective factors, and access to services which can be used to complement prevalence estimates.

1.3 Protective and Risk Factors, including at-risk populations

- Sheffield generally benchmarks around the national average for protective and risk factors, however this masks the wide inequalities experienced across the city – which reflect broader inequalities in health.
- The Relative Index of Multiple Deprivation can give an indication of cumulative risk factors for poor emotional wellbeing and mental illnesses. In Sheffield the population is clustered towards higher levels of
deprivation, with a total of 34.2% of the Sheffield population living within the most deprived fifth of areas in England. This equates to 38,991 0-17 year olds.

- Certain populations are at greater risk of poor emotional wellbeing and mental illnesses, for example LAAC, SEN, Substance misuse, NEETS (data relates to range of age ranges). An estimated 19 000 CYP fall into these categories.
- In Sheffield an estimated 15 000 CYP live with a parent with mental health disorder.
- 40% children experience insecure attachment which is also a risk factor for poor mental health.
- There are a number of factors which point to increased risk in early years compared to our statistical neighbours and England: there has been a recent decline in access to Free Early Learning, achievement of the Personal Social Emotional Development element of EYFS (also reflected in the Best Start Sheffield study) is low and the % inequality gap for EYFS – while similar to Y&H is low in comparison to England and our statistical neighbours

1.4 Service provision

1.4.1 Emotional Wellbeing and Mental Health System

- Support for children and young people’s emotional wellbeing and mental health is articulated within the local policy context, both in terms of population mental health and commitment to commissioning intentions for service delivery at all Tiers.
- However, there is no whole system model of emotional wellbeing and mental health provision and this is recognised as a concern by stakeholders. The system is broader than that which is commissioned by NHSS CCG and SCC and there is potential for further investigation and quantification of the mental health impact of wider services.
- Tier 1 and Tier 2 provision is broad and disjointed, and the boundaries (and pathways) between the Tiers are not clear.
- The young person centred model of Mental Health services created by Right Here presents a view of the mental health system which is needs led and contrasts with the ‘service-led’ Tiers model. Presenting the Mental Health system in this way would help articulate the CYP journey through the Mental Health system and may help identify gaps.
- The diagram below shows current services at each tier and estimated relative need (where the figures are available). Further discussion of provision at each tier follows.
1.4.2 Tier 1
- There is a broad service offer at Tier 1 but support for Mental Health is not always articulated well (or quantified) within it.
- There is an emerging discourse around positive mental health nationally and locally e.g. 5 ways to wellbeing; resilience; everyone has mental health (Right Here); which could be co-ordinated better and built upon to reduce stigma and further develop informal support structures around mental health: families, peers etc.

1.4.3 Tier 2
- Most mental health support for CYP is embedded (but not always quantified) within broader Tier 2 support services e.g. MAST and CYTs. In the case of MAST there is a clear route into Tier 3 support via Primary Mental Health workers.
- There is a small targeted counselling resource at Tier 2, this does not currently have formal links with CAMHS or AMHS.
- Although there are a range of pathways between Tier 2 and 3, (e.g social workers, paediatricians and educational psychologists and via primary mental health workers based within MAST) this could be further developed to facilitate wider access by other universal and targeted services (including schools) to consultation advice and specialist services.
- Support for CYP stepping up and down into Tier 3 services has been identified as a gap by stakeholders.
1.4.4 Tier 3
- Capacity for service delivery at Tier 3 is much less than the expected prevalence of mental illness and disorders and there is evidence of a significant increase in demand over recent years which is reflected in increased referrals and waiting lists.
- There is variation in age ranges for different service delivery e.g. up to 16, up to 18, up to 25. There are changes planned around commissioning of Tier 3 services which will mean that CAMHS provision will go up to age 17 from 1st October 2014.
- The Community CAMHS teams accept approximately 70% of referrals – the remaining 30% are signposted back to the referrer and into tier 2 or universal support. More investigation of the referral process and referrals would be helpful to see if there is scope to reduce the number of inappropriate referrals.
- CAMHS referral rates and DNAs show a correlation with deprivation – there are proportionally more referrals and more DNAs from more deprived areas. There are some areas with a high level of deprivation that seem to have a low rate of referral to CAMHS. There are wards with over 25% missed appointments (DNAs and cancellations combined) – this suggests a potential for some geographically targeted work to bridge access to CAMHS.
- There is under-representation of BME patients in CAMHS and AMHS. There is under-recording of ethnicity in AMHS and IAPT – this is less so in CAMHS.
- There is a difference in gender demographics in terms of access to CAMHS and AMHS – 63% of CAMHS patients are male compared to 51.3% of AMHS patients. 66.5% of IAPT clients are female which reflects the gender demographic of the prevalence of neurotic disorders which is the focus of IAPT provision.

1.4.5 Tier 4
- Late 2013, NHS England Specialised Commissioning Oversight Group (SCOG) commissioned a review which was designed to map current CAMHS Tier 4 service provision, to consider issues that had arisen since April 2013 when commissioning arrangements transferred from local CCGs to NHS England.
- The main issue reported by providers was a lack of bed capacity. There was an increase in referrals into T4 CAMHS in 2013/14 compared to the previous year – it is felt this is more likely to be due to the changes in commissioning rather than in increase in need or demand in the population.
- The report makes a series of recommendations for development work – these are outlined in the HNA.

1.4.6 Training and capacity building support
- There are a number of training and development support providers but this is not currently joined up and can result in duplication. An option would be to link at least SCC and NHSS CCG commissioned provision, for example a training and professional consultation support system which is underpinned by CAMHS but not always delivered by CAMHS

1.4.7 Increase in need/increase in demand on services
- There is some evidence that there is an increase in prevalence of mental disorders and illnesses. A national longitudinal study showed increases in emotional problems and conduct problems; locally the ECM survey shows an increase in self-reported negative emotions such as sadness, anger, stress etc. National data shows an increase in seeking support for self-harm and locally there has been a marked increase in the number of children attending A&E following a deliberate self-harm (86 in 2004; 165 in 2013).
- There is a recent significant increase in demand for specialist CAMHs with a 30.7% increase in referrals in 2013/14 compared to 2012/13.
- The increase is mainly located in Community CAMHS where referrals have increased from 1461 in 2012/13 to 1975 in 2013/14 (35.2%). A similar proportion of referrals across the 2 years (approx. 70%) are being accepted – meaning that community CAMHS accepted 394 more cases in 2013/14 than 2012/13.
- Referrals into the Deliberate Self-Harm team have increased from 32 in 2012/13 to 62 in 2013/14.
2 Introduction
The purpose of this paper is to describe the emotional wellbeing and mental health needs of children in Sheffield. It will be used to inform the direction of the Emotional Wellbeing and Mental Health Strategy and future commissioning of services.

Content is derived from national and local indicators, informed by the evidence base of protective and risk factors for emotional health and wellbeing. The report also considers self-reported measures from local surveys and consultations.

The current range of commissioned services is briefly outlined including activity levels where available.

This report utilises the 3 main approaches to Health Needs Assessment in order to present as complete a picture as possible. It also reflects the depth and range of data available, locally and nationally on this topic.

The 3 main approaches are:

- Epidemiological: to include a statement of the ‘problem’; prevalence and incidence data; the services available
- Stakeholder evaluation (corporate): structured collection of knowledge and views of stakeholders; recognition of the importance of information and knowledge available from those involved in local services including service users and wider population.
- Comparative: contrasts with other areas where the information is available.

2.1 Context

2.1.1 Local Policy context
The findings from this Health Needs Assessment will underpin activity which relates to the following local strategies:

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<tr>
<td>Sheffield Joint Health and Wellbeing Strategy</td>
<td>Outcome 2: Health and wellbeing is improving</td>
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<td>Sheffield children, young people and adults to be emotionally strong and resilient, and for emotional wellbeing to be promoted across the city.</td>
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<td>Work stream: Emotional Wellbeing and Mental Health</td>
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<tr>
<td>Sheffield City Council: Standing up for Sheffield 2011-2014 Corporate Plan</td>
<td>Outcome Area 2: Better health and wellbeing</td>
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<td>Outcome Area 3: Successful Children and Young People</td>
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<td>Outcome Area 4: Tackling Poverty and Increasing Social Justice</td>
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<tr>
<td>NHS Sheffield CCG Commissioning Intentions 2014-19 (DRAFT)</td>
<td>4.5 We will have put in place support and services that will help</td>
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<td>Develop Emotional wellbeing and mental health services by supporting</td>
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Children and Young People’s Emotional Wellbeing and Mental Health: Health Needs Assessment

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<th>Children and Young People’s Emotional Wellbeing and Mental Health Strategy 2011-2014 (due to be reviewed)</th>
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<td>all children have the best possible start in life</td>
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<tr>
<td>the implementation of Children’s IAPT; ensure a seamless transition from children’s to adult services and address the 16-18 transitional gap, commissioning a single service from one provider</td>
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1. **Involve** Children, Young People, Parents and Carers in the planning and commissioning of local services
2. Help children and young people learn the skills they need to stay emotionally healthy by **developing resilience**. This should be promoted through development of positive emotional health within learning environment settings such as schools, colleges and youth settings.
3. Develop **information** for children, young people, parents, carers and practitioners to support an understanding of local networks and support.
4. **Raise the awareness and capability** in local targeted and universal services to enable local professionals, and subsequently parents and ensure the best possible support, to reduce the need for referral to specialist services and ensure improved step down care for children discharged from specialist services.
5. Target prevention and early intervention through **maternal mental health, positive parenting** and ensuring emotional wellbeing of infants through the first 5 years of life.
6. Develop new innovative solutions, and packages of support and care, to enable children and young people with **complex needs**, where mental health problems are a primary need, to **remain in Sheffield or as close to home as possible**.
7. Develop **transition** arrangements and ensure services for young people moving into adulthood are fit for purpose and providers are working together.

### 2.1.2 Scope

**In scope:**
- Demographic data relating to CYP, 0-25 years where available
- Protective factors for emotional wellbeing and mental health
- General population risk factors for poor emotional health and wellbeing
- High risk groups for mental disorder and low well being
- Overview of current service provision and activity levels

**Out of scope**
- Children with Complex needs where mental health and emotional wellbeing is not the primary need (see Sheffield Complex Child Health Needs Assessment 2014).

The services included within this report are from across all 4 Tiers of emotional wellbeing and mental health services in Sheffield. The services include those that are jointly or separately commissioned by NHS Sheffield CCG and Sheffield City Council. In addition some significant voluntary sector projects have been included.

The report has used the Joint Commissioning Panel for Mental health: Guidance for Commissioning Public Mental Health Services (Practical Mental Health Commissioning) (2013) and the Children and Young people’s emotional health and wellbeing needs assessment by Liverpool Public Health Observatory (2012) as key source documents.

### 2.1.3 Population

The table below shows the Sheffield population of children and young people aged 0-25, in 5-year age bands. This report will consider data for young people up to the age of 25 where it is available.
The graph below shows Sheffield population trends and projections to 2021. The number of 0-4s is projected to grow by 5% over the next 9 years, growth has been and will continue to be higher in the more deprived parts of the city. There is expected to be an increase in the number of 5-14 year olds; the number of 15-19 year olds is expected to decline and then plateau; and the number of 20-25 year olds is expected to increase sharply and then decline steadily.
The table below reprofiles the Sheffield population of Children and Young People to relate to usual divisions in service provision i.e. Early Years, 5-15s, 16 & 17 year olds, and 18-25 year olds.

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<td>45,261</td>
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### 2.1.4 Early Years

The preschool years, including both infancy (birth through to age 1 year) and toddlerhood (1 to 3 years), involve children undertaking a number of important developmental tasks relating to their physical development (e.g. establishing healthy patterns of eating and activity), social and emotional development (e.g. establishing a capacity for self-regulation via their attachment relationship to the primary caregiver) and language and cognitive development (e.g. early acquisition of both expressive and receptive language skills, and wider learning). *Fair Society, Healthy Lives* (Marmot 2010) suggested that in order to reduce future social and health inequalities we need to give every child the best start in life, and this reflects the view that the origins of much adult disease lie in the ‘developmental and biological disruptions occurring during the early years of life’ and more specifically what has recently been referred to as ‘the biological embedding of adversities during sensitive developmental periods’ (Davies et al 2012).

### 2.1.5 Adolescence

The scope of this report includes young people aged up to 25 years. This is because adolescents have experienced the least improvement in health status of any age group in UK in last 50 years (Davies et al 2012). Specifically in relation to mental health 50% of lifetime mental illnesses arise by age 14; and 40% of young people experience at least one mental disorder by age 16 (JCPMH 2013).

The widening gap between physical and sexual maturity and adult social and financial independence has been offered as an explanation for growing mental health, and behavioural issues amongst young people. The gap between puberty and adult social and financial independence has widened from around 6 years in the 1950s to 15 years today (Davies et al 2012).

There is a surge of brain development in early adolescence, continuing into early 20s, and this brings with it both great potential for building lifelong wellbeing and resilience, and significant risk; there is a window of vulnerability to risky behaviours around 14-17 years particularly in the presence of peers and choices made in this period heavily determine future life chances.

Multiple risky behaviours are associated with a cluster of common factors, deprivation, poor parental connection, loss, violence, low self-esteem, poor mental health. New social determinants also arise in adolescence, connection (sense of belonging) with peers, schools and neighbourhoods and can become a key protective factor, that influence the transition from childhood into adult life.

### 2.2 Definitions of emotional wellbeing and mental health

It should be noted that definitions for mental health and emotional wellbeing vary across different disciplines. Where possible this document uses the definitions used by the Joint Commissioning Panel for Mental Health (2013)

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

Mental illness – this refers to depression and anxiety (which may also be referred to as ‘common mental disorder’) as well as schizophrenia and bipolar disorder (which may also sometimes be referred to as severe mental illness).

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

### 3 Protective factors for emotional health and mental wellbeing

#### 3.1 Overview

The over-arching protective factors for mental health and emotional wellbeing are: enhancing control, increasing resilience and community assets and facilitating participation and promoting inclusion (NMHDU 2010). The JCPMH (2013) describe a range of protective factors are associated with wellbeing

- Genetic and early environmental factors
- Socioeconomic factors including higher income and socio-economic status
- Living environment
- Good general health
- Education
- Employment including autonomy, support, security and control in an individual’s job
- Activities such as socialising, working towards goals, exercising and engaging in meaningful activities
- Social engagement and strong personal, social and community networks
- Altruism (doing things for others)
- Emotional and social literacy life skills, social competencies and attributes such as communication skills, cognitive capacity, problem-solving, relationship and coping skills, resilience and sense of control
- Spirituality is associated with improved well-being, self-esteem, personal development and control
- Positive self-esteem
- Values

Resilience is associated with wellbeing and can also help safeguard mental well-being particularly at times of adversity. It arises through the interaction between factors at the individual, family and community level. Different levels of emotional and cognitive resilience or ‘capital’ include:

- Emotional and cognitive: includes optimism, self-control and positive personal coping strategies
- Social: includes networks and resources that enhance trust, cohesion, influence and cooperation for mutual benefit within communities
- Physical health
- Environmental: includes features of the natural and built environment which enhance community capacity for wellbeing
- Spirituality: incorporates a sense of meaning, purpose and engagement as well as religious belief for some.

(JCPMH 2013)

Recently the Five Ways to Well-being has been promoted nationally and locally as a tool to support emotional wellbeing. These were developed by the New Economics Foundation from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing in 2008. The Five Ways to Well-being are a set of evidence-based actions which promote people’s wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give (nef 2013).

This section looks at the prevalence of protective factors for children's wellbeing in Sheffield. Where city level data is available - our city averages tend to be similar to the national averages, this masks wide variation usually between the South West and North East of the city.

#### 3.2 Attachment & Parenting

Attachment is a specific outcome of early care. Through their relationships with their mothers and fathers, children develop an "internal working model" of social relationships. If an infant experiences her or his parents as a source of warmth and comfort, she or he is more likely to hold a positive self-image and expect positive reactions from others later in life. With a secure attachment, the child has a "secure base" from which to explore, learn and develop independence (Moulin et al 2014).
Evidence from a number of longitudinal studies shows that securely attached children function better across a range of domains including emotional, social and behavioural adjustment (Davies et al 2012).

Children with insecure attachment are at risk of the most prominent impediments to education and upward social mobility in the UK: behavioural problems, poor literacy, and leaving school without further education, employment or training. Behaviour problems are a particular concern for the UK where the gap in such problems between the most disadvantaged children and their peers is larger than in Australia, Canada or the US. The international research suggests that:

- Insecurely attached children are at a higher risk of externalising problems, characterised by aggression, defiance, and/or hyperactivity.
- Insecurely attached children, on average, have poorer language development, and weaker executive function, skills associated with working memory and cognitive flexibility.
- Insecurely attached children are less resilient to poverty, family instability, and parental stress and depression.
- Positive pro-active parenting (e.g. involving praise, encouragement and affection) is strongly associated with high child self-esteem and social and academic competence and is protective against later disruptive behaviour and substance misuse.

Among boys who lived under the poverty threshold at some point between 18 months and five years, those with secure attachments at 18 months were two and a half times as likely as others to show positive adjustment – a lack of behavioural problems or below-average social skills – five and a half years later. The teenagers whom teachers rated as less confident and resilient, and more likely to be bullied or bully at school, were those who had insecure attachments in early childhood.

While the majority of children are securely attached, 40 per cent are insecurely attached. This is split into the 25 per cent of children who learn to avoid their parent when they are distressed, because the parent regularly ignores their emotional needs (avoidant attachment) and the highest risk 15 per cent of children, rising to 25 per cent in disadvantaged cohorts who learn to resist the parent, because the parent often amplifies their distress or responds unpredictably (disorganised or resistant attachment) (Moullin et al 2014).

A further protective factor is having at least one healthy relationship with a supportive adult and/or a good relationship with peers. A positive adult-child relationship built on trust, understanding, and caring will foster children’s cooperation and motivation and increase their positive outcomes at school (Webster-Stratton, 1999). In a review of empirically derived risk and protective factors associated with academic and behavioural problems at the beginning of school, Huffman et al. (2000) identified that having a positive preschool experience and a warm and open relationship with their teacher or child care provider are important protective factors for young children. These protective factors operate to produce direct, ameliorative effects for children in at-risk situations (Luthar, 1993) (taken from The Centre on the Social and Emotional Foundations for Early Learning).

3.3 Breastfeeding
Breastfeeding has been linked to positive emotional, as well as health and cognitive outcomes for children. The Sheffield average for breastfeeding at initiation in 2012/13 was 77.7%, which is higher than the average of 73.9% nationally. In 2012/13, 50.8% of Sheffield babies were receiving breastmilk at 6-8 weeks, which is again higher than the national average of 47.2%.

3.4 Education – provision for children under 5 years
The table below shows the percentages of 3 and 4 year olds benefitting from some free early learning provision. The % in Sheffield has increased to 94% in 2014 from a 6 year low in 2013 of 93% (LAIT 2014).
The following table shows the number of 2 year olds that are benefitting from free early learning education. This is not expressed as a percentage as not all 2 year olds are eligible for free early learning.

<table>
<thead>
<tr>
<th>Local Authority, Region and England</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>373 Sheffield</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9120.00</td>
</tr>
<tr>
<td>982 Yorkshire and The Humber</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9910.00</td>
</tr>
<tr>
<td>Statistical Neighbours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>600.00</td>
</tr>
<tr>
<td>970 England</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>88637.00</td>
</tr>
</tbody>
</table>

It should be noted that the quality of childcare is important. In the 1990s, a team of researchers in the US launched a major longitudinal study to assess the effects of early childcare on children’s attachment. The results showed that early non-parental childcare in general did not affect children’s attachment. However, for children who are already at risk of poor attachment, low-quality early childcare elevated this risk at age 15 months and also led to heightened risk of risky behaviour and externalising problems as late as adolescence (Moullin et al 2012).

The table below shows the percentage of 3 and 4 year olds benefitting from funded early education in a Good/Outstanding provider. In Sheffield this is only 63% which is considerably lower than the national, regional or statistical neighbour figure.

<table>
<thead>
<tr>
<th>Local Authority, Region and England</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>373 Sheffield</td>
<td>53.00</td>
</tr>
<tr>
<td>982 Yorkshire and The Humber</td>
<td>72.60</td>
</tr>
<tr>
<td>Statistical Neighbours</td>
<td>75.50</td>
</tr>
<tr>
<td>970 England</td>
<td>76.00</td>
</tr>
</tbody>
</table>

The following table shows the percentage of 2 year olds benefitting from funded early education in a Good/Outstanding provider. Although for Sheffield this is lower than the national, statistical neighbour and regional figures, the difference is not as great as those for 3 and 4 year olds.

<table>
<thead>
<tr>
<th>Local Authority, Region and England</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>373 Sheffield</td>
<td>68.00</td>
</tr>
<tr>
<td>982 Yorkshire and The Humber</td>
<td>70.00</td>
</tr>
<tr>
<td>Statistical Neighbours</td>
<td>72.30</td>
</tr>
<tr>
<td>970 England</td>
<td>71.00</td>
</tr>
</tbody>
</table>

### 3.5 Children achieving a good level of development at EYFS Age 5

In 2012/2013 the measure of a ‘good level of development’ at Foundation Stage changed. To achieve a ‘good’ level of overall progress in 2013 a child needed to reach ‘Expected’ or ‘Exceeding’ status in 12 separate areas of learning:

- Listening and attention
- Understanding
- Speaking
- Moving and handling
- Health and self-care
- Self-confidence and self-awareness
- Managing feelings and behaviour
- Making relationships
- Reading
In 2012/13 3,264 children achieved a good level of development at EYFS. This equates to 51% of children, compared with England average of 52% (DfE, 2013). This figure masks inequalities across the city and variations across Children's Centre areas are shown in the graph below:
In 2013, with the introduction of a new method of measuring early years achievement, the emphasis fell increasingly upon a teacher assessment of a child’s development at the end of the EYFS (the end of the academic year in which the child turns five). The new profile places a stronger emphasis on 3 prime areas identified for children’s healthy development: communication and language; physical development and personal, social and emotional development.

In 2012/13 51% of Sheffield children achieved a good level of development, this is similar to Yorkshire and Humber (50%) our statistical neighbours (49.6%) and England (52%) (LAIT 2014). It is possible to isolate data around each of the prime areas. Looking at Personal, Social and Emotional Development learning goals, Sheffield compares to England as follows:

- Self-confidence and self awareness: Sheffield 80.9% compared to England 85%
- Managing feelings and behaviour: 79.7% compared to 83%
- Making relationships: 81.6% compared to 85%

The percentage inequality gap for Sheffield, between the lowest achieving 20% and all children is 41.3%, this is similar to Yorkshire and Humber (40.1%) but greater than our statistical neighbours (37.61%) and England (36.6%) (LAIT 2014).

3.6 GCSE achieved 5A*-C inc English and Maths

Having GCSEs is associated with a reduced risk of depression at the age of 42 by five percentage points (Ubido et al 2012). In 2012/13 57.3% of Sheffield pupils achieved 5A*-C in GCSEs (including English and Maths). This compares to 59.5% in Yorkshire and Humber, 57.69% for our statistical neighbours and 59.2% for England (LAIT 2014).
3.7 Participation

3.7.1 Education, Training and Employment
Sheffield City Council undertakes an annual Y11s Leavers survey. This tracks the next destination of Y11 leavers e.g. continuing full time education, training, employment etc. The tables below are taken from the Citywide 2013 activity survey (IYSS database, PAS, Sheffield City Council).

This table summarises the destinations of the 2013 cohort – showing that 94.3% continue into learning – either as formal education, apprenticeships or employment with training. This is a slight increase on previous years: 2011 92.6%, 2012 92.4%.

<table>
<thead>
<tr>
<th>Summary</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time Education</td>
<td>2415</td>
<td>2555</td>
<td>5000</td>
<td>85.9%</td>
</tr>
<tr>
<td>Full Time Training (not emp)</td>
<td>155</td>
<td>75</td>
<td>231</td>
<td>4.0%</td>
</tr>
<tr>
<td>Employment with Training</td>
<td>184</td>
<td>77</td>
<td>261</td>
<td>4.5%</td>
</tr>
<tr>
<td>Employment without Training</td>
<td>26</td>
<td>4</td>
<td>30</td>
<td>0.5%</td>
</tr>
<tr>
<td>Part Time Employment</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>NEET</td>
<td>100</td>
<td>89</td>
<td>189</td>
<td>3.2%</td>
</tr>
<tr>
<td>Moved out of contact</td>
<td>9</td>
<td>16</td>
<td>25</td>
<td>0.4%</td>
</tr>
<tr>
<td>No response</td>
<td>41</td>
<td>45</td>
<td>86</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>2953</td>
<td>2971</td>
<td>5924</td>
<td>100%</td>
</tr>
</tbody>
</table>

The 2012 Y11 leavers from were invited to retake the survey in Dec 2013 – of this cohort 83.1% were now in learning and 9.3% were NEET.

For comparison the overall nationally reported NEET figures for a proportion of total age 16-18 year olds (2012): Sheffield 7.7%, compared with England average of 5.8% (CHIMAT 2014).

3.7.2 Participation in at least 3 hours of sport or PE at school
In 2009/10, 32 113 children took part in at least 3 hours of sport/PE per week: 49.5% compared with 55.1% nationally (CHIMAT 2013)

4 Risk factors for mental illness and disorders and low levels of emotional wellbeing

4.1 Overview
As described above there is little up to date prevalence data for mental disorders, and local data is dependent on extrapolation from national estimates. Prevalence data therefore needs to be complemented with data around risk factors and service provision. Looking at the prevalence data for risk factors gives an indication of the levels of local support needs for children and young people around emotional wellbeing and mental health.

Furthermore, addressing risk factors can prevent mental disorder as the number of people who have a particular disorder is directly related to the mean population level of the underlying symptoms or risk factors. A small reduction in average symptoms/risk factors within a population can reduce the overall number with mental disorder (Campion 2013). National policy therefore identifies that a twin track approach is needed for mental health: prevention and promotion as well as treatment (HMG 2011).

There is a significant opportunity during childhood and adolescence given most lifetime mental disorder has arisen before adulthood.

The prevalence of risk factors in Sheffield is characterised by inequalities across the city, these are described below where the data is available.
4.2 Inequalities and deprivation
The Index of Multiple Deprivation (IMD), combines a number of the other indices, and gives an overall score for the relative level of multiple deprivation experienced in small geographical areas. To produce the Overall IMD there are 38 separate indicators that are combined and weighted. Broadly, the indicators fall across seven Domains:
- Income
- Employment
- Health and Disability
- Education, Skills and Training
- Barriers to Housing and Services
- Crime
- Living Environment.

As such, relative IMD can give an indication of cumulative risk factors for poor emotional wellbeing and mental illnesses.

There is a great inequality in deprivation across Sheffield, and most of the city’s population live within relatively more deprived areas. There are 125,000 [22%] Sheffield people living within most deprived areas ranked as being in the worst tenth of areas nationally, and 47,000 [8%] living within least deprived areas ranked as being in the best tenth nationally.

Compared to all other local authorities in England Sheffield has relatively more deprivation, although it is not amongst the most deprived local authorities in the country. Compared to other nearby urban local authorities Sheffield is of a similar deprivation rank. We are ranked similar to Barnsley, Doncaster and Rotherham, and ranked more deprived than Bassetlaw. Manchester and Liverpool remain as the relatively most deprived Core Cities; Bristol is the relatively least deprived. Out of the 8 Core Cities, Sheffield is 6th least deprived.

Sheffield has within it great deprivation inequality. Rural areas to the west generally have the least deprivation; urban and industrial areas to the east have the most. However, there are pockets of deprivation within non-deprived surroundings. The map below shows how the areas of deprivation in the city.
The table below shows the map above as a bar chart form. The chart shows how the population of Sheffield is distributed across national deprivation deciles. The population is clustered towards higher levels of deprivation, with 22.0% residing in the most deprived decile of areas in England, and another 12.2% in the second most deprived decile; that makes a total of 34.2% of the Sheffield population living within the most deprived fifth of areas in England. This equates to 151,634 adults (18+) and 38,991 0-17 year olds.

### 4.2.1 Free School meals

Number of children in receipt of free school meals can also be used as a deprivation measure and can help to demonstrate challenges faced at school level.
There are 57 primary schools (out of 135 total) with FSM eligibility above the Sheffield primary school average (22.47%). 22 Primary schools have FSM eligibility above 40%, and there are 6 schools above 50%. The highest FSM eligibility in a primary school is 64.5%.

There are 11 secondary schools with FSM eligibility above the Sheffield secondary school average (17.8%). Only one secondary school has FSM eligibility above 40%, and the FSM eligibility at that secondary school is 40.6%.

For Sheffield overall there were 9375 Primary School children (22.5%) and 5,234 Secondary School children (17.8%) eligible for Free School Meals in 2014.

4.3 Parental factors

4.3.1 Maternal smoking and low birth weight

Smoking in pregnancy was shown to be linked to poorer developmental outcomes for the child at the age of five years. Further evidence has shown that early exposure to household tobacco smoke can be associated with increased propensity toward physical aggression and antisocial behaviour when the child is older (CHIMAT 2013a).

There is a seven fold difference at Local Area Partnership level in the proportion of women who are smoking ‘at delivery’, with higher rates in the more deprived areas. The percentage of Sheffield mothers smoking at delivery was lowest in 2009-2010 (13.6% equivalent to around 860 mothers). Over the last three years this has increased to 14.1% in 2012/13 (just over 900 mothers). This increase runs counter to the national trend – the national figure for 2012/13 was 12.7%.

Maternal smoking is a key risk factor for low birth weight - low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle factors of the mothers and/or lack of access to maternity services. In Sheffield in 2011 2.8% of term live babies were of low birth weight compared with a national figure of 2.9%.

4.3.2 Family breakdown or loss of a parent

In the 2004 B-CAMHS survey the prevalence of children with mental disorder was higher in lone-parent (16%) compared with two-parent families (8%). According to the 2011 Census there were 46 329 dependent children living in lone parent families in Sheffield.
4.3.3 Children in out of work families
Parental unemployment is linked to a 2–3 fold increased risk in onset of emotional/conduct disorder in childhood (Campion 2013). 26 400 0-16 year old children in Sheffield live in families where the parents are not working (including couple and lone parent families) (HMRC 2011).

4.3.4 Children of parents with mental disorder
Children are at increased risk for insecure attachment and externalising problems when their mothers are depressed, particularly if their depression is persistent. This effect of the depression does not merely reflect the correlation between poverty and depression. Depression makes it harder to be responsive and sensitive as a parent, and is often a response to other issues the family faces (Moullin et al 2014).

Babies appear to be particularly sensitive to mother’s stress and depression. One study of 570 families found that four-and-a-half year olds living with highly stressed mothers had high cortisol levels, but only if their mothers had also been under stress or depressed when the children were infants (Moullin et al 2014)

The Social Care Institute for Excellence (SCIE see CHIMAT 2013b) commissioned two systematic reviews in the area of parental mental health and child welfare. The first review considered evidence on the prevalence of mental health problems among parents and their detection in health, social care and children’s services. This research excluded post-natal depression.

They found that in a population of non-elderly adults, at any given time:
- 9 to 10% of women and 5 to 6% men will be parents with a mental health problem
- Most will have “common mental disorders” such as depression or anxiety
- A very small proportion will have any kind of psychotic disorder (for example schizophrenia).

The review looked at whether certain groups of parents were more likely to suffer from a mental health problem. The research found that mothers were at higher risk of mental health problems than fathers. Some evidence suggested that younger mothers were more likely to have a mental health problem than older mothers. The research attempted to estimate the number of children who have a parent with a mental health problem. While there is limited evidence, it is suggested that as many as 25% of children aged 5 to 15 years have mothers who would be classed as at risk for common mental health problems. This would mean that up to 15,150 children aged 5 to 14 years in Sheffield could be living with a parent dealing with mental health problems (CHIMAT 2013b)

4.3.5 Domestic Violence
There is no specific calculation to estimate the number of children affected by domestic abuse in Sheffield. However using available data, there is an estimated 12 276 children living with a female victim of domestic abuse (SSCB 2013).

4.4 School Factors

4.4.1 Persistent absence
Persistent absence is defined as absence for 15% of the time a child should be in school. The 2013/14 national average was 3.0% for primary and 6.4% for secondary. In Sheffield the persistent absence rates for 2013/14 were 4.4% (1613 children) for primary and 7.9% (2169 children) for secondary; these are slightly higher than the national average (3.0% and 6.4% respectively)

4.4.2 Exclusions
In 2013/14 there were 335 primary school children who were excluded for a fixed term (temporary exclusion); some were excluded more than once and the total number of exclusions was 746, resulting in 1413 school days lost. In the same year there were 18 primary school children (out of 41,727 total) who were permanently excluded from school.

In 2013/14 there were 1635 secondary school children who were excluded for a fixed term (temporary exclusion); some were excluded more than once and the total number of exclusions was 3943, resulting in 7502 school days lost. In the same year there were 78 secondary school children (out of 26084 total) who were permanently excluded from school.

Using national comparator figures for 2011/12 (LAIT 2013) Sheffield compares as follows:
### 4.4.3 Behaviour in schools - bullying

The Sheffield ECM survey 2013 was responded to by 8,926 children across Years 2, 5, 7 and 10. 37% of Y2s, 34% of Y5s, 27% of Y7s and 22% of Y10s said they had been bullied while in their current school year. This is an increase on reported levels for 2012 for Years 2, 5 and 10 (in 2012, 30% of Y2s, 33% of Y5s, 31% of Y7s and 38% of Y10s said they had been bullied while in their current school year). Further investigation into the data for Y10s found that there was a higher frequency of depression and feelings of sadness; anger; anxiety and stress experienced by children who reported having been bullied. It should be noted that these factors could be a result as well as a cause.

### 5 Particular groups at higher risk of mental illness and disorder and low emotional well-being

#### 5.1 Overview

#### 5.2 Looked After Children

**5.2.1 LAC and prevalence of mental disorders**

A national survey carried out by Meltzer et al in 2002 on behalf of the ONS and cited in the statutory guidance found that 45% of looked after children aged 5-15 were assessed as having a mental health disorder. This figure rose to 72% for those in residential care. This compares to around 10% of the general population aged 5-15.

37% of looked after children had conduct disorders, 12% had emotional disorders (anxiety and depression) and 7% were hyperactive. Some looked after children had more than one type of disorder. When compared to children from private households, even those from the most deprived socio-economic groups, looked after children had significantly higher rates of mental health disorders (Ford et al, 2007 as cited in statutory guidance).

A further longitudinal study of children who remained in care for at least a year found that at the point of entry into care 72% of looked after children aged 5-15 had a mental or behavioural problem. This study also included under 5’s and showed that nearly 1 in 5 showed signs of emotional or behavioural problems (Sempik et al (2008), as cited in statutory guidance).

A study by Beck in 2006 in an inner-London local authority used the Strengths and Difficulties questionnaire to compare the mental health of looked after children who move placement frequently. The study found that young people who had moved placement three or more times in the last year were three times more likely to have a ‘probable’ psychiatric diagnosis. They were also significantly more likely to report deliberate self-harm in the last six months compared to those who had moved placement less frequently.

As at 31st March 2014 there were 536 children being looked after by Sheffield City Council, two thirds of whom were placed within Sheffield (354 out of the 532 whose placement addresses could be traced). Overall numbers of Sheffield looked after children have been substantially lower than other core cities and statistical neighbours since before 2007 and have been lower than the national and regional averages since 2010. In March 2014 Sheffield had 47 looked after children for every 10,000 in the under 18 population; this is far lower than all statistical neighbours, the closest of which being Rotherham with 70 (SCC LAAC Strategy 2014).

**5.2.2 Strengths and Difficulties Questionnaire (SDQ)**

In 2008 the SDQ was introduced as a national measure of the emotional health of children between the ages of 4 and 16 who have been in care for at least 12 months. The SDQ is a short behavioural screening questionnaire. It

<table>
<thead>
<tr>
<th></th>
<th>Sheffield</th>
<th>Statistical neighbours</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary fixed period exclusions</td>
<td>1.12%</td>
<td>1.22%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Primary permanent exclusions</td>
<td>-</td>
<td>0.02%</td>
<td>0.02%</td>
</tr>
<tr>
<td>Secondary fixed period exclusions</td>
<td>8.87%</td>
<td>9.79%</td>
<td>7.85%</td>
</tr>
<tr>
<td>Secondary permanent exclusions</td>
<td>0.06%</td>
<td>0.18%</td>
<td>0.14%</td>
</tr>
</tbody>
</table>
has five sections that cover details of emotional difficulties; conduct problems; hyperactivity or inattention; friendships and peer groups; and also positive behaviour.

Average total difficulties score and coverage are reported nationally as part of the annual statistical return. For this national statistical return process the primary carer is the only person who completes the questionnaire, and this has a significant influence on the figures reported in this analysis and must be considered in the interpretation of this analysis. A high score represents a higher level of difficulty.

The average SDQ score for LAC aged 4-16 in Sheffield in 2014 (15.9) is higher than that in England (13.9) and Yorkshire and the Humber (14.1). It is not possible to calculate statistical significance from the available data.

The charts below show how Sheffield LAC score in the SDQ against comparative national figures (data gathered from a national sample of children). It shows that more of LAC score more highly in the SDQ than the national sample. (Source: SCC PAS 2013)
5.2.3 LAC and Population risk factors

LAC as a population are much more vulnerable to risk factors found in the general population. In Sheffield there are much lower numbers of LAC in comparison to our statistical neighbours – this means that it is more likely that those children who are looked after in Sheffield demonstrate a higher need for support and higher prevalence of risk factors compared to LAC in other cities. e.g.

- In summer 2013 the 5 A* - C inc English and Maths GCSE achievement rate for children aged 16 who have been looked after continuously for at least 12 months is 16.3% compared with 57.3% for all children. This compares with 14.1% in Yorkshire and Humber; 15.30% in England and 18.08% for statistical neighbours.

- The Sheffield School Census of January 2013 indicates that the proportion of LAC educated in Sheffield who have registered SEN needs is similar to the general population, though these are distributed more towards SA+ and Statements, as shown in the table below.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>School Action</td>
<td>4.1</td>
<td>11.3</td>
<td>3.6</td>
<td>10.3</td>
<td>3.1</td>
</tr>
<tr>
<td>School Action Plus</td>
<td>13.5</td>
<td>10.8</td>
<td>15.8</td>
<td>10.9</td>
<td>14.8</td>
</tr>
<tr>
<td>Statmented</td>
<td>8.9</td>
<td>2.7</td>
<td>7.6</td>
<td>2.6</td>
<td>7.3</td>
</tr>
<tr>
<td>Total SEN</td>
<td>26.5</td>
<td>24.8</td>
<td>27.0</td>
<td>23.8</td>
<td>25.3</td>
</tr>
</tbody>
</table>
The graph below shows that a greater proportion of LAC SEN primary needs are for behaviour, emotional and social difficulty as compared to the non-LAC school population.

- Care leavers are less likely to be in education, employment or training than the general population. The numbers in education, employment and training have declined to 57% (2013) from a peak of 80% in 2011. Current LAC figures are similar to national, Yorkshire & Humber and our statistical neighbours. In 2014 the focus was on 19, 20 and 21 year old care leavers of which 34% were in education employment or training. However, there is not currently any comparable information for this figure.

- Offending by children aged 10-17 who have been looked after continuously for at least 12 months has declined steeply over the last 4 years to a rate of 5.9% in 2014. This decline is reflected nationally.

### Offending by children who have been looked after continuously for at least 12 months

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheffield</td>
<td>13</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Core cities</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Yorkshire &amp; the Humber</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Statistical neighbours</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>England</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
There is conflicting data regarding rates of substance misuse by children who have been looked after continuously by more than 12 months. The DfE Statistical First Release shows that 1.0% of LAC are recorded by social workers as having a substance misuse problem; however the Tier 3 treatment population records show that 16.5% of LAC are currently receiving treatment for substance misuse. This indicates that there may be serious under-recording issues.

5.3 Children with Learning Disabilities and Special Educational Needs

There are an estimated 0.7 million disabled children in the UK (ONS 2007). Boys are twice as likely as girls (69% to 32%) to be categorised as disabled. Children under five are less likely to be known to be disabled and there are equal numbers of young people in age range 5-11 years old and 12-18 years old (TCRU, 2008). Nationally, ONS estimated that there are 42.3 per 1,000 children who are disabled (ONS, 2007).

Children with a long-term physical illness are twice as likely to suffer from emotional or conduct disorder problems (DH 2011a). Although there is reason to suspect that people with physical disability will experience a higher rate of mental health conditions compared to people without disabilities, there is a lack of literature in this area, especially amongst children with disabilities (Hagiliassis et al, 2005).

A review of the evidence on the emotional wellbeing of young people by the University of London (TCRU, 2007) found the following links between learning disability and mental health:

- children with learning disabilities were three to four times more likely to have behavioural problems than peers without a disability;
- there is a 40% prevalence of diagnosable mental disorder within the learning disabled population of children, young people and adults; for children and young people with severe learning difficulties, the incidence rate is three to four times higher than in the general population;
- the learning disabled living in urban and deprived communities are at particular risk of emotional wellbeing and mental health problems
- one in ten of all children with referred mental health problems had a learning disability, and 50% of those lived in poverty.
- 25-30% of the increased risk of emotional and behavioural problems among children with learning difficulties was related to households with very low income;
- the presence of intellectual disabilities should be considered a highly significant risk factor for the development of some specific forms of psychiatric disorders (conduct disorders, anxiety disorders, attention deficit and hyperactivity disorder/hyperkinesis and pervasive developmental disorders);
- research has suggested the prevalence of intellectual disabilities among South Asian children and young people is three times higher than in other communities. (TCRU, 2007 in Ubido et al 2012)
- Higher levels of absenteeism have been reported for school children with special educational needs, especially those with learning disabilities and emotional disturbances (Redmond and Hosp, 2008 in Ubido et al 2012).

The diagram below shows the overlap between SEN and disability.
Sheffield data illustrates that overall there has been a decrease in numbers of children identified with SEN overall, however patterns are changing. Between 2009 and 2014 there has been an overall decrease in numbers of children registered on School Action Plus (from 7843 to 7447 children; peak of 8265 in 2010) and SEN (from 2038 to 1915 children).

The charts below show the categorisation of SEN primary need for School Action + and SEN and the following points can be noted:

- decrease in % of ‘other’ categorisation, implies that there is a more sensitive recording of children’s needs
- increase of Autistic Spectrum Disorder categorisation at SEN and a greater increase at SA+
- decrease in Behaviour, Emotional and Social difficulty at SA+ and a slight increase at SEN statement level
- decrease in SEN statements where physical impairment or visual impairment is the primary need; and an increase in SA+ for these categorisations.
- Decrease in SEN and SA+ categorisation of moderate and specific learning difficulties

It can be inferred from the charts that there is a change in profile of student’s primary needs as they are categorised by SA+ and SEN. This may reflect an underlying change in SEN profiles or could reflect more sensitive recording.
SEN prevalence in Sheffield varies by ward and reflects the deprivation profile.

5.4 Children with parents in prison
Findings from qualitative interviews conducted with the children of imprisoned parents (n=17) indicated a range of emotions relating to their situation, including being upset, angry, and shocked, as well as hoping that their father will return, with their biggest fear being that he may not. Children also had the feeling of being stigmatised, reporting that they often kept their parents imprisonment a secret from others around them (Williams et al 2012).

Children of prisoners have about twice the risk of antisocial behaviour and poor mental health outcomes compared to children without imprisoned parents, although it is difficult to establish causality as these problems may have been caused by other disadvantages in children’s lives that existed before parental imprisonment occurred.

In Sheffield there are estimated to be about 1360 children who currently have a parent in prison (from Barnados Children of Prisoners work, based on 200,000 such children in the UK - 1% of the total child population of the country).

5.5 Young People who are NEET and at risk of NEET
Being in education, employment and training between the ages of 16-18 increases a young person’s resilience and is essential to their future employability and wellbeing (ChiMat 2012). Being NEET between the ages of 16-18 is a major predictor of later unemployment, low income, teenage motherhood, depression, and poor physical health. A study by the Princes Trust found that Young people aged 16-25 not in work are less likely to be happy.
Children and Young People's Emotional Wellbeing and Mental Health: Health Needs Assessment

(reported in Freer et al, 2010, p.243). In Sheffield in 2013-14 (Nov-Jan average) there were 1109 young people not in education, employment or training. As a proportion of total age 16-18 year olds: this equates to 6.6%, compared with an England average of 5.3% (CHIMAT 2014)

There is a further cohort of young people who are identified as being At Risk of NEET – these young people are identified using a scoring matrix which includes vulnerability measures such as IMD, attendance, exclusions, attainment and referral to Educational Psychology.

5.6 Young Offenders
Young offending as measured by First Time Entrants to the Youth Justice System (age 10-17) rates per 100,000 population has decreased locally to 369.5 per 100,000 from a peak in 2005 of 2493 - this equates to 180 children and young people in 2012. There is a decreasing national trend as shown in the figure below and Sheffield compares favourably to England (534.0)

The ECM survey (2013) found that 26% of Y10s said they had been involved in committing some form of anti-social behaviour. The top reason they had done it was ‘boredom’. This was also the main reason given in 2011 and 2012. An additional option was added in 2012: ‘Because I had been drinking or taking drugs’. 27% selected this option as a reason for their involvement in anti-social behaviour in 2012, compared to 24% in 2013

The correlation between young people involved in the criminal justice system and mental health and emotional wellbeing needs has been documented in a number of studies over the years and most recently highlighted in the research published by Young Minds: ‘Same Old… the experiences of young offenders with mental health needs.’ (Young Minds 2013). A study from the National Office of Statistics found that 95% of young people in young offenders’ institutions aged between 16 and 20 years had a mental disorder and many of them had more than one disorder (Lader, et al, 1997). More specific to Sheffield, the Youth Justice Service undertook an audit in February 2014 which found that over, a two year period, 87% of cases sampled had an identified emotional or mental health need. Within the audit the most common behaviour related to these needs was the presentation of anger and aggression. This is undoubtedly one of the reasons for violence being a top cause of young people entering the criminal justice system. The second and third most common presentations of mental health and emotional wellbeing needs were suicide attempt/ideation and self-harm, showing that these young people pose a risk to themselves as often as others.

5.7 Substance misuse
Substance misuse is associated with significant health risks including anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death. Young people who smoke cannabis by the age of 15 are 3 times more likely to develop serious mental health illnesses including schizophrenia (Arseneault et al, 2002 in Freer et al, 2010).
Young people in the treatment population are more likely to be male than female: 80 (73.4%) compared to 29 (26.6%) which is a trend more pronounced in the Sheffield population than seen nationally.

The age profile of the treatment population in Sheffield leans towards the older age group of 16 and 17 year olds. Younger age groups (< 15 years of age) have all seen increases over the last four years of data.

There is no direct referral route into CAMHS from substance misuse services, referral is via MAST. There are case study examples of challenges presented by dual diagnosis of substance misuse and mental health disorders whereby mental health interventions are delayed subsequent to management of the substance misuse.

5.8 Young Carers
A Carers Health Needs Assessment was carried out by NHS Sheffield in 2012 (Gilwhite 2012) which outlined health needs of carers of all ages including young carers. The findings show that Young carers as a population are at increased risk of the prevalence of risk factors for poor mental health as outlined in this report. The potential risks to physical and mental health for young carers include: physical strain such as backache, mental strain such as stress and tiredness; truancy and underachievement at school and college; increased risk of coping behaviours such as self-harm or substance misuse. Young carers are affected by poverty and isolation resulting from family illness or disability, low income and dependence on benefits. This is coupled with stress and worry of having a sick or disabled parent.

Young carers are at particular risk of experiencing educational and employment inequalities as a result of high levels of caring responsibilities. Longer hours of caring can limit attendance at school and completing school work and make transitions into adulthood and employment more problematic.

Attendance at school or college can be sporadic for young carers and when they do attend they can be tired, pre-occupied and unable to focus on their studies. This can result in young carers being at a disadvantage in terms of staying in education to gain qualifications and employment. A profile of young carers in the Yorkshire and Humber region (2010) highlighted that ‘young adult carers, aged 16-19 were much less likely to have any qualifications or to be in employment or educations that other people of this age’.

It is estimated that there are at least 2000 children and young people under the age of 16 caring in the city.

5.9 Black and Minority Ethnic groups
The ethnic composition of the Sheffield population is shown below

<table>
<thead>
<tr>
<th>Ethnicity Breakdown for Sheffield School Pupils, 2014</th>
<th>Primary School Children (Years 0-6)</th>
<th>Secondary School Children (Years 7-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage of Total</td>
</tr>
<tr>
<td>White British</td>
<td>27713</td>
<td>65.9%</td>
</tr>
<tr>
<td>Any other White Background</td>
<td>2276</td>
<td>5.4%</td>
</tr>
<tr>
<td>Indian</td>
<td>300</td>
<td>0.7%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>3503</td>
<td>8.3%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>497</td>
<td>1.2%</td>
</tr>
<tr>
<td>Any Other Asian Background</td>
<td>763</td>
<td>1.8%</td>
</tr>
<tr>
<td>Any Black Background</td>
<td>2228</td>
<td>5.3%</td>
</tr>
<tr>
<td>Any Mixed Background</td>
<td>2988</td>
<td>7.1%</td>
</tr>
<tr>
<td>Any Other Ethnic Background</td>
<td>1543</td>
<td>3.7%</td>
</tr>
<tr>
<td>Black/Minority Ethnic (BME) Total</td>
<td>14098</td>
<td>33.5%</td>
</tr>
<tr>
<td>Information Not Available</td>
<td>264</td>
<td>0.6%</td>
</tr>
<tr>
<td>Total</td>
<td>42075</td>
<td></td>
</tr>
</tbody>
</table>

The B-CAMHS survey found some variation in mental health by ethnicity, however as there were only a small number of ethnic minority children and young people in the studies the findings should be treated with caution. The
survey showed that children aged 5–10 who are white, Pakistani or Bangladeshi appear more likely to have a mental disorder than black children. Indian children are least likely to have such problems. Amongst black girls aged 11-16 however, the prevalence of mental health problems is much higher than average, at 17.1%, compared with 10.3% for all girls in that age group (ONS, 2005). Overall prevalence rates for ages 5-16 are as follows:

- Black children 12%;
- White children 10%;
- Pakistani and Bangladeshi children 8%; and
- Indian children 4%.

A review of the evidence on the emotional wellbeing of young people by the University of London (TCRU, 2007) found the following links between ethnicity and mental health:

- people from black and minority ethnic communities are those most commonly cited as finding mental health services difficult to access because of either language barriers or cultural issues
- studies found that ethnic background influenced which service provider was likely to refer children and young people to CAMHS. While White British children were more likely to be referred by GPs, Black and South Asian children were more likely to be referred by specialist doctors, Black children by education services, and mixed race children by social services.
- research into differences in help seeking patterns between Pakistani and White British mothers indicated that Pakistani and White British mothers were both good at identifying problems of emotional wellbeing and mental health in their children, yet, despite this, Pakistani mothers were less likely to seek treatment or consider a referral to CAMHS for mild or moderate problems

(TCRU, 2007)

5.9.1 Asylum Seekers, refugees and immigrants

Asylum seekers arriving in the UK or any other host nation may have a very limited knowledge of the health care and welfare systems of that nation (Crawley, 2010). They are likely to experience poverty, dependence and a lack of cohesive social support arriving in a new country as a refugee. Children and young people could be living with adults that are unfamiliar to them. They may have experienced the death of a close family member or friend, or be unaware of their current circumstances leading to an increased sense of vulnerability (Connelly et al. 2006). Such factors can undermine both physical and mental health. Health is culture dependent (Burnett & Peel, 2001) and both what a young person is able to talk about in relation to their health, and the symptoms they present with may be influenced by their cultural background and current circumstances. For example, in some cultures having stomach aches or headaches or a low mood, may be their way of discussing anxiety or depression. This is experienced locally and this lack of a shared language (including with interpreters) around mental health can cause delays in accessing appropriate treatment.

On top of the basic health needs, an asylum seeker is likely to face a restrictive, complex and overloaded asylum system in an alien society and psychological distress is widespread (Burnett & Peel, 2001). Communication is also likely to be a barrier in accessing health care as many GP surgeries or other health care settings do not make interpreters available leading to complex health problems being undetected. The new government mental health strategy noted that the rates of mental health problems in particular migrant groups, and subsequent generations, can be higher than in the general population. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries (DH, 2011a).

Most refugee children are entitled to routine health surveillance and health promotion (DoH, 1989). In fact, the new National Institute for health and Clinical Excellence (NICE) PH28 guidance, “Promoting the quality of life of looked after children and young people” includes references to unaccompanied asylum seeking children (UASC) and they have their own specific recommendations. For example, of the 52 recommendations in the report, no 10 is to “ensure access to mental health services for UASC who are looked after”. However, many young refugees find health services very difficult to access. Studies of refugees of all ages have found that one in six has significant physical health problems and over two thirds have suffered from anxiety or depression (Carey-Wood et al. 1995). This figure is likely to include children and young people. Higher rates of mental health problems in children from asylum seeker or refugee backgrounds are likely to be related to experiences they have had prior to arriving in the UK. The impact of war, torture, loss, disrupted attachments to parents and fear all impact on emotional and mental health, but so do social exclusion, isolation and racism on arrival in the UK (Levenson & Sharma, 1999).

(references above all in Ubido et al 2012)
5.9.2 Gypsy, Roma and Traveller children

It has been noted that Gypsy, Roma and Traveller children have the worst education outcomes of any ethnic group in the UK and high rates of school exclusion (Ridge, 2010). Ridge found that many Gypsies and Travellers say that the anti Gypsy Traveller racism they experience in the school and education system often leads to young people dropping out of school. This was found to be most marked in secondary school. This is likely then to have an important impact on social inclusion, achievement and mental health of Gypsies, Travellers and Roma right across the life course.

There is a shortage of literature on the mental health needs of travelling children. A study of the health status of adult Gypsy Travellers in Sheffield found that the proportion reporting any problems with ‘nerves’ or ‘feeling fed up’ was significantly greater than a matched comparison group of urban deprived residents (35% compared to 19%) (Van Cleemput and Parry, 2001). Van Cleemput and Parry used this terminology rather than ‘anxiety and depression’ which they found may have been unfamiliar to some of the gypsy and traveller community.

Recently there has been extensive local data profiling on the Sheffield Roma children population – as such we now have a good understanding of demographic and school factors which enables some correlation with risk factors for poor mental health. For the purpose of these reports, ‘Roma’ is used as an umbrella term to categorise a vulnerable group of pupils in Sheffield. It should be made clear that this is not ascribing ‘Roma’ as an ethnic category to any pupil, and that this categorisation is based on locally available information about communities living in the city for the sole purpose of providing support to those communities and to the schools which these pupils attend.

In terms of detail, these reports have defined ‘Roma’ on the following basis:

- If pupils have an ethnic code of ‘White Gypsy/Roma’;
- If they have an ethnic code of ‘White Eastern European’, ‘Any Other Ethnic Group’ or ‘Any Other White’ and Slovak as their first language;
- Or if they have ‘Romany English’ or ‘Romany International’ as a first language regardless of their ethnicity.

As per the above definition there are currently over 2100 Roma pupils in Sheffield’s educational system (including post-16 settings). Roma pupils experience a greater prevalence of risk factors of poor mental health:

- They are more likely experience deprivation as measured by eligibility for free school meals as a population levels are equivalent to those wards which have highest levels of eligibility citywide (Schools data SCC PAS 2014)
- Less likely to achieve a good level of development at age 5: 3% compared to city average of 52% (Early Years Foundation Stage attainment 2013; Schools data SCC PAS 2014)
- Less likely to achieve 5 A*-C GCSEs including English and Maths: 2% compared to 57% city average (KS4 Attainment schools data SCC PAS 2014)
- More likely to be persistently absent from school compared to city average: primary 11%, compared to 4% and secondary 12% compared to 6%. (Schools absence trends; Schools data SCC PAS 2014)
- More likely to be excluded from school 22%, compared to city average of 14% (Schools absence trends; Schools data SCC PAS 2014)
- In secondary schools more likely to be registered as SEN: 39% compared with 24% (Schools data SCC PAS 2014)
- The proportion of Roma at risk of becoming NEET is higher than the overall school figure. Currently, 24% of Roma children are in the top 8% most at risk of becoming NEET in the city. (At risk of NEET; Schools data SCC PAS 2014)

6 Prevalence of Mental Disorders

6.1 Overview

Mental disorders arise early in the life course and impact on a young person’s development and can stop them realising their potential. Furthermore mental disorders often last for a long period of time:

- 50% of lifetime mental illness (except dementia) arises by age 14
- 40% of young people experience at least one mental disorder by age 16 (JCPMH 2013)
The figures below show the proportion of lifetime mental illness that starts by age 14 and by mid-twenties (source: Campion 2013)

**At Age 14**
50% of lifetime mental illness (excluding dementia) starts by age 14

**By Mid Twenties**
75% of lifetime mental illness (excluding dementia) starts by mid twenties

Mental disorder in childhood and adolescence is associated with:
- Poorer health, poorer social skills and lower levels of educational achievement
- Higher risk of self-harm and suicide
- Several fold higher levels of health risk behaviour including smoking, alcohol consumption and drug misuse
- Higher rates of antisocial and offending behaviour and violence
- Poorer outcomes and inequalities in adulthood: higher risk of homelessness; unemployment and debt problems; crime and violence

(JCPMH 2013)

The table below shows the relationship between emotional and conduct disorder and other health risk behaviours (source: Campion 2013)

<table>
<thead>
<tr>
<th>Risk Behaviour</th>
<th>Emotional disorder (4%)</th>
<th>Conduct disorder (6%)</th>
<th>No mental disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke Regularly (age 11-16)</td>
<td>19%</td>
<td>30%</td>
<td>5%</td>
</tr>
<tr>
<td>Drink at least twice a week (age 11-16)</td>
<td>5%</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>Ever Used Hard Drugs (age 11-16)</td>
<td>6%</td>
<td>12%</td>
<td>1%</td>
</tr>
<tr>
<td>Have ever self harmed (self report)</td>
<td>21%</td>
<td>19%</td>
<td>4%</td>
</tr>
<tr>
<td>Have no friends</td>
<td>6%</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>Have ever been excluded from school</td>
<td>12%</td>
<td>34%</td>
<td>4%</td>
</tr>
</tbody>
</table>

6.1.1 UNICEF Child well-being in rich countries: A comparative overview; Innocenti Report Card 11
UNICEF (2013) recently carried out a comparative study of children’s wellbeing in 29 industrialised countries which puts the UK in 16th position, this is an improvement from the position stated in the previous study (2007) in which
the UK ranked lowest. The 2013 score and is developed from 5 dimensions of wellbeing: Material Wellbeing (UK ranked 14th); health and safety (16th); education (24th); behaviours and risks (15th); housing and environment (10th). The report authors note that this relates to 2009/10 data and as such we do not yet see full impact of economic shifts since 2008.

The report also provided a Children’s Life Satisfaction League Table which looked at self-reported measures of wellbeing, the UK ranked 14th by this measure.

6.2 Sheffield prevalence

There are a number of national studies which can be used to estimate Sheffield prevalence by applying the national estimates to the Sheffield population (using ONS 2012 mid-year estimates).

6.2.1 Early years

Despite the increasing recognition of the importance of the early years as a focus for early intervention, there has been less research on the profile and rates of problems in the under-5s. One study showed that the prevalence of mental health problems for 3-year-old children was 10% (equivalent to 686 3 year olds in Sheffield) with 66% of parents sampled having one or more concerns about their child. A further study showed that 7% of children aged 3–4 years exhibited serious behaviour problems (equivalent to 955 3-4 year olds in Sheffield).

Differentiating normal from abnormal behaviour in younger children can be difficult and a substantial proportion of children will ‘grow out of’ early childhood problems, particularly among the under-3s. However, longitudinal studies suggest that 50–60% of children showing high levels of disruptive behaviour at 3–4 years will continue to show these problems at school age. Moreover, neurodevelopmental problems including language delay, ADHD and autism spectrum disorders are first manifest in the pre-school years. (CMO report)

Sheffield has recently submitted a final stage bid to the Big Lottery Fulfilling Lives programme. This has a focus on 0-3 year olds and 3 specific themes within this bid: Communication and Language, Nutrition and Social and Emotional Development. There was a significant amount of research carried out to inform this bid.

The Social Research Unit at Dartington (2014) undertook some research to inform an Area Well being profile – this was a household survey which targeted 600 households across Sheffield (weighted to the three target wards for the lottery bid Manor Castle, Darnall and Shiregreen and Brightside). There were some key findings which indicate prevalence of mental health problems or risk factors in the early years – though the small data sample should be acknowledged.

- Poor communication and language development: Sheffield 4.9% compared to English/US average of 9%
- Poor social and emotional development: Sheffield 31.8% compared to English/US average of 37%
- Not ready for school: 26.1% (no national comparator). A child is considered as not being ready for school if they have at least two or more impairments in the following areas: communication and language; social and emotional development; behaviour; and any chronic health conditions. School readiness is assessed from three to eight years of age. It therefore includes how ready children are for school both prior to and during the early years of school.
- Early onset of poor behaviour (measured by SDQs): Sheffield 19.5% compared with UK average 4.6%
- Poor self-regulation 12.2% (no national comparator). Self-regulation is the child’s ability to think before acting and manage their emotions when upset or distressed.
- At least one chronic health condition (including obesity): 27.4% (no national comparator)

The data also estimates likely prevalence of ADHD/hyperactive disorder amongst 4-8 year olds as 12.7%.

6.2.2 Estimates of prevalence of mental disorders in children aged 5-16

The most recent British surveys carried out by the Office of National Statistics of children and young people aged 5-15 in 1999 and 2004 (these are often referred to as the British Child and Adolescent Mental Health Surveys or B-CAMHS) found that 10% had a clinically diagnosable mental health disorder. The table below show how this breaks down into types of disorder and how these figures would apply to the Sheffield population.
6.2.3 Estimates of prevalence of Neurotic Disorders in young people aged 16-24

A study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 24 inclusive living in private households. The tables below show how many 16 to 24 year olds would be expected to have a neurotic disorder if these prevalence rates were applied to the population of Sheffield.

### National Prevalence Estimates (rate per 1000 population) of Neurotic Disorders, Applied to Sheffield Population (Singleton et al. 2000)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Women</th>
<th>Men</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-19</td>
<td>16502</td>
<td>29654</td>
<td>16683</td>
</tr>
<tr>
<td>20-24</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Age Group**
- 16-19
- 20-24

**Mixed anxiety and depressive**
- Rate: 124
- Number: 2046

**Generalised anxiety disorder**
- Rate: 11
- Number: 182

**Depressive episode**
- Rate: 27
- Number: 446

**All phobias**
- Rate: 21
- Number: 347

**Obsessive compulsive disorder**
- Rate: 9
- Number: 149

**Panic disorder**
- Rate: 6
- Number: 99

**Any neurotic disorder**
- Rate: 192
- Number: 3168

PH Intelligence Team, SCC, Jan 2014

6.2.4 Estimates of prevalence of mental disorders in young people aged 16-24

Young people aged 16 and over are included in the Office for National Statistics surveys of adult psychiatric morbidity. In the 2007 survey of adults in England in the 16–24-year-old age group: 16.4% experienced anxiety disorder; 2.2% experienced a depressive episode; 4.7% screened positive for posttraumatic stress disorder; 0.2% had a psychotic illness and 1.9% had a diagnosable personality disorder. (Davies et al 2012)

6.2.5 Self-harm and Suicide

Self-harm among young people is a major concern. In the 2004 ONS survey (Green et al) the rate of self-harm in 5–10 year olds was 0.8% in those with no disorder, rising to 6.2% in those with an anxiety disorder and 7.5% among the group of children with hyperkinetic disorder, conduct disorder or one of the less common disorders. The prevalence increased dramatically in adolescence with rates of 1.2% in those with no disorder, rising to 9.4% in those with an anxiety disorder and 18.8% in those with depression.
Childline (Can I Tell You Something 2013) recently reported that in 2012/13 they counselled 22,532 young people whose main concern was self-harm. This represented 8 per cent of all the counselling that took place this year, compared with 5 per cent the previous year.

In total self-harm was mentioned in almost 47,000 counselling sessions representing a 41 per cent year-on-year increase. Where age was known, 70 per cent of the contacts received about self-harm came from young people aged 12-15 years.

In 2011/12 self-harm was a top five concern for 14 year olds. This year, it featured as a top five concern for 13 year olds for the first time. There was also nearly a 50 per cent rise in contacts with 12 year olds about self-harm – the highest increase of any age.

Over the past year it has become clear there is an enormous divide in the genders when it comes to self-harm – with girls outnumbering boys by 15:1. There was a 37 per cent increase in self-harm counselling with girls, compared with 10 per cent with boys.

Local data (SCH NHSFT 2014 unpub.) shows a marked increase in recent years in the number of children attending SCH A&E following a Deliberate Self-Harm.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Time period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>86</td>
<td>Jan-Dec</td>
</tr>
<tr>
<td>2005</td>
<td>80</td>
<td>Jan-Dec</td>
</tr>
<tr>
<td>2006</td>
<td>103</td>
<td>Jan-Dec</td>
</tr>
<tr>
<td>2007</td>
<td>77</td>
<td>Jan-Dec</td>
</tr>
<tr>
<td>2008</td>
<td>71</td>
<td>Jan-Dec</td>
</tr>
<tr>
<td>2009</td>
<td>83</td>
<td>Jan-Dec</td>
</tr>
<tr>
<td>2010</td>
<td>86</td>
<td>Jan-Dec</td>
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<tr>
<td>2011</td>
<td>101</td>
<td>Jan-Dec</td>
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<tr>
<td>2012</td>
<td>127</td>
<td>Jan-Dec</td>
</tr>
<tr>
<td>2013</td>
<td>165</td>
<td>Jan-Dec</td>
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</tbody>
</table>

In a 2007 survey of young adults (McManus et al 2009) 6.2% of 16–24 year olds had attempted suicide and 8.9% had self-harmed in their lifetime. Suicide is the leading cause of death in young people. The suicide rate among 10–19 year olds is 2.20 per 100,000; it is higher in males (3.14 compared with 1.30 for females) and in older adolescents (4.04 among 15–19 year olds compared with 0.34 among 10–14 year olds). Recent research has shown a significant fall in the rates among young men in the period 2001–2010. Sheffield rates are slightly lower than national rates.

6.3 Changes in prevalence of mental disorders
Research looking over a 25 year period from 1974-1999 found increases in conduct problems in young people, affecting males and females in all social classes and family types. There is also evidence for a rise in emotional problems, but mixed evidence in relation to rates of hyperactivity.

Evidence for a recent rise in levels of psychological distress is provided by data from the West of Scotland Twenty-07 study in which marked increases in GHQ 12 ‘caseness’ (a scoring system for mental health) were found in females between 1987 and 1999, and in both males and females between 1999 and 2006. (Davies et al 2012)

6.4 Self-reported emotional wellbeing and mental health
National data estimates can be supported with local survey data. The Every Child Matters Survey has been carried out annually since 2006 and in 2013 just under 9,000 children from 88 schools responded. The survey asked students a range of questions about health and wellbeing, staying safe, perceptions of where they live, home life and school life.

In response to questions about emotional wellbeing the majority of young people in Y10 said they feel happy most of the time. Around 10% said they hardly ever or never feel happy.
Regarding negative emotions experienced by young people (Y10), the following graph shows the percentages of respondents who said they feel the emotions listed ‘most of the time’. Analysis of these statistics by gender showed that, overall, females are more likely to feel these types of emotions. The highest differences related to feeling stressed (14% higher for females) and feeling (11% higher for females).

Every Child Matters Survey Report 2013

The survey has also identified that although the number of Y10s saying they feel sad or depressed ‘most of the time’ increased from 9% in 2011 to 14% in 2012, for 2013 the proportion remained the same as that for 2012 (14%).

There is however evidence to suggest that the majority of Y10 children are normally contented and happy. 90% (1,514) of respondents said that they felt happy or contented some or all of the time. This partially contradicts the responses for the question on sad or depressed.

Further positive findings relate to available support for those dealing with negative feelings. Only 3.3% (54) of Y10 respondents said that they wouldn’t know who to talk to if they needed advice or support to help them deal with their feelings, although 14.7% (243) said that they wouldn’t want to talk to anyone.
7 Young People’s Perspectives – Right Here Sheffield

Right Here Sheffield was a partnership project managed by YMCA White Rose with the support from Chilypep and 7 other partners from the voluntary and statutory sector: YASY, Sheffield Futures, Interchange Sheffield CIC, NSPCC, Sheffield City Council, Child and Adolescent Mental Health services (CAMHS SCH NHS FT), Adult Mental Health (SHSC NHS FT). The programme ran from September 2009 – October 2013, and worked with children and young people aged 16-25, with a focus on those more at risk of developing poor mental health and who may find it harder to access support e.g. young people who are NEET, young parents and black and minority ethnic young people.

7.1 Programme delivery

There were 3 strands to the work:

1. Early intervention and prevention activities: including therapeutic group work and workshops
2. Young people’s involvement: staff recruitment, project design, evaluation, designing and developing anti-stigma and awareness raising materials for other young people
3. Influencing young people’s mental health provision in the city including service design to meet the needs of this age group

7.2 Evaluation and recommendations

The project evaluation made the following 5 recommendations for learning and future service development in the city

1. An integrative approach to young people’s mental health – based on young people’s needs and supported by the development of positive relationships.

2. Young people’s involvement in mental health provision as a principle, including the design, delivery and evaluation of services.
   a. Provide training to support young people’s involvement
   b. Use peer based group work approaches with full partnership working between the delivery practitioners and young people
   c. Use participation models that are relevant to young people and to the organisation to create meaningful opportunities

3. Creating opportunities for discussions around mental health e.g. PSHE in schools and colleges, peer led Mental Health Ambassador programmes, building the capacity of youth workers to have these conversations.

4. A mental health service designed for young people offering help early on

5. The importance of relationships and building social capital through group work opportunities
7.3 A young person centred model for mental health in Sheffield

Right Here also developed a redefined model for mental health in Sheffield. This shows the provision available according to the need of the young person.

Right Here Mental Health and Emotional Well Being Model for 16-25 year olds in Sheffield

- **Level of Need - 1**: Promotion and Prevention
  - Do I know how to look after my emotional well-being?
  - Type of support and who it is provided by:
    - Level of need 1 -12
    - Type of support: Individual/Counselling
    - Location: Health and Wellbeing Line

- **Level of Need - 2**: Exploring my needs
  - Who can I talk to about my emotional well-being?
  - Type of support and who it is provided by:
    - Level of need 1 -12
    - Type of support: Support group/Peer Support
    - Location: Community Centres

- **Level of Need - 3**: Early intervention
  - What should I do?
  - Type of support and who it is provided by:
    - Level of need 1 -12
    - Type of support: Early intervention Services
    - Location: Primary Care

- **Level of Need - 4**: Support for more serious mental health problems
  - I have more serious mental health needs (moderate - severe)
  - Type of support and who it is provided by:
    - Level of need 1 -12
    - Type of support: Hospital Inpatient, Community Mental Health Teams
    - Location: Community Centres

- **Level of Need - 5**: Early crisis support
  - Need to cut crisis support
  - Type of support and who it is provided by:
    - Level of need 1 -12
    - Type of support: Hospital Inpatient, Community Mental Health Teams
    - Location: Community Centres

7.4 A young people’s mental health manifesto

As part of Right Here Sheffield’s campaign work they wrote a manifesto around youth mental health to set out the issues that young people face and recommendations on how these issues can be overcome. The manifesto draws on work throughout the programme as well as work done in specific focus groups led by Mental Health Ambassadors with young people who were LGBT, BME, homeless, care experienced, young parents or carers and new arrivals.

**Young People’s Mental Health Manifesto:**

- **1. STAMP Out Stigma**: Start talking about mental health and give young people the opportunity to talk about, and explore, mental health.

- **2. Act now, tomorrow could be too late!** The mental health system encourages people to "get worse before we can get better". Help us early on so things don't get so bad.

- **3. Educate don't discriminate**: Schools hinder rather than help our mental health. Put mental health on the curriculum and train school staff around young people’s mental health so that we can be supported, not discriminated against or labeled.

- **4. Abandoned at 16**: "As soon as you are no longer a child services wash their hands of you" - there is no real service in place for 16-18 year olds. There should be.

- **5. A voice and a choice!** Young people’s participation is key - we are the experts in our own mental health and we have a right to be listened to and our views acted upon.
6. By young people, for young people: There are a lack of services for young people over 16 that meet their needs - we need a service designed by young people for young people aged 16-25.

7. Stuck in the mud: We are often passed from pillar to post - services need to work better together so we're not stuck in the middle.

8. We gotta fight for our rights: Getting help is hard, especially if we don't know our rights. Tell us what they are and offer us advocates to support us.

9. TREATment not HARASSment: “Current crisis support desperately needs improving”: Stop turning us away when we are in crisis or locking us up for being ill – support us instead!
8 Stakeholder consultation regarding emotional wellbeing service provision

In October 2013 a written questionnaire regarding emotional wellbeing service provision was responded to by: Sheffield Children’s Hospital NHS Foundation Trust Community, Wellbeing and Mental Health Division, Sheffield City Council CYPF including MAST; Community Youth Teams, Youth Justice Service, Sheffield City Council Educational Psychology Service, Sheffield Health and Social Care NHS Foundation Trust, NHS Sheffield CCG, Right Here Project, SYEDA, Becton School, Cellar Space, Family Action, Interchange Sheffield CIC

In January 2014 Sheffield City Council hosted an Emotional Wellbeing and Mental Health Whole Systems Workshop facilitated by BOND consortium: this was attended by 70 representatives from across statutory and voluntary sector (including those listed above)

Both the above consultations and engagement activities highlighted a consensus on key gaps in the current emotional wellbeing and mental health ‘system’:

- CYP focussed, accessible provision for mental health promotion, resilience building (‘prevention’) and flexible therapeutic support at a lower ‘tier’ (‘early intervention’) than CAMHS
- step up and step down element including waiting list for CYP who are referred into / out of CAMHS
- A ‘walk-in’ offer, self-referral, provision of a range of interventions, reach out to CYP in their own environment, enable the building of relationships,
- consistent, equitable schools based provision
- consistent targeted skills development in the workforce
- general information provision for CYP and their families and service providers
- routine involvement of CYP in planning, commissioning and review
- tailored provision to young people up to the age of 25

9 Outcomes from the CAMHS scrutiny 2014

The CAMHS (Child & Adolescent Mental Health Service) Working Group was set up by the Healthier Communities & Adult Social Care Scrutiny Committee in September 2012 to undertake a review into CAHMS services in Sheffield. The review covered the full range of CAMHS services from tiers 1-4.

The Working Group used a variety of methods to gather data for the review, including desk top research and speaking with a wide range of individuals and organisations involved with the CAMHS service, including young people who receive a CAMHS service and their parents / guardians. The Group have also spoke with agencies involved in both the commissioning and provision of CAMHS services; the Clinical Commissioning Group (CCG), Sheffield Children’s Hospital, GP’s and Sheffield Councils Children Young People & Families services.

Based on the concerns raised, the Working Group believes there are two key areas to focus on:

- The Pathway, and
- Raising awareness amongst young people, effective signposting and involvement

Under these headings the Group identified 10 “principles” or values which they believe the service should be built on and should deliver against

<table>
<thead>
<tr>
<th>The Pathway</th>
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<tbody>
<tr>
<td>1 Communication - is key at all stages of the process, this includes information on waiting times / interim support / outcomes and reasons for case closure.</td>
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<tr>
<td>2 Clear information – should be produced to outline the services available and the referral routes. This needs to be accessible to both those making referrals and those who access services (see point 10 co-production).</td>
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<td>3 Family assessment and confidentiality- where possible, a family assessment should be offered to ensure a more holistic approach (accepting that this is not always possible as some young people will request confidentiality). There also needs to be a clear route for parents to pass on information confidentially throughout the process.</td>
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<tr>
<td>4 Role of the GP– GP referral notes should be transferred onto the Assessor and should be fully used as part of the assessment process. Communication channels between the GP and the Assessor should remain open.</td>
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<td>5 Transitions - there needs to be early preparation for those transitioning out of a service and clarity in terms of</td>
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**Raising awareness amongst young people, effective signposting and involvement**

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<th></th>
<th>next steps</th>
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<tbody>
<tr>
<td>9</td>
<td>Role of Schools - The role of Schools needs to be increased to improve communication with young people and aid an early intervention / prevention approach. Schools need to consistently promote the services that are available i.e. through the School email services / intranet, and should have staff with the knowledge/skills to make referrals.</td>
</tr>
<tr>
<td>10</td>
<td>Co-production - young people who access the service and their carers need to be involved in designing the service, including producing communication materials and performance monitoring criteria.</td>
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The Working Group believes that adopting these 10 principles could help ensure the following key outcomes for the service.
10 Service Provision

10.1 Overview
The definitions of the tiers are taken from JCPMH Guidance for commissioners of child and adolescent mental health services (2013).

10.2 Tier 1
Tier 1 providers should be able to promote mental wellbeing, recognise when a child or young person may have developmental or mental health problems that a service cannot meet and know what to do when this is the case. In Sheffield there is a broad and sometimes disjointed Emotional wellbeing offer at Tier 1. Support for emotional wellbeing is not always articulated well (or quantified) within universal services.

10.2.1 Early Years

10.2.1.1 Maternity Services
Women have their first meeting and contact with the maternity services at around 7-9 weeks of pregnancy. This important ‘booking appointment’ includes a comprehensive risk assessment, taking account of the woman’s social, medical and obstetric history. Women who screen positive for issues that might affect her wellbeing, e.g. mental health problems, lead to referral to the appropriate team or agency. The vulnerability team based at Jessop Wing have expertise in caring for women with substance misuse issues, safeguarding concerns, mental health and learning disability, they carry a caseload of 268 women, plus a further 60 women in the homeless and asylum seeker team. There is also a team of community midwives who can provide 1-1 care for women who would benefit from extra continuity of carer and additional midwifery support.

The stop smoking in pregnancy specialist midwives provide 1-1 support for pregnant smokers in the city. There are 2.6 wte specialist stop smoking midwives plus stop smoking champions in each community team. There are 1000-1200 referrals annually into this service, all of whom receive at least a contact and most take up some level of support. 1/6 of referrals then go on to quit smoking (158 in 2013/14).

There is a Birth Afterthoughts service provided by STH NHS FT Maternity services – this is for women who feel anxious or troubled about what happened at birth. The numbers of women who access this service have gradually increased as people become aware of the service; most referrals come from health visitors, and the service sees 55-90 women a year. The objectives are for women to be able to talk through what happened during delivery and make sense of it, with the added clarification of the medical notes. The referral form states that it is not a counselling service - women who need counselling are referred back to GP and IAPT. Some women have PTSD symptoms which need psychology input but this is currently not commissioned within maternity.

There is a perinatal mental health service provided by SHSC NHS FT see 9.4.1

10.2.1.2 Healthy Child Programme (Health Visiting)
A Maternal Mental Health Assessment is carried out at the 6-8 week postnatal visit, and can refer into a universal plus service or universal partnership plus service, GP or MAST support as appropriate. The numbers are not currently recorded.

Health visitors are required to provide information, advice and intervention strategies to women where mood changes associated with pregnancy and childbirth have been identified through:

- maternal mood assessment as part of the universal element of the HCP (‘Wooley questions’ from NICE guidelines on antenatal and postnatal mental health)
- referral in the antenatal period by midwifery colleagues or other services e.g. Primary Care Mental Health Team for acute anxiety in pregnancy

10.2.1.3 Maternity Services Liaison Committee (MSLC) – Maternal Mental Health User Survey
A recent survey carried out by the MSLC showed a low awareness of mental health support services available to pregnant women and new mothers. The survey was responded to by 455 women who were asked: ‘Which of the services listed below have you heard about for helping mums deal with low mood and anxiety during pregnancy or after childbirth?’

A summary of the responses is given below and shows a low level of awareness of support services available and that women do not feel that they are being signposted to or offered these services:
10.2.1.4 Children’s centres

There are 17 children’s centres in Sheffield. Children’s centre provide universal support which can provide a protective factor for maternal and infant mental health – providing a first point of engagement with services. Children Centre also provide a programme of volunteering opportunities which are often taken up by parents increasing participation which is a protective factor for mental health.

10.2.1.5 Breastfeeding Peer Support

Breastfeeding Peer Supporters are located in each Children’s Centre and can provide group or one-to-one support to mums who are Breastfeeding. They support early engagement, maternal bonding, attunement and attachment which are protective factors for maternal and infant mental health. The service sees all women antenatally and all breastfeeding women postnatally within 48h. Ongoing support is provided individually, in groups, via a website and Facebook group.

10.2.1.6 Family Nurse Partnership

The FNP is an evidence based preventive programme for young first time mothers. It offers intensive, therapeutic and structured home visiting, delivered by specially trained nurses (Family Nurses). Intensive and structured support focusing on six specific domains: Physical Health; Life Course Development; Environment; Maternal Role; Relationships/Family and Friends; Utilisation of services

The Family Nurse Partnership support first time mothers aged 19 and under at conception, who have low social capital e.g., care leavers, no school qualifications, low social support. They have approximately 175 open cases at any given time and support women from the 16th week in pregnancy until 2 years postnatally. Emotional health in the family is one of the 6 core domains of the programmes work.

Currently attention is focussed on supporting the transition out of the service either to a Health Visitor or MAST support e.g. MAST prevention workers are starting to have some long term contact with women alongside FNP support. FNP mothers are also eligible for access to the 2 year FEL (Free Early Learning for their child from 2 years of age).

10.2.1.7 Minding the Baby (NSPCC)

Provides support to young mothers aged 24 or under at conception, with low social capital – from 28th week of pregnancy to 2 years postnatally. This is a Randomised Control Trial and NSPCC expect to work with 60-80 mothers in Sheffield. This service works additionally health and social care e.g. health workers and social workers attend alternate visits.

10.2.1.8 Volunteer provided support: Community Health Champions

Pregnancy and Early Years Health Champions (Sheffield Cubed) provide support to families during pregnancy and up to the 2 years. They aim to improve health and wellbeing, build confidence and support the development of parenting skills and access to services. One-to-one and group activities e.g. health walks, healthy cooking sessions, swimming, healthy weaning, dad's groups, signposting to other support, support to access universal and specialist provision. A priority of the Health Champions programme is the personal development of the Champions themselves. In 2013/14 50 Health Champions were recruited and they supported approximately 2500 clients.
10.2.1.9 HENRY – Health Exercise Nutrition for the Really Young

The programme was developed to give practitioners the knowledge and practical skills to be able to influence parents and help them provide a home environment that will most benefit their children. The HENRY approach is underpinned by current evidence relating to obesity, parenting and lifestyle and adopts the Family Partnership Model, a way of working proven to be of benefit in supporting parents. It involves reflective practice, and takes a strengths-based approach to helping families find their own solutions and the motivation to put these into practice.

To date 99 workers have received ‘Core Training’ the greater number of these being early year’s staff in the City. This will enable these staff to feel more confident with working one to one with parents and in particular ‘motivational interviewing’. Of these, 10 staff has in addition received 2 x day Group Facilitation Training (some have now left) which will enable them to run an 8 week programme for parents. Of these 3 staff have become trainers, which mean they can run the Core Training in Sheffield.

Funding has been secured through the Public Health grant to enable delivery of further Core Training and additional Group Facilitation Training during 2014/15 that should enable delivery of ‘Let’s Get Healthy with HENRY’ family courses during the second half of 2014/15.

10.2.2 Schools

10.2.2.1 National Healthy School Programme

98.8% of schools achieved National Healthy School status by March 2011 (the last 2 schools achieved National Healthy School status in March 2012 and May 2013). 37 schools had renewed their Healthy School status by completing the national Annual Review Tool by March 2011. Subsequent to this a Sheffield audit checklist was developed to enable schools to maintain Healthy School status. This has been completed by 44 schools. It is suggested that schools complete this biennially.

25 schools have now completed a case study as evidence that they are engaged with the new Healthy Schools approach which is based on a plan, do, review model. Here a priority is selected by examining a range of data and impact is measured by against two meaningful outcome statements (whole school and targeted group). Most schools have chosen healthy weight as their priority in the first instance, and in 2014 schools will be targeted for Healthy Schools support based on National Child Measurement Programme data.

Schools are encouraged to choose ‘improving emotional health and wellbeing’ or ‘improving sex and relationships education’ as their second priority. Examples of activities and interventions that schools might consider are: use the new TaMHS toolkit, review their reward system, update their PSHE curriculum in line with current guidelines.

10.2.2.2 PSHE in Sheffield

A PSHE review of secondary schools is currently being jointly conducted by Birley Community College and the Children and Young People’s Public Health Team. There are 2 aspects of the review: a survey of all secondary PSHE leads, and evaluation visits to secondary schools carried out by young people from the Sheffield Youth Cabinet and the evaluation team. A report with recommendations for schools will be written when the review is completed. It is proposed that a similar review will be conducted in primary schools in the future. The annual Every Child Matters (ECM) survey results are often used to provide information about various aspects of behaviour e.g. dental health, healthy eating, physical activity, bullying, emotional health and wellbeing, and smoking. The data is used to target schools for support and to inform them about specific areas where interventions are needed.

10.2.2.3 TAMHS Family Action

Family Action is commissioned by Sheffield City Council to provide capacity building support to schools. In 2013/14 they offered the following training modules:

- Focusing on Solutions to School
- Introduction to Emotional Wellbeing and Child Mental Health in Schools
- ADHD Awareness
- Pathological Demand Avoidance (PDA) Awareness
- Attachment, Trauma and Loss in the Classroom
- Autism Awareness
Children and Young People’s Emotional Wellbeing and Mental Health: Health Needs Assessment

- Dyslexia Awareness
- Coping with Depression, Building Resilience
- Death, Grief and Dying

Training was attended by 969 delegates which included representation from 50 schools, Sheffield City Council, NHS and voluntary sector organisations. They also provided in school training to 17 schools.

TAMHS was commissioned directly by 3 primary schools for ½ a day each for 13 weeks and one primary school for one day a week for 13 weeks. The traded service was for therapeutic work, which included individual, group and family work.

In 2013 TAMHS launched the TAMHS toolkit which supports the development of in-house support by schools.

10.2.4 Sheffield Park Academy Emotional Wellbeing Pilot
In the school year 2013/14 the NHSS CCG innovations fund granted funding for a schools based emotional wellbeing and resilience pilot to be commissioned by Sheffield City Council. This programme of activity is being delivered by Interchange Sheffield CIC and Family Action TAMHS at Sheffield Park Academy and is operational throughout the Spring and Summer term. Learning from the pilot is expected to inform future service design.

10.2.3 VCF sector organisations
The Sheffield Mental Health Partnership Network recently compiled an overview of the VCF contribution to Mental Health Service provision in Sheffield: No mental health without VCF mental health: a review of mental health services in the voluntary, community and faith sector in Sheffield (2013). The scope of the paper includes services provided to children, young people and over 18s. The services described straddle this paper’s definitions of Tier 1 and Tier 2. The following is extracted from the report.

Sheffield has well over 40 organisations in the voluntary, community and faith sector which work specifically with people with mental health difficulties and the people who care for them. They range from small, user-led peer support groups to registered charities which employ over 30 staff and have limited company status.

Some are locally governed affiliates of national organisations such as Samaritans, Mind and CRUSE Bereavement Care. Others are ‘home grown’ and established locally in response to community needs, such as SAGE Greenfingers, St Wilfrid’s and Your Voice. They provide services to people currently experiencing, in recovery from or at risk of developing mental health difficulties, ranging from mild to moderate anxiety and depression to severe and enduring mental health problems such as schizophrenia, bipolar disorder and personality disorders. VCF organisations deliver services directly themselves, and also facilitate the take up of statutory mental health services through the provision of information and signposting, interpretation, translation, support and advocacy.

As an indication of scale, every week VCF mental health organisations in Sheffield
- provide 196 counselling and psychotherapy sessions for adults
- take over 300 calls on helplines
- provide 104 bed spaces in supported accommodation
- run support groups for people living with conditions including bipolar disorder, depression, anxiety and OCD

In addition RETHINK run a crisis house and 24hr crisis line for 18yr + with severe mental health crises as an alternative to admission by Adult Mental Health Services.

Where the information is available further detail has been added under particular service headings.

10.3 Tier 2
These are targeted services which include mental health professionals working singularly rather than as part of a multi-disciplinary team; school counsellors and voluntary sector youth counselling services. Targeted services also include services provided for children and young people with milder problems. Nationally, these are often provided by primary mental health workers (as outreach from Tier 3 CAMHS) who may work with the child or young person directly or indirectly by supporting professionals working in universal services. Targeted services also include those provided to specific groups of young people who are at increased risk of developing mental health problems.

Like Tier 1, provision is broad and can be disjointed. Most mental health support for CYP is embedded (but not always quantified) within broader Tier 2 support services e.g. MAST and CYTs. Additional therapeutic support is commissioned by Sheffield CC from Interchange Sheffield CIC and by NHSS CCG from IAPT.
10.3.1 MAST
The Multi-Agency Support Teams (MAST) are part of the Early Intervention and Prevention Service within Children and Families in the local authority. The 3 Service Areas (North, East and West) receive referrals from a variety of sources, largely from schools, GPs and social care with around 9,000 such referrals in 2013/14 regarding approximately 15,000 children and young people.

The following diagram identifies the primary presenting issue across all types of referrals as assessed during the MAST screening process. 50% of referrals present with ‘Family/Home’ these are often families where parents and carers are struggling to address behaviour issues of their child. This behaviour often indicate difficulties with emotions, self-control, conflict, relationship-forming and social competence.

MAST uses the SDQ (Strengths and Difficulties Questionnaire) and the Warwick-Edinburgh Mental Well-Being Scale to measure the impact of interventions. Analysis of before and after scores in 2013/14 (to Dec 2014) shows the following:

- SDQ overall stress measure: a 3.4 point drop (from 18.0 pre intervention to 14.6 post intervention) on average: a drop in score indicates improvement. This takes scores from the High range to the Borderline range.
- Warwick Wellbeing Scores: a 5.6 point increase (43.3 pre intervention to 48.9 post intervention). This is within the ‘average’ range of 40-59 points, however improvements in score by 3 to 8 points demonstrate “mental health meaningfully improved” (NHS Scotland 2012)

MAST also carry out interventions to support the emotional wellbeing and health of parents and carers. Self-assessment by MAST workers showed they achieved this is 77.5% of 227 interventions. In Actions where the Intervention type was to “access specialist health services for parent/carer e.g. Adult Mental Health”, MAST workers self-assessed that they achieved this in 36 out of 52 actions (69.2%). There is currently a pilot supported by SHSC with 4 adult mental health workers working with the MAST team to identify, liaise and support families where parental mental illness is an important part of the problem.

In looking specifically at Parenting Programmes and those participating, a total of 482 parents started and ended an accredited parenting programme between September 2012 and September 2013. The informant-rated version of the SDQ (i.e. where parents rated their own children) was used with parents and improvements were demonstrated on all five subscales (behavioural difficulties, emotional distress, hyperactivity and attention difficulties, difficulty getting on with others and pro-social behaviour) following the parenting programme. The largest impact on families was in the reduction in ‘overall stress’ experienced by families after completing a parenting programme (Evaluation of Sheffield Parenting Programmes, Sept12-Sept13, Early Intervention and Prevention Service, Nov 2013)

1 The Warwick-Edinburgh Mental Well-being Scale was funded by the Scottish Executive National Programme for improving mental health and well-being, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh
The Warwick-Edinburgh Mental Well-Being Scale administered during the parenting programmes to assess changes in parental well-being saw average scores post-intervention significantly higher than at the start of the programme. This demonstrates the impact that the programmes can have on the mental health and well-being of parents which is a significant resilience factor in securing positive outcomes for families (Evaluation of Sheffield Parenting Programmes, Sept12-Sept13, Early Intervention and Prevention Service, Nov 2013).

10.3.2 Volunteer provided support in Early Years: Sheffield Volunteer Doula Service and Home Start

- Eligibility criteria for Volunteer Doula support includes mental health problems, care leavers, already receiving AMST support, drugs and alcohol misuse. Referral is by a midwife, and Doula provides support from 34 weeks pregnancy to 6 weeks postnatally. The doula supports the mother with issues around attachment, emotional issues, engagement with services, safeguarding. The Doula service supports approximately 100 women per year. This is a volunteer service and there are currently 50-60 active Doulas.

- Home-Start volunteers provide emotional and practical support to parents during pregnancy and up to 2 years. Support is aimed at supporting parents to grow in confidence, develop and strengthen their relationship with their children, and widen their links with the local community. The service provides home visiting, group support and parenting education. Support is available for parents with a variety of need, and they have projects that specialise in postnatal depression, early attachment and child development.

10.3.3 Educational Psychology Service

There are 15 FTE Educational Psychologists; each school has a named EP and a baseline allocated number of visits.

Nurture Groups

These are school based groups that have been set up with the support of the Educational Psychology service.

The numbers of children in the nurture groups at any one time averages between 6 and 8. The length of time the children stay in the groups is on average between 2-4 terms. The vast majority of staff who run the groups are either teachers or HLTAs.

10.3.4 CAMHS Core Skills Training

CAMHS provide 'core skills' training to the CYP workforce in social care, education and health – prioritising those that work with vulnerable groups, in particular MAST workers. In the calendar year 2013 the following training was provided:

- Introduction to Child and Adolescent Mental Health (2 days): 211 attendees
- Working with Self Harming Behaviour in Children & YP: 27 attendees
- ADHD, Youth Offending & the LAC: 24 attendees
- Early Psychosis: 22 attendees
- Autistic Spectrum Disorder, Youth Offending & the LAC: 26 attendees
- Teenagers – What's the Point?: 26 attendees
- Children with Special Needs: Understanding Neuro Developmental Problems 2: 20 attendees
- Building Attachment & Promoting Resilience: 25 attendees
- Working with the Depressed Adolescent: 25 attendees
- Children & Therapy: What works?: 24 attendees
- ADHD in Children & Young People: 23 attendees
- Eating Disorders in Children & Young People: 24 attendees
10.3.5 Primary Mental Health Workers (CAMHS)
The aim of the service is to strengthen and support the provision of child and adolescent mental health and emotional well-being services at the universal level by providing support to Multi-agency Support Teams (MAST). Primary Mental Health workers enhance the capacity and capability of MAST to respond to families where a child’s emotional wellbeing and mental health is of concern; they can also directly refer from MAST through to Specialist CAMHS thereby supporting early intervention and improving access to services. There are currently 5 WTE CAMHS PMHWs co-located with MAST

PMHW Activity April 2012 – March 2013

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with professional</td>
<td>676</td>
</tr>
<tr>
<td>Consultation with professional with family present</td>
<td>222</td>
</tr>
<tr>
<td>Total</td>
<td>898</td>
</tr>
</tbody>
</table>

SHSC NHS FT and SCC have recently introduced an adult primary mental health worker role within MAST to support parents with mental health illnesses. There is no activity data available as yet.

10.3.6 Community Youth Teams
Community Youth Teams bring together a range of support services for young people into a single targeted youth support service. CYTs are a partnership between SCC, Sheffield Futures and South Yorkshire Police, and include CRI (substance misuse service) as an embedded service. The teams are aimed at young people aged 8-19+ in need of additional support. The primary focus is to work with young people who are involved in anti-social behaviour and at risk of becoming involved in crime, or who are not in education employment or training (NEET) to help them improve their life chances.

CYTs have access to a small counselling resource funded by SCC and provided by Interchange Sheffield CIC – see below.

10.3.7 Interchange Sheffield CIC
Interchange Sheffield CIC provides a one-to-one and group counselling service for Children and Young people up to 25 years, with a particular focus on vulnerable groups in transition to adulthood. Activity is specified by a number of pockets of time-limited funding from SCC, external grants and individual schools or other agencies.

Counselling may be short term (up to 6 sessions), medium term or long term, depending on clinical need, client choice and funding.

SCC fund provision via referral by CYTs. Interchange have further contracts with YJS and Probation (Ending Gangs and Youth Violence), Sheffield Futures, VOYCE project (Young Carers) and 18 secondary schools.

Some schools (currently 3) have commissioned Interchange to provide onsite provision of between 1 and 4 days a week.

In 12/13 Interchange had 300 plus new referrals; female: male ratio of 2:1

Age range:

<table>
<thead>
<tr>
<th>Age range</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- 11-15 years</td>
<td>- 16-19 years</td>
<td>- 20-25 years</td>
</tr>
<tr>
<td>- 42%</td>
<td>- 44%</td>
<td>- 20%</td>
</tr>
</tbody>
</table>

A recent analysis (Motara 2014) of SCC funded activity by Interchange found the following:

- Between 01/02/2012 – 30/06/2014, SCC directly funded 200 referrals received by Interchange.
- Number of SCC funded referrals increased by 76% to 109 in Yr2 (2013/2014) compared to 62 referrals in the previous year.
- Majority of referrals come from Community Youth Teams. There is also an increasing trend in referrals coming from Youth Justice.
- Generally, there is an even number of females and males using the service.
On average, of the total referrals received, 58% of young people presenting were 11-15 years, 39% were 16-19 year olds and 3% were 20-25 year olds.

For the last two years, 18% of young people using Interchange described themselves as coming from a BME background (compared to approximately 27% in general population).

In 2013/2014, the top 5 presenting issues amongst young people were anger (49%), relationship with parent/carer (45%), family breakdown (26%), feeling down/depression (16%) and anxiety/panic attacks (14%).

The average wait for all SCC-referrals from referral to assessment being offered was 5.16 weeks.

Majority of young people rated themselves more positively after Interchange intervention in areas such as coping strategies, self-harming, talking about their problems.

### 10.3.8 Adult IAPT managed by SHSC

The Improving Access to Psychological Therapies (IAPT) service is commissioned to provide access to psychological therapies for people over the age of 18 suffering from mild to moderate depression and anxiety disorders including PTSD and OCD. The service is available in Sheffield at every GP practice. The service provides a range of interventions varying in intensity – including psycho educational work, guided self-help, CBT and counselling. The table below profiles clients by diagnosis.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2013/14</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Diagnosis</td>
<td>1974</td>
<td>39.9%</td>
</tr>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td>1230</td>
<td>24.9%</td>
</tr>
<tr>
<td>Mental disorder, not otherwise specified</td>
<td>1136</td>
<td>23.0%</td>
</tr>
<tr>
<td>Other</td>
<td>605</td>
<td>12.2%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4945</strong></td>
<td></td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014

10.3.8.1 Caseload demographics (data provided by SHSC NHFT to SCC PH Intelligence team, April 2014)

The following 3 tables show caseload demographics for IAPT in 2013/14. A total of 4945 young people aged 16-25 accessed IAPT during 2013/14, 729 of these were under 18 - even though the service is not commissioned for this age group. For context the total number of IAPT patients in the same time was 18736.

The majority of IAPT clients are female and White British.

The male to female ratio in accessing IAPT is similar to the estimated ratio of prevalence of neurotic disorders given in section 5.2.3. Clients from BME backgrounds are likely to be underrepresented, but there is a significant under-recording issue around ethnicity with 32.5% recorded as 'unknown'.
### Improving Access to Psychological Services (IAPT) Clients by Age Group, 2013/14

Data from insight as at 15th April 2014

Age is calculated at the end of the period

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2013/14</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>105</td>
<td>2.1%</td>
</tr>
<tr>
<td>16</td>
<td>257</td>
<td>5.2%</td>
</tr>
<tr>
<td>17</td>
<td>367</td>
<td>7.4%</td>
</tr>
<tr>
<td>18-25</td>
<td>4216</td>
<td>85.3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4945</td>
<td></td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014

### Improving Access to Psychological Services (IAPT) Clients by Gender, 2013/14

Data from insight as at 15th April 2014

<table>
<thead>
<tr>
<th>Gender</th>
<th>2013/14</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>3287</td>
<td>66.5%</td>
</tr>
<tr>
<td>Male</td>
<td>1658</td>
<td>33.5%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4945</td>
<td></td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014

### Improving Access to Psychological Services (IAPT) Clients by Ethnicity, 2013/14

Data from insight as at 15th April 2014

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2013/14</th>
<th>% of Total</th>
<th>% of Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>2890</td>
<td>58.4%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1608</td>
<td>32.5%</td>
<td></td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>125</td>
<td>2.5%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Mixed</td>
<td>117</td>
<td>2.4%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Chinese/Other</td>
<td>82</td>
<td>1.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td>White Non British</td>
<td>63</td>
<td>1.3%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>60</td>
<td>1.2%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total BME</td>
<td>447</td>
<td>9.0%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Total of Known Ethnicity</td>
<td>3337</td>
<td>67.5%</td>
<td>100%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4945</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014

#### 10.3.8.2 DNAs

The table below shows the number of contacts recorded as DNA for IAPT. IAPT has an overall DNA rate of 17% for this age group. This is higher than Adult Community Mental Health Teams overall DNAs for the same age group and higher than CAMHS.
### Number of contacts recorded as DNA for IAPT clients aged under 25, 2013/14.

Age is calculated at the beginning of the reporting period

IAPT = Improving Access to Psychological Services

Data is from ingisght as at 7th May 2014.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of DNAs</th>
<th>Total number of contacts</th>
<th>DNA rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>32</td>
<td>159</td>
<td>20.1%</td>
</tr>
<tr>
<td>16</td>
<td>88</td>
<td>578</td>
<td>15.2%</td>
</tr>
<tr>
<td>17</td>
<td>141</td>
<td>812</td>
<td>17.4%</td>
</tr>
<tr>
<td>18-25</td>
<td>1688</td>
<td>9885</td>
<td>17.1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1949</td>
<td>11434</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014

### 10.3.9 SPACES Transition group (SHSC NHS FT Adult Mental Health)

This group is now open to referrals from primary care and adult community mental health teams. Previously open to young people 16-25 with any mental health diagnosis it will in future concentrate on the over 18 age group, however, 16+ young people who are thought mature enough to manage will be accepted.

The service receives 30 and 40 referrals, from which they form a group with between 6 and 10 young people attending consistently over the 10 week course. Currently 2 groups run per year but it is hoped this can increase with additional resource. At the moment they are planning a new 2 day summer group for this July for those who need some support over the summer period.

SPACES REP group – (SHSC NHS FT Adult Mental Health)

This group runs on a rolling basis throughout the year (i.e. people can join at any part of the programme). It offers a time limited service for up to 6 months and a 12 week rolling programme of sessions designed to help recovery, educate and prevent relapse. It concentrates on self-management, development of coping strategies, psycho-education, access to education, training and voluntary work and development of peer support. It is jointly run with young volunteers. Alongside this is the opportunity to develop an individual recovery plan with a key worker. Referral is possible from primary care and CMHTs. It accepts people of all ages.

### 10.3.10 South Yorkshire Eating Disorders Association (SYEDA)

SYEDA is a regional charity that supports anyone affected by an eating disorder. They give information and advice and run support services for people with eating disorders and their parents or carers. They offer the following services to people with eating disorders: Counselling, Befriending, Complementary Therapies, Support Group, Library, Drop In, Art Psychotherapy.

In 2012/13 they saw 47 young people over the age of 16: 42 females and 5 males.

### 10.4 Tier 3

These are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. In Sheffield access is via referral from a GP, Primary Mental Health Worker, Social Worker, Educational Psychologist, Paediatrician or Adult Mental Health. Tier 3 services are commissioned by NHS Sheffield CCG with a contribution from Sheffield City Council as an associate commissioner.

### 10.4.1 Perinatal Mental Health Service

The Perinatal Mental Health Service is a specialised service for women with serious and/or complex mental illness who cannot be managed effectively by primary care services.

The Service provides assessment and care for women:
- With postpartum psychosis, bipolar affective disorder, serious affective disorder and/or other psychoses
- With severe depressive disorder
- With a history of serious mental illness, e.g. schizoaffective disorder, bipolar affective disorder or severe depressive illness (postnatally or at other times)
- With a history of postpartum psychosis
- With requirements for a high level of integrated working with obstetric and other services because of their complex mental health needs.

The Service also provides pre-conception counselling to high risk women with chronic serious mental illness or those with a history of serious mental illness who are considering pregnancy.

They have 2.6 FTE clinical/managerial/medical staff and received 412 referrals 2012/13 and 553 in 2013/14.

A recent audit (March 2014) showed that 71% of recent referrals met the criteria for being taken on, 50% of the total referrals were seen, the gap is due to women not attending (cancellations and DNAs).

### 10.4.2 Specialist CAMHS

Sheffield Specialist Child and Adolescent Health Services are commissioned by NHSS CCG and provided by Sheffield Children's Hospital NHS Foundation Trust. Provision consists of 2 generic community CAMHS teams (Beighton and Centenary), and three city wide specialist Tier 3 CAMHS pathways which are targeted to children from specific vulnerable groups: Looked After Children; Forensic and Youth Justice; and Learning Disability and Mental Health. The age range is from birth to 15 years (inclusive) and up to 17 years for looked after children and for forensic/youth justice referrals. There are changes planned around commissioning of Tier 3 services which will mean that CAMHS provision will go up to age 17 from 1st October 2014.

Mental health conditions considered appropriate for referral to Tier 3 include:

- Depressive disorders
- Anxiety disorders
- Hyperkinetic disorders
- Developmental disorders
- Psychotic disorders
- Eating disorders
- Conduct disorders
- Obsessive compulsive disorders
- Post traumatic syndromes
- Somatic syndromes
- Severe behavioural problems
- Significant issues relating to attachment

<table>
<thead>
<tr>
<th>2012/13</th>
<th>Centenary</th>
<th>Beighton</th>
<th>Forensic&amp;YOS</th>
<th>MAPS</th>
<th>LD/MH</th>
<th>Deliberate self harm</th>
<th>whole service</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of cases (accepted referrals)</td>
<td>534</td>
<td>499</td>
<td>46</td>
<td>137</td>
<td>27</td>
<td>30</td>
<td>1273</td>
</tr>
</tbody>
</table>

### 10.4.2.1 Caseload demographics April 2013 (March 2013 KPI report provided by SCH NHS FT to NHSS CCG)

The tables below show a snapshot profile of CAMHS caseload demographics at April 2013: gender, age and ethnicity. The majority of CAMHS service users are male, aged between 8-15 years old. BME children seen by CAMHS are under-represented compared to the % of BME children in the general population: 15.8% compared with 29%. Current proposals to extend the age-range of CAMHS to 17 years will affect the future age profile of CAMHS patients, and it is recommended that this be monitored to track any impact on access rates for younger children.
10.4.2.2 Presenting problem at referral

The figure below shows the CAMHS presenting problem at referral for 2012/13. The data shows that a large proportion of referrals present with emotional disorders and conduct disorders which reflect national profiling. In addition however, approximately 30% of referrals are defined as presenting with an ‘unknown’ or ‘other’ problem. This demonstrates the challenge of diagnosis on referral and that being the principal measure of the prevalence of types of disorder. In reality the picture is likely to be more complex and what a child ‘presents’ with may be different to their eventual diagnosis.
10.4.2.3 Postcode analysis of referrals, attendances and DNAs

A postcode analysis has been carried out on CAMHS referrals, attendances and DNAs across the whole service. This table shows ward variances in referrals into CAMHS expressed as a number of referrals and as a percentage of total referrals. The table also shows referrals expressed as a rate per the population of 5-15 year olds in that ward. It should be noted that this data refers to all referrals not just accepted referrals: in 2012/13 24% of referrals were rejected – (mainly Community CAMHS referrals).

### Total Referrals into the CAMHS service 2012/13

**Child and Adolescent Mental Health Service**  
**Sheffield Residents by Electoral ward, and Non-Sheffield residents**

<table>
<thead>
<tr>
<th>Wards Ordered by referral rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Authority</strong></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>Sheffield</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
The following table shows ward variance in total number of appointments, and of those how many were missed either as a cancellation (in advance by the patient) or as a DNA. The table is ordered from high to low total % missed appointments: the highest is Southey at 25.9% and the lowest is Dore and Totley at 11.8%. Across the service there were 20.1% missed appointments.

The highest % of DNAs is also in Southey (14.5%), and the lowest is in Fulwood (2.2%). In total there were 1587 missed appointments due to DNAs in 2012/13, equivalent to 8.2%.

The highest % of patient-cancelled appointments is in Stocksbridge and Upper Don (16.9%) and the lowest is Dore and Totley (7.6%)
### Attended sessions and DNAs in CAMHS service 2012/13

**Child and Adolescent Mental Health Service**

**Sheffield Residents by Electoral ward, and Non-Sheffield residents**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Electoral Ward</th>
<th>Total Appointments</th>
<th>No. of DNAs</th>
<th>No. of Cancellations</th>
<th>Total missed appointments</th>
<th>% DNA</th>
<th>% Cancellations</th>
<th>% missed appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheffield</td>
<td>Southey</td>
<td>760</td>
<td>110</td>
<td>87</td>
<td>197</td>
<td>14.5</td>
<td>11.4</td>
<td>25.9</td>
</tr>
<tr>
<td></td>
<td>Shiregreen and Brightside</td>
<td>1049</td>
<td>109</td>
<td>160</td>
<td>269</td>
<td>10.4</td>
<td>15.3</td>
<td>25.6</td>
</tr>
<tr>
<td></td>
<td>Central</td>
<td>304</td>
<td>32</td>
<td>43</td>
<td>75</td>
<td>10.5</td>
<td>14.1</td>
<td>24.7</td>
</tr>
<tr>
<td></td>
<td>Stocksbridge and Upper Don</td>
<td>520</td>
<td>39</td>
<td>88</td>
<td>127</td>
<td>7.5</td>
<td>16.9</td>
<td>24.4</td>
</tr>
<tr>
<td></td>
<td>Manor Castle</td>
<td>1179</td>
<td>110</td>
<td>169</td>
<td>279</td>
<td>9.3</td>
<td>14.3</td>
<td>23.7</td>
</tr>
<tr>
<td></td>
<td>Firth Park</td>
<td>943</td>
<td>96</td>
<td>127</td>
<td>223</td>
<td>10.2</td>
<td>13.5</td>
<td>23.6</td>
</tr>
<tr>
<td></td>
<td>Arbourthorne</td>
<td>1071</td>
<td>130</td>
<td>118</td>
<td>248</td>
<td>12.1</td>
<td>11.0</td>
<td>23.2</td>
</tr>
<tr>
<td></td>
<td>Beaucie and Greenhill</td>
<td>818</td>
<td>76</td>
<td>102</td>
<td>178</td>
<td>9.3</td>
<td>12.5</td>
<td>21.8</td>
</tr>
<tr>
<td></td>
<td>Mosborough</td>
<td>517</td>
<td>42</td>
<td>69</td>
<td>111</td>
<td>8.1</td>
<td>13.3</td>
<td>21.5</td>
</tr>
<tr>
<td></td>
<td>East Ecclesfield</td>
<td>457</td>
<td>35</td>
<td>59</td>
<td>94</td>
<td>7.7</td>
<td>12.9</td>
<td>20.6</td>
</tr>
<tr>
<td></td>
<td>Gleadless Valley</td>
<td>1091</td>
<td>108</td>
<td>112</td>
<td>220</td>
<td>9.9</td>
<td>10.3</td>
<td>20.2</td>
</tr>
<tr>
<td></td>
<td>Burngreave</td>
<td>939</td>
<td>87</td>
<td>101</td>
<td>188</td>
<td>9.3</td>
<td>10.8</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>Nether Edge</td>
<td>580</td>
<td>32</td>
<td>84</td>
<td>116</td>
<td>5.5</td>
<td>14.5</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>West Ecclesfield</td>
<td>530</td>
<td>44</td>
<td>62</td>
<td>106</td>
<td>8.3</td>
<td>11.7</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>Woodhouse</td>
<td>609</td>
<td>50</td>
<td>71</td>
<td>121</td>
<td>8.2</td>
<td>11.7</td>
<td>19.9</td>
</tr>
<tr>
<td></td>
<td>Richmond</td>
<td>851</td>
<td>68</td>
<td>98</td>
<td>166</td>
<td>8.0</td>
<td>11.5</td>
<td>19.5</td>
</tr>
<tr>
<td></td>
<td>Walkley</td>
<td>815</td>
<td>73</td>
<td>85</td>
<td>158</td>
<td>9.0</td>
<td>10.4</td>
<td>19.4</td>
</tr>
<tr>
<td></td>
<td>Ecclesall</td>
<td>619</td>
<td>24</td>
<td>96</td>
<td>120</td>
<td>3.9</td>
<td>15.5</td>
<td>19.4</td>
</tr>
<tr>
<td></td>
<td>Broomhill</td>
<td>273</td>
<td>14</td>
<td>37</td>
<td>51</td>
<td>5.1</td>
<td>13.6</td>
<td>18.7</td>
</tr>
<tr>
<td></td>
<td>Graves Park</td>
<td>687</td>
<td>47</td>
<td>79</td>
<td>126</td>
<td>6.8</td>
<td>11.5</td>
<td>18.3</td>
</tr>
<tr>
<td></td>
<td>Hillsborough</td>
<td>857</td>
<td>56</td>
<td>98</td>
<td>154</td>
<td>6.5</td>
<td>11.4</td>
<td>18.0</td>
</tr>
<tr>
<td></td>
<td>Darnall</td>
<td>523</td>
<td>45</td>
<td>47</td>
<td>92</td>
<td>8.6</td>
<td>9.0</td>
<td>17.6</td>
</tr>
<tr>
<td></td>
<td>Birley</td>
<td>783</td>
<td>48</td>
<td>80</td>
<td>128</td>
<td>6.1</td>
<td>10.2</td>
<td>16.3</td>
</tr>
<tr>
<td></td>
<td>Stannington</td>
<td>573</td>
<td>29</td>
<td>52</td>
<td>81</td>
<td>5.1</td>
<td>9.1</td>
<td>14.1</td>
</tr>
<tr>
<td></td>
<td>Beighton</td>
<td>444</td>
<td>30</td>
<td>32</td>
<td>62</td>
<td>6.8</td>
<td>7.2</td>
<td>14.0</td>
</tr>
<tr>
<td></td>
<td>Fulwood</td>
<td>411</td>
<td>9</td>
<td>46</td>
<td>55</td>
<td>2.2</td>
<td>11.2</td>
<td>13.4</td>
</tr>
<tr>
<td></td>
<td>Crookes</td>
<td>318</td>
<td>13</td>
<td>29</td>
<td>42</td>
<td>4.1</td>
<td>9.1</td>
<td>13.2</td>
</tr>
<tr>
<td></td>
<td>Dore and Totley</td>
<td>713</td>
<td>30</td>
<td>54</td>
<td>84</td>
<td>4.2</td>
<td>7.6</td>
<td>11.8</td>
</tr>
<tr>
<td></td>
<td>Not Known</td>
<td>9</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>11.1</td>
<td>44.4</td>
<td>55.6</td>
</tr>
<tr>
<td><strong>SHEFFIELD TOTAL</strong></td>
<td></td>
<td>19243</td>
<td>1587</td>
<td>2289</td>
<td>3876</td>
<td>8.2</td>
<td>11.9</td>
<td>20.1</td>
</tr>
<tr>
<td>Barnsley</td>
<td></td>
<td>324</td>
<td>14</td>
<td>45</td>
<td>59</td>
<td>4.3</td>
<td>13.9</td>
<td>18.2</td>
</tr>
<tr>
<td>Bassetlaw</td>
<td></td>
<td>33</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0.0</td>
<td>9.1</td>
<td>9.1</td>
</tr>
<tr>
<td>Doncaster</td>
<td></td>
<td>341</td>
<td>4</td>
<td>27</td>
<td>31</td>
<td>1.2</td>
<td>7.9</td>
<td>9.1</td>
</tr>
<tr>
<td>Rotherham</td>
<td></td>
<td>658</td>
<td>18</td>
<td>64</td>
<td>82</td>
<td>2.7</td>
<td>9.7</td>
<td>12.5</td>
</tr>
<tr>
<td>Not Known</td>
<td></td>
<td>1494</td>
<td>49</td>
<td>137</td>
<td>186</td>
<td>3.3</td>
<td>9.2</td>
<td>12.4</td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td></td>
<td>22093</td>
<td>1672</td>
<td>2565</td>
<td>4237</td>
<td>7.6</td>
<td>11.6</td>
<td>19.2</td>
</tr>
</tbody>
</table>

Data Source: Sheffield Childrens NHS FT
Public Health Intelligence Team, Sheffield CC. April 2014

10.4.2.4 **Postcode analysis of referrals, attendances and DNAs – and correlation with the Index of Multiple Deprivation**

The above data has also been cross-referenced with the Index of Multiple Deprivation. As outlined earlier in the HNA deprivation is a key risk factor for poor mental health and the numbers of referrals into CAMHS correlate with this. There are also, however, more missed appointments in the more deprived areas. This indicates the potential for some targeted bridging work into CAMHS in those wards with high missed appointments, particularly DNAs.
### Total Referrals into the CAMHS service 2012/13

**Child and Adolescent Mental Health Service**

**Sheffield Residents by Deprivation Decile**

<table>
<thead>
<tr>
<th>IMD 2010 Quintile of deprivation</th>
<th>No. of referrals</th>
<th>% of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Deprived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>257</td>
<td>14.6</td>
</tr>
<tr>
<td>2</td>
<td>282</td>
<td>16.0</td>
</tr>
<tr>
<td>3</td>
<td>222</td>
<td>12.6</td>
</tr>
<tr>
<td>4</td>
<td>202</td>
<td>11.5</td>
</tr>
<tr>
<td>5</td>
<td>188</td>
<td>10.7</td>
</tr>
<tr>
<td>6</td>
<td>142</td>
<td>8.1</td>
</tr>
<tr>
<td>7</td>
<td>132</td>
<td>7.5</td>
</tr>
<tr>
<td>8</td>
<td>136</td>
<td>7.7</td>
</tr>
<tr>
<td>9</td>
<td>77</td>
<td>4.4</td>
</tr>
<tr>
<td>Least Deprived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>121</td>
<td>6.9</td>
</tr>
<tr>
<td><strong>Sheffield total</strong></td>
<td><strong>1759</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Data Source: Sheffield Childrens NHS FT  
Public Health Intelligence Team, Sheffield CC. April 2014*

### Attended sessions and DNAs in CAMHS service 2012/13

**Child and Adolescent Mental Health Service**

**Sheffield Residents by Deprivation Decile**

<table>
<thead>
<tr>
<th>IMD 2010 Quintile of deprivation</th>
<th>Total Appointments</th>
<th>No. of DNAs</th>
<th>No. of Cancellations</th>
<th>Total missed appointments</th>
<th>% DNA</th>
<th>% cancellations</th>
<th>% missed appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Deprived</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2677</td>
<td>304</td>
<td>322</td>
<td>626</td>
<td>11.4</td>
<td>12.0</td>
<td>23.4</td>
</tr>
<tr>
<td>2</td>
<td>2296</td>
<td>247</td>
<td>281</td>
<td>528</td>
<td>10.8</td>
<td>12.2</td>
<td>23.0</td>
</tr>
<tr>
<td>3</td>
<td>2584</td>
<td>259</td>
<td>329</td>
<td>588</td>
<td>10.0</td>
<td>12.7</td>
<td>22.8</td>
</tr>
<tr>
<td>4</td>
<td>1959</td>
<td>179</td>
<td>219</td>
<td>398</td>
<td>9.1</td>
<td>11.2</td>
<td>20.3</td>
</tr>
<tr>
<td>5</td>
<td>1878</td>
<td>209</td>
<td>239</td>
<td>448</td>
<td>11.1</td>
<td>12.7</td>
<td>23.9</td>
</tr>
<tr>
<td>6</td>
<td>1755</td>
<td>148</td>
<td>225</td>
<td>373</td>
<td>8.4</td>
<td>12.8</td>
<td>21.3</td>
</tr>
<tr>
<td>7</td>
<td>1451</td>
<td>71</td>
<td>170</td>
<td>241</td>
<td>4.9</td>
<td>11.7</td>
<td>16.6</td>
</tr>
<tr>
<td>8</td>
<td>1455</td>
<td>65</td>
<td>138</td>
<td>203</td>
<td>4.5</td>
<td>9.5</td>
<td>14.0</td>
</tr>
<tr>
<td>9</td>
<td>1353</td>
<td>45</td>
<td>160</td>
<td>205</td>
<td>3.3</td>
<td>11.8</td>
<td>15.2</td>
</tr>
<tr>
<td>Least Deprived</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>1826</td>
<td>59</td>
<td>202</td>
<td>261</td>
<td>3.2</td>
<td>11.1</td>
<td>14.3</td>
</tr>
<tr>
<td><strong>Sheffield total</strong></td>
<td><strong>19234</strong></td>
<td><strong>1586</strong></td>
<td><strong>2285</strong></td>
<td><strong>3871</strong></td>
<td>8.2</td>
<td>11.9</td>
<td>20.1</td>
</tr>
</tbody>
</table>

*Data Source: Sheffield Childrens NHS FT  
Public Health Intelligence Team, Sheffield CC. April 2014*
10.4.2.5 Increases in referrals to CAMHS 2012/13 and 2013/14

There has been a recent increase in referrals to Sheffield specialist CAMHS. This mirrors national trends and is also reflected in a substantial increase in self-harm presentations to the Emergency Department at Sheffield Children’s Hospital (see section 6.2.5). The increase in referrals is most significant in Community CAMHS with a year on year increase in referrals of 35.2%. CAMHS are still accepting a similar percentage which presents a significant pressure on the service.

Approximately 30% of referrals to Community CAMHS are signposted back to other services, the service reports that this is likely to be influenced by initiatives to reduce waiting lists. This figure may suggest scope for improving referral efficiency including a lack of awareness of thresholds for referral or insufficient detail provided by the referrer.

<table>
<thead>
<tr>
<th>referrals</th>
<th>Accepted</th>
<th>% accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community CAMHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>1461</td>
<td>1033</td>
</tr>
<tr>
<td>2013/14</td>
<td>1975</td>
<td>1427</td>
</tr>
<tr>
<td>Vulnerable children’s team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>188</td>
<td>183</td>
</tr>
<tr>
<td>2013/14</td>
<td>169</td>
<td>167</td>
</tr>
<tr>
<td>Learning difficulties/Mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>39</td>
<td>27</td>
</tr>
<tr>
<td>2013/14</td>
<td>42</td>
<td>39</td>
</tr>
<tr>
<td>Deliberate Self-harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>2013/14</td>
<td>62</td>
<td>62</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>1720</td>
<td>1273</td>
</tr>
<tr>
<td>2013/14</td>
<td>2248</td>
<td>1695</td>
</tr>
</tbody>
</table>

10.4.3 Multi-Systemic Therapy

Sheffield City Council provides a Multisystemic Therapy team and a DfE funded MST-Problem Sexual Behaviour service in partnership with the NHS.

The MST team deliver intensive support in homes, neighbourhoods, schools and communities. It aims to keep children out of the care system by working alongside the main caregivers and family support systems.

There are 3 WTE staff in the MST team, each carrying a case load of 15.

There are 3 WTE staff in the MST-PSB team.

10.4.4 Adult Mental Health Services – Community Mental Health Team

The 4 Adult Community Mental Health teams are provided by SHSC and have historically taken referrals from 16+ (This is due to be changed to 18+ from Oct 2014). They provide mental health assessments and treatment packages for the following types of condition: depression, anxiety, obsessive compulsive disorder, personality disorder, attention deficit hyperactive disorder and post-traumatic stress schizophrenia and other psychoses.

There are approximately 150 new referrals per year to the CMHTs, triaged and assessed by the access team, short term work (up to 6 months) is undertaken by the access teams and longer term more complex work is managed by the recovery teams (approximately 2600 cases are under recovery teams and the associated outreach teams for people with complex schizophrenia). There is an Early Intervention in Psychosis (EIS) subteam within the CMHT provided with in conjunction with CAMHs from 14+ who see approx 60 new cases per year. The CMHTs triage
referrals on a daily basis and aim to provide face to face contact within a month in a majority of cases. Same day crisis assessment is possible if there is a high level of risk and extra support can be accessed through the home treatment team if admission is being considered.

10.4.4.1 Caseload demographics
The following 3 tables show caseload demographics for the AMHS Community Mental Health teams: gender, age and ethnicity. In contrast with CAMHS where the majority of clients are male, here there is a fairly even gender split. BME young people are under-represented compared with the general population, although there is under-recording of ethnicity.

### Community Mental Health Team (CMHT) Clients by Age Group, 2013/14

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2013/14</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>96</td>
<td>5.0%</td>
</tr>
<tr>
<td>16</td>
<td>179</td>
<td>9.3%</td>
</tr>
<tr>
<td>17</td>
<td>182</td>
<td>9.5%</td>
</tr>
<tr>
<td>18-25</td>
<td>1462</td>
<td>76.2%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1919</td>
<td></td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014

### Community Mental Health Team (CMHT) Clients by Gender, 2013/14

<table>
<thead>
<tr>
<th>Gender</th>
<th>2013/14</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>935</td>
<td>48.7%</td>
</tr>
<tr>
<td>Male</td>
<td>984</td>
<td>51.3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1919</td>
<td></td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014
## Community Mental Health Team (CMHT) Clients by Ethnicity, 2013/14
Data from insight as at 15th April 2014

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2013/14</th>
<th>% of Total</th>
<th>% of Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>1118</td>
<td>58.3%</td>
<td>80.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>523</td>
<td>27.3%</td>
<td></td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>67</td>
<td>3.5%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Mixed</td>
<td>70</td>
<td>3.6%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Chinese/Other</td>
<td>60</td>
<td>3.1%</td>
<td>4.3%</td>
</tr>
<tr>
<td>White Non British</td>
<td>22</td>
<td>1.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>59</td>
<td>3.1%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Total BME</td>
<td>278</td>
<td>14.5%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Total of Known Ethnicity</td>
<td>1396</td>
<td>72.7%</td>
<td>100%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1919</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014

### 10.4.4.2 DNAs
The table below shows DNAs as a proportion of the total number of contacts. There is a higher rate of DNAs for outpatient appointments compared with community appointments (16.8% compared with 7%). Overall % DNAs for the Adult Community Mental Health Team are higher than that for CAMHS.

### Number of contacts recorded as DNA for CMHT clients aged under 25, by appointment type, 2013/14.

Age is calculated at the beginning of the reporting period
CMHT = Community Mental Health Team
Data is from insight as at 7th May 2014.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of DNAs</th>
<th>Total number of contacts</th>
<th>DNA rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMUNITY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Outside the clinic set up)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 16</td>
<td>9</td>
<td>146</td>
<td>6.2%</td>
</tr>
<tr>
<td>16</td>
<td>42</td>
<td>491</td>
<td>8.6%</td>
</tr>
<tr>
<td>17</td>
<td>73</td>
<td>684</td>
<td>10.7%</td>
</tr>
<tr>
<td>18 - 25</td>
<td>3255</td>
<td>47157</td>
<td>6.9%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3379</td>
<td>48478</td>
<td>7.0%</td>
</tr>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Any clinic appointment with)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 16</td>
<td>18</td>
<td>105</td>
<td>17.1%</td>
</tr>
<tr>
<td>16</td>
<td>62</td>
<td>295</td>
<td>21.0%</td>
</tr>
<tr>
<td>17</td>
<td>55</td>
<td>298</td>
<td>18.5%</td>
</tr>
<tr>
<td>18 - 25</td>
<td>2011</td>
<td>12038</td>
<td>16.7%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2146</td>
<td>12736</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

PH Intelligence Team, SCC, 23/05/2014
10.4.5 SEDS
Sheffield Eating Disorders Service is a community based specialist outpatient service provided by SHSC NHS FT, providing assessment and psychologically based interventions to those with severe eating disorders. The Team is multi-disciplinary and includes:

- Team Coordinator
- Consultant Psychiatrist
- Clinical Nurse Specialist
- Clinical Psychologists
- Liaison Nurse
- Dietitian
- Team Secretary

Many of the staff work into the Team on a part time basis and hence there is the equivalent of 3.5 clinical staff.

10.5 Tier 4
Tier 4 services include day and inpatient services, some highly specialist outpatient services and increasingly services such as crisis/home treatment services which provide an alternative to admission. Such services are often provided on a regional or supra-regional basis. Locally these services are commissioned by NHS England Local Area Team.

10.5.1 Becton Centre
In Sheffield Tier 4 services are located at the Becton Centre. 2 lodges (wards) provide inpatient facilities and 2 provide day patient facilities. In total they provide 15 day places, 40 intensive outreach places and 30 inpatient beds. Referral is through a consultant psychiatrist for children and young people (up to 18th birthday) who have serious and complex mental health and emotional difficulties.

The chart below shows the reasons for admission to T4 services by area. There is some significant variation between areas, although the reasons for admission for the majority of patients fall into 3 broad categories. These are:

- a) Eating Disorders
- b) Psychosis, Hyperkinetic, Epilepsy, Bi-polar
- c) Self-harm, suicidal, depressed, emotional

Source: CAMHS Tier 4 in Yorkshire & Humber 2011-2014 – Service Strategy
10.5.2 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report

Late 2013, NHS England Specialised Commissioning Oversight Group (SCOG) commissioned a review which was designed to map current CAMHS Tier 4 service provision, to consider issues that had arisen since April 2013 and to identify specific improvements. The report which was published in July 2014 was described as a first stage review to assess and understand the current services with a particular focus on a factual assessment of current provision and commissioning issues.

The process of the review included surveys with providers and commissioners and case histories. The information which follows is extracted from the Review with the purpose of describing the CAMHS Tier 4 offer in the context of the Health Needs Assessment. For the full report please see http://www.england.nhs.uk/2014/07/10/camhs-report/

10.5.2.1 Main issues facing T4 CAMHS Providers

The provider survey asked respondents to describe the main issues facing inpatient CAMHS at the moment. This is summarised in the table below:

![Main Issues for Inpatient CAMHS](image)

10.5.2.2 Referral Activity

The table below shows the national number of referrals recorded and submitted by providers across Tier 4 CAMHS commissioned by NHS England. The provider returns show a sudden increase in referrals commencing in July 2013. Although the number has settled at a lower level, it has remained consistently higher than the pre-July 2013 levels.

A range of providers report a year on year increase in referrals. Providers have stated they have become aware of multiple referrals being made in respect of the same patient as commissioners (or providers who have undertaken the assessment) search for a bed. It has been observed locally that changes in the commissioning may have influenced gatekeeping and decision making processes around referral, which would then carry through to the number of referrals. There is no evidence that the increase in referrals reflects an increase in need or demand; it is more likely to be due to system changes.
Locally, South Yorkshire and Bassetlaw Area team report an average of 29 referrals per month pre-April 2013 and 39 per month post-April 13.

10.5.2.3 Admissions Activity

The table below shows the number of admissions across T4 CAMHS nationally. The shape of the graph echoes number of referrals. Nationally, the average length of stay did not differ significantly between 2012 and 2013 (123 days compared with 116). There was no significant difference in ‘planned’ vs ‘unplanned’ admissions. Bed occupancy in South Yorkshire and Bassetlaw was approximately 80% (slight increase in 2013, compared with 2012).

10.5.2.4 Out of Area Admissions

It was noted within the report that ‘out of area’ definitions vary in interpretation, so it is difficult to systematically review this. Providers were asked to identify for 2012 and 2013 the number of admissions out of area defined by ‘admissions deemed to be placements where young people are harmed by the distance and disconnection from local services, family and friends’.
Analysis of the 100 case histories provided highlights some of the geographical and sub specialty factors where long distance admissions are more of an issue. Areas of the country which have low bed provision experience longer distances. There is recognition within the report that there is an under-provision of beds for South Yorkshire and Bassetlaw.

Whilst most admissions were within area, the reason for out-of-area placements was more often lack of local beds than a specialist bed required.

### 10.5.2.5 Discharge planning – Delayed Discharges

South Yorkshire and Bassetlaw benchmarks well in terms of delayed discharges. The common causes of delayed discharges are listed below which point to issues within the broader health and social care system.
10.5.2.6 CAMHS Tier 4 – available patient information
The table below shows the national age range of patients in 2013.
10.5.2.7 Diagnosis

Providers responses regarding diagnosis on discharge have been grouped into broad themes in the table below – showing national figures. NB self-harm was used as a stand-alone category by some respondents (and therefore in this table), but is likely to have been a contributing factor to the admission of patients in other categories – hence this is likely to be an underestimation of self-harm within this population.

10.5.2.8 Recommendations from the CAMHS Tier 4 Report

The following recommendations were made for the commissioners of the report, they are included here to show direction of travel.

- Interaction of geography, sub-specialty and age in influencing admissions

Development of a national framework to inform decision making about where to place C&YP; every area should have adequate bed capacity

- Contracting issues

Incorporate best practice into the Mental Health Standard Operating Manual; standardise procedures; outline clear expectations for involvement of CYP and their families; standardise monitoring of waiting times and discharges; sustainable case management; consider live reporting of bed availability; better access to information including patient identifiable information;

- Standards
Consultation and early implementation of standard practice across the country in particular access, best practice for trial or home leave, discharge thresholds and planning, management of suicidal ideation.

- Procurement

Need and capacity mapping; short term procurement of additional capacity for those areas of the system most acutely affected by current inaccessibility of beds, with longer term procurement to follow in the context of wider recommendations.

- Further recommendations for consideration by commissioners working in the wider system

Provider networks to be established; explore collaborative and joint commissioning models for Tier 3 and 4 services (to include Local Authorities); further work to develop models of care across the care pathway for CYP with an eating disorder, learning disability and services providing an alternative to admission; NHS England to pursue with Health Education England a wider system discussion regarding the need to develop an adequate CAMHS workforce.
11 References

Campion, J. (2013) Public mental health presentation with focus on child and family Director of Population Mental Health (UCLPartners) Visiting Professor of Population Mental Health (UCL) unpub.

CHIMAT (2013a) CAMHS Needs Assessment

CHIMAT (2013b) Key risk factors indicating harm or poorer developmental outcomes in children
Selection: Sheffield Geographies: Top level local authority accessed 16/09/2013

CHIMAT (2014c) Child health profile 2014 Sheffield MCD


Healthy Schools Profile Sheffield (accessed 17/09/13)
http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=9&geoTypeId=4

HMRC (2013) Personal tax credits: finalised award statistics - small area data - LSOA and Data Zone


Longstaff, B. (2013) No mental health without VCF mental health: a review of mental health services in the voluntary, community and faith sector in Sheffield. for the Sheffield Mental Health Partnership Network


NHS England SYB AT (2014) Briefing from Specialist Mental Health Team re CAMHs Tier 4 February 2014


Sheffield City Council (2013) Every Child Matters Survey 2012 Summary report of the findings

Sheffield Safeguarding Children Board Annual Report 2012-13 Sheffield City Council


The Social Research Unit at Dartington (2014) “Sheffield Area Wellbeing Profile (0-8) – For Sheffield including specific focus on Target Wards: Darnall, Manor Castle, Shiregreen and Brightside”


Young Minds (2013) ‘Same old… the experiences of young offenders with mental health needs’