

# Emotional and Mental Health Needs Assessment for Children and Young People in Kent

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## | 1. Introduction

The aim of this Emotional and Mental Health Needs Assessment for Children and Young People in Kent is to answer the questions:

- What does health and wellbeing in my area look like?
- What should we be doing?
- What are we doing?
- What can we do better?
- What more do we need to know?

It builds upon and replaces the CAMHS Health Needs Assessment published in 2014 by Kent Public Health Observatory and on the CAMHS Health Needs Assessment available through the National Child and Maternity Intelligence Network

<http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34&geoTypeId=> . It should be read in conjunction with Public Health England's Children and Young People's Mental Health and Wellbeing Profiling Tool <https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh> which is updated with County, CCG and District benchmarked data on risk factors, prevalence, health and social indicators.

Health Needs Assessments which also include the emotional and mental health of children and young people are the Health Needs Assessments for Perinatal Mental Health, for Neurodevelopmental Conditions and for Personality Disorders. All of these will be published on the Kent Public Health Observatory Website <http://www.kpho.org.uk/>

Appendix 1 provides additional detail on the methodology, key definitions and measures and some of the key limitations of the health needs assessment.

## Background

### National Context

The current Government has made children and young people's mental health and emotional wellbeing a priority. An independent review of Tier 4 CAMHS commissioned by NHS England resulted in the CAMHS Tier 4 Report in 2014, which was presented at the House of Commons Health Committee's inquiry (2014) into children and young people's mental health. This showed that many children and young people with mental health and emotional difficulties did not receive timely, high quality, accessible or evidence-based support. The consequences of untreated mental health problems during childhood and adolescence can be long lasting and far reaching, thus effective early intervention is essential.

The Children and Young People's Mental Health and Wellbeing Taskforce was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organized, commissioned and provided.

The Taskforce published its report 'Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing' in March 2015. The report made key recommendations to schools, commissioners, and early years staff, emphasizing that children and young people's emotional and mental health is everyone's business and that an integrated, partnership and multi sectorial approach was required to define and meet need.

In summary, the themes of 'Future in Mind' were:

- promoting resilience, prevention and early intervention
- improving access to effective support – a system without tiers (including single point of access)
- care for the most vulnerable
- accountability and transparency
- developing the workforce.

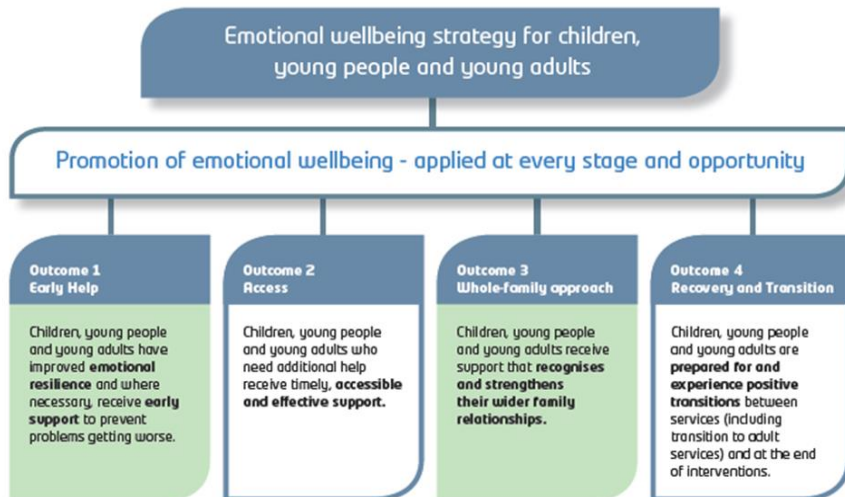
The NHS led programme 'Transformation of Children and Young People's Mental Health' implements the vision of 'Future in Mind' through an allocation of additional funding to local Clinical Commissioning Groups (CCGs) to support multi sectorial transformation articulated in an annual Children and Young Persons Mental and Emotional Health Transformation Plan.

### **Local Context**

In Kent, significant work has taken place since 2013 to better understand and improve the mental health of children and young people in Kent. This includes:

- 'The Way Ahead: Emotional and Mental Health Strategy for Children'
- CAMHS Health Needs Assessment 2013
- a joint commissioning plan for the procurement of emotional and mental health services
- Kent Head Start Programme
- the 2015/16 and 2016/17 Local Children and Young People's Mental Health Transformation Plan.

'The Way Ahead' was informed by significant consultation with children and young people, with parents, carers, and with practitioners, clinicians and teachers in the wider children and young people's workforce. It focussed attention on the following outcomes:



**Source: The Way Ahead**

[https://www.kent.gov.uk/\\_data/assets/pdf\\_file/0003/46821/Emotional-Wellbeing-Strategy-part-1-strategic-framework.pdf](https://www.kent.gov.uk/_data/assets/pdf_file/0003/46821/Emotional-Wellbeing-Strategy-part-1-strategic-framework.pdf)

## | 2. Executive Summary

### Summary of Findings

#### Prevalence of Mental Health Conditions

The overall prevalence of mental health disorders in children and young people is hard to estimate in the absence of systematic screening, the consistent application of diagnostic criteria and measurement tools, the differing perspectives of children and young people, their carers and their parents on presenting symptoms and finally, the high prevalence of comorbidity. Prevalence estimates for 10-15 year olds are largely based on survey work undertaken in 2004, although this survey is currently being repeated with findings available in 2019.

Comorbidity is the norm rather than the exception for mental health disorders and this can result in an underestimation of incidence and a difficulty in engaging, assessing and treating children, young people and families particularly where there are coexisting mental health needs and exposure to adversity and trauma. That said, we have considerable intelligence about the estimated prevalence of mental health disorders and the distribution of those disorders at district and CCG level.

Despite the limitations of estimates for mental health disorders in children and young people, the prevalence and incidence is increasing in Kent. This is driven by population increases in Kent and by increasing need which varies by mental health disorders.

National evidence also suggests that there has been a slight decrease in behavioural (externalizing) disorders which are more prevalent than internalizing mental health conditions and are more prevalent amongst boys (although not exclusively). This may be the result of an increased focus on resourcing behavioural interventions. However, in the context of socio-economic deprivation, which is strongly associated with behavioural disorders, the cut to budgets in the education, health and social care sector may result in increased geographical variation and a change in this trend.

#### **Groups of children and young people at risk of mental health conditions, their utilisation of services and opportunities for early intervention and prevention**

Much is known about the risk and prevalence of mental health disorders amongst high-risk groups. We can also apply these estimates to CCG and districts. It is however, not possible to provide any detailed analysis as to whether the needs of high risk groups are being met because the service data that it is possible to access does not provide protected characteristics or presenting symptoms/ diagnoses. This will change with the introduction of a locally developed standardised dataset in Kent, referred to as the core dataset. If it is possible to understand the utilization of mental health services according to presenting symptoms and diagnoses, it should also be possible to better direct resources to prevent the onset of those symptoms and diagnoses. In the meantime, the use of Equality Impact

Assessment with any actions improving resilience and emotional and mental health could go some way to ensuring that children and young people from high risk groups are not excluded and benefit equally.

### **Death by Suicide, Suicidal Ideation and Suicidal Attempts**

Fortunately the number of deaths by suicide (and undetermined cause) by children and young people under the age of 18 are small in number. The number varies year on year, analysis of the number of deaths by suicide for those under 25 shows a slight increase over the last decade. There has been an increase in 2017-18. Through the Child Death Panel process, it should be possible to identify and disseminate learning across the system to prevent these incidents.

Evidence also shows that children in care, children and young people who misuse substances, children and young people who have been exposed to multiple adversity and cumulative trauma and who are LGBTQ, in particular transgender young people, are of particular risk of suicide attempts and they need to be targeted for preventative interventions. Risk of death by suicide increases for boys over the age of 17.

Suicidal ideation and suicidal attempts are more prevalent than suicide, particularly amongst girls.

### **The impact of children and young people's mental health on adult mental health**

Seventy-five per cent of mental health conditions emerge under the age of 24, with 50% emerging under the age of 14. An increase in mental health disorders amongst children and young people without a stepped change in the prevention, treatment, recovery and management will result in an increase in mental health conditions in adulthood.

### **The ecological approach to children and young people's mental health and the need to make emotional and mental health everybody's business**

Recognizing an ecological approach to children and young people's emotional and mental health including wider social determinants is critical to reducing the risk of mental health disorders, targeting prevention, intervening early and supporting effective treatment and recovery. This will require a multi-sectorial response and a commitment to making children and young people's emotional and mental health everybody's business, an area of health where everybody can play a part in the prevention, treatment and supporting the recovery of children and young people.

### **Reducing the impact of adversity and trauma on children and young people's emotional and mental health**

Building emotional resilience and working to understand and overcome the impact of trauma on children and young people may provide a means to mitigate risk factors and build and maintain protective factors. This may reduce the onset and escalation of mental health



disorders alongside other evidence-based interventions focused at mild to moderate mental health needs.

Adverse Childhood Experiences (ACE) including sexual abuse, domestic abuse, parental mental health and substance misuse which impact negatively on attachment and trauma are associated with higher rates of mental health disorders in childhood and in adulthood.

### **Children, young people's emotional and mental health, and the impact of parents**

Pressures on families including parental separation and debt will impact on children and young people's emotional and mental health. Parenting education and skills development is critical to preventing and treatment of mental health disorders. Parents and carers are key to supporting children and young people in treatment and in recovery.

Access to early years education including that provided through children's centres and also to intensive health visiting support as well as parenting skills courses are key to identifying and intervening to improve social and emotional health.

### **Prevalence of mental health amongst girls**

National evidence also suggests there is an increase in emotional health problems in girls and young women including depression, anxiety and Post Traumatic Stress Disorder (PTSD) and self-harm. That said, these conditions are not exclusively experienced by girls.

### **Prevalence of mental health amongst ethnic minority groups**

Although inconclusive, there is likely to be some variation in mental health condition according to ethnicity, which will intersect with gender, social economic status and how the culture and religious practice within ethnic groups act as protective factors and build resilience.

The higher prevalence of eating self-harm in South Asian women is noted and needs to be reflected in access to and benefit from self-harm interventions.

### **Prevalence of mental health amongst children and young people with disabilities**

Children with disabilities have higher rates of mental health disorders and may not benefit from interventions due to coexisting Speech Language and Communication Needs (SLCN).

### **Prevalence of mental health disorders and speech language and communication needs**

Children and young people with SLCN are more vulnerable to mental health disorders and may be harder to identify. Many of these children and young people will also be children in care, young offenders, in special schools, with EHC plans, in PRUs and Colleges.

### **Prevalence of mental health disorders amongst children in care and children in need**

Children in care and children in need are at risk of poor emotional and mental health for many a consequence to the neglect and maltreatment which has resulted in them being placed in care.

### **Prevalence of mental health disorders amongst children and young people in contact with the criminal justice system**

Young people in contact with the criminal justice system have high levels of mental health disorders and exposure to adversity and trauma. Integrated mental health workers in Youth Offending Teams have been advocated nationally and show promising results. Given the high prevalence of externalizing mental health disorders amongst this group this is also likely to require systemic support for parents and foster carers.

### **Prevalence of mental health disorders amongst children and young people who are young carers**

Young Carers report poor mental health and may not be able to access services due to these caring responsibilities.

### **Prevalence of mental health disorders amongst children and young people who live in socially and economically deprived communities**

Social inequality is associated with increased mental health problems in the population. Children and young people are particularly vulnerable to poor health as a result of inequality. If inequality continues to rise so will mental health conditions.

### **Prevalence of mental health disorders amongst children and young people who misuse substances**

The early onset of substance misuse (under the age of 15) is associated with behavioural issues in childhood and drug dependence in adulthood. Children and young people affected by attention deficit (hyperactivity) disorder (ADHD) and conduct disorder (CD) are reported as a high-risk group for drug use.

The coexistence of mental health disorders and problematic substance misuse, referred to as dual diagnosis, has long presented challenges to effective treatment, resulting in the development of guidelines and dual diagnosis integrated pathways.

### **Prevalence of mental health disorders amongst children and young people with long-term conditions**

Long-term conditions, also known as chronic conditions, are health conditions which require management over a number of years or possibly over a person's lifetime. Common long-term conditions in children and young people include are asthma, epilepsy, diabetes and anaphylaxis. The association between mental ill health and the long-term condition is two directional. The long-term condition may limit children and young people's life such that their mental health declines, conversely periods of stress may trigger episodes of ill health.

### **The system of emotional and mental health care for children and young people in Kent**

Findings suggest that there is insufficient activity in tier 1 and 2 of the system of emotional and mental health care, and overuse of tiers 3 and 4. It is important to note that this judgment is based on prevalence data from 2004. Indications are that mental health

disorders have increased in children and young people Therefore the estimate of the sufficiency at each Tier of need may be an underestimate.

There are comprehensive guidelines in place for the prevention, management and treatment of many mental health disorders. It is not clear whether they are in place at the scale required to meet the need of the child population in Kent or whether the workforce with the skills and competencies to deliver them effectively are available.

At present, service monitoring data is not routinely collected and aggregated to understand the demand and utilization of services for children presenting with different feelings, thoughts and behaviours, what diagnoses they receive, what interventions they receive and what their outcomes are. Work is taking place to review pathways including ASD/ADHD pathway in East Kent and Eating Disorder pathway.

Stakeholders in the wider children and young people's system recognize the pressure on specialist mental health treatment service. There is also a lack of confidence in access to treatment (waiting times) and what treatment can achieve, particularly with children and young people in at risk populations like children in care and children and young people in Special Schools who are not being assessed as requiring treatment or persistently engaged in treatment.

The Tier 2 services' which meet the needs of children with mild to moderate mental health needs, report increased demand from children and young people with increasingly complex needs and multiple adversities.

There are providers in the community and voluntary and private sector which are not commissioned by the NHS or by the local authority, who may be small but together have capacity. They are not currently engaged in Kent's strategic approach to improving and transforming children and young people's emotional and mental health.

School and colleges are settings which have the potential to impact positively on resilience and emotional health through the adoption of whole school approaches including anti-bullying policies, destigmatising mental health and self-harm, building health literacy, delivering behavioural interventions and intervening early and supporting children and young people in treatment and in recovery.

Schools and colleges report increasing levels of anxiety amongst their pupils and greater complexity of need. Schools and colleges vary in the approach they take and the resources they allocate to promoting emotional health, preventing and intervening early in mental health. Schools and colleges want to play a role in children and young people's recovery from treatment. Financial pressures on schools risk reducing these resources. School staff do not always have the information they require around children and young people's family or their mental health to be able to support them, where they do have this knowledge they may not all have the confidence and competence to respond to mental health needs. Schools work with the services they have confidence in and sometimes control over like school counselling.

There is a need to ensure that schools and colleges have access to the effective advice, resources and skills and knowledge development to deliver this potential.

Public Health School Nursing Services have identified resilience and emotional health as an area where they are able to have a high impact.

### **Acute care utilisation for children and young people with emotional and mental health conditions**

Evidence from acute care in Kent suggests that there is a decline in attendances for self-harm but an increase in admissions for self-harm and other mental health disorders. This may indicate issues of effective management of existing disorder, a lost opportunity to prevent the onset of a disorder or unanticipated and undiagnosed needs. This will vary with each mental health disorder.

For under 18s, the A&E attendance rate for self-harm has remained fairly static. Under 18s account for 17% of all self-harm attendance rates. Eighteen to twenty-four year olds account for 22% of all attendances. Both South Kent Coast (19.6) and Thanet CCGs have a significantly higher A&E attendance than Kent. Dover and Thanet districts have significantly higher A&E attendance rates than Kent.

For 18 to 24 year olds, the self-harm A&E attendance rate has decreased from 56.4 per 10,000 registered populations in 2009/10 - 2011/12 to 42.3 in 2013/14 - 2015/16. Rates in South Kent Coast and Thanet CCGs have remained substantially higher than Kent. Ashford CCG has also had a markedly higher A&E self-harm attendance rate than Kent; however, this has been decreasing (although plateaued in the most recent time period).

For under 18s, the hospital admission rate with a primary or secondary diagnosis of mood affective disorder, for self-harm has increased consistently.

Shepway district had a significantly higher hospital admission rate for self-harm than Kent, while Maidstone had a significantly lower rate.

The rate for admission for primary or secondary diagnosis of mood affective disorder in Thanet CCG has fluctuated and despite having the highest rate of all Kent CCGs in 2009/10 - 2011/12 had the lowest rates within the last two time periods. This requires further investigation.

Across Kent, the admission rate with a primary or secondary diagnosis of an eating disorder increased from 10.3 per 100,000 resident population in 2006/07 - 2008/09 to 19.7 in 2011/12-2013/14. Since then, it has remained relatively stable, increasing marginally to 20.8 in 2013/14 - 2015/16. There is variation and fluctuation at district level but particular note is the rate in Shepway has been increasing at a significantly faster rate than Kent (95% confidence intervals).

For 18 to 24 year olds, the self-harm A&E attendance rate has decreased from 56.4 per 10,000 registered populations in 2009/10 - 2011/12 to 42.3 in 2013/14 - 2015/16. Rates in

South Kent Coast and Thanet CCGs have remained substantially higher than Kent. Ashford CCG has also had a markedly higher A&E self-harm attendance rate than Kent; however, this has been decreasing (although plateaued in the most recent time period). The higher rates at CCG level are also reflected in higher rates of attendance in Ashford (60.2), Dover (94.8) Shepway (74.7), Thanet (91.0) districts. The rate in Tunbridge Wells (68.5), which sits within West Kent CCG, is also significantly higher than in Kent.

At district level for 18 to 24-year olds, the hospital admission rate for self-harm has increased from 45.0 per 10,000 resident population in 2006/07-2008/09 to 60.3 in 2009/10-2011/12. Since then, the rate has decreased to 50.0 in 2013/14-2015/16. Admission rates in Thanet were markedly higher; however have now decreased substantially. Tunbridge Wells, Shepway, Maidstone and Dartford districts have all had higher rates than Kent in the past three-time periods.

For under 25s, the hospital admission rate with a primary or secondary diagnosis of schizophrenia has increased consistently, from 14.1 to 27.7 admissions per 100,000 registered population between 2006/07-2008/09 and 2013/14-2015/16. The admission rate in Thanet CCG has been consistently higher than Kent, and the rate in South Kent Coast has increased at a significantly faster rate than observed across Kent (95% confidence intervals).

Across Kent, for under 25s, there were 27.7 hospital admissions with a primary or secondary diagnosis of schizophrenia per 100,000 registered population, ranging from 18.1 in Ashford CCG to 39.9 in South Kent Coast CCG. South Kent Coast had a significantly higher hospital admission rate than Kent. The hospital admission rate has increased consistently, from 14.0 to 27.6 admissions per 100,000 registered population between 2006/07-2008/09 and 2013/14 - 2015/16.

The admission rate in Thanet has been routinely higher than Kent, and the rates in Dover and Shepway have increased consistently to rates above that of Kent.

Across Kent, there were 27.6 hospital admissions with a primary or secondary diagnosis of schizophrenia per 100,000 resident population, ranging from 18.1 in Gravesham to 40.4 in Dover. None of the districts have a rate that is significantly different to that of Kent.

Between 2013/14 and 2015/16, 74.6% hospital admissions with a primary or secondary diagnosis of a mood affective disorder were female, accounting for 2,097 admissions out of 2,810 among under 25s. Just over 8% of hospital admissions were for people aged under 25.

The length of stay ranges from 0 to 273 days, with a median of one day.

People aged under 25 accounted for a significant minority, 46.6%, of the 614 total admissions, with one in four admissions for an individual aged between 18 and 24 years. The length of stay ranged from 0 to 284 days, with a median of just two days.

For under 25s between 2013/14 and 2015/16 approximately two thirds of admissions for eating disorders were emergency admissions, with 50% of individuals admitted via A&E. Among non-Kent trusts, 61% were elective, and 86% were elective for KMPT. This suggests

that it is possible to make improvements to eating disorder services in the community and increase planned (rather than emergency) use of acute care beds. Variation at CCG level including Ashford CCG (9.5) where the pooled admission rate is significantly lower than in Kent (20.9) and Canterbury and Coastal CCG (32.5) where the pooled rate is significantly higher (95% confidence intervals) may offer some learning with regards this. These differences are also reflected in the pooled rates for Canterbury and Ashford district.

### | 3. Recommendations

#### **Increasing the access to effective interventions, investment, early intervention, prevention and health promotion**

Increasing levels of mental health need requires additional interventions, particularly at Tier 2 but also at Tier 3, investment and increased efforts to promote emotional health and resilience to build protective factors and prevent the onset and escalation of mental health disorders through early intervention and prevention.

Children and young people and their parents and carers need to be systematically engaged in the commissioning, development, delivery and review of efforts to promote emotional health and resilience and deliver prevention, early intervention and treatment. This is explicit in CYP IAPT and You're Welcome Effort needs to be focussed on ensuring that work to engage children and young people is inclusive of those groups of children and young people who are most at risk of mental health disorders.

Providers of mental health services which are not commissioned by the NHS or the local authority, who may be smaller providers, including those in the voluntary sector and private sector e.g. school counselling need to be invited to collaborate in Kent's strategic approach to improving children and young people's emotional and mental health. This may result in more effective use of resources and maximising the workforce available to meet the needs of children and young people.

There is a need to review the evidence base for early intervention on emotional and mental health conditions to understand where effective interventions exist, which groups of children and young people they benefit what disorders they can prevent and prioritise these for investment on the basis of an economic evaluation.

Work has already been piloted in Kent around early intervention in self-harm (Mind and Body) and early intervention for eating disorders (PETs). Both these interventions have been subject to observational evaluation and report a positive impact but would benefit from an additional and economic evaluation.

Resilience based approaches are being tested through Head Start Kent. This programme provides a significant opportunity to learn about what works for 10-15 year olds. Efforts need to focus on how the learning from Head Start in Kent and nationally can be applied to primary aged children and in the Early Years.

Whole school and setting approaches to building emotional health and resilience are an integral part of emotional health promotion. This needs to include the implementation of anti-bullying policies and practice which extends into the virtual world.

Schools and colleges including Special Schools must be seen as integral to early intervention and care pathways from treatment to recovery. Schools and colleges need access to training

to understand the system of care, to build relationships and their own skills and competencies around emotional and mental health.

Reducing children and young people's exposure to adversity should be everyone's priority. Exposure to adversity in the virtual world, for example online bullying, grooming and sexual exploitation needs to be considered as part of any prevention or treatment.

Compliance re NICE guidance on attachment needs to be understood and implemented across the system of mental health care.

The stigmatisation of emotional and mental health disorders and of exposure to adversity require that proactive enquiry and identification as well as anti-stigma campaigns are needed. The evidence of routine enquiry with children and young people needs to be assessed.

Trauma informed approaches should be tested in Kent within the robust research and development framework in order to understand the impact on mental health outcomes for children and young people.

Improvements in the mental and emotional system of care will be mitigated by increases in social inequality and poverty. The monitoring of these social determinants need to be incorporated into any evaluation of the programme of improvement.

### **Improving informatics in order to access the impact of the system of care on different conditions, at risk groups and health inequalities**

Work needs to progress to implement the core dataset and outcomes framework across the system of care for children and young people which will enable the identification of high risk groups and those with protected characteristics and understand if the system of care is benefiting them. Linking this dataset to education and social care data will enable in-depth enquiry into the effectiveness of the system of care for children and young people in Kent.

In the short-term, there would be value in identifying, prioritizing and scheduling pathway audits, which can assess quality and effectiveness including sexual abuse and sexually harmful behavior.

In the short-term subjecting the system improvements to an Equality Impact Approach will provide additional analysis and opportunities to improve access and outcomes for girls and boys, LGBTQ young people, children and young people with disabilities, BME children and young people, children in care, in need and children and young people who are socially and economically deprived.

### **Improving informatics in order to access the impact of the system of care on different conditions in particular the balance between emotional and behavioral interventions**

There is a need to better understand whether interventions for behavioural and emotional disorders are currently been provided in line with known prevalence. NHSE has already



identified the need to increase the capacity and effectiveness of early intervention psychosis services and eating disorder treatment.

Externalising mental health disorders like conduct disorder are the most common mental health disorder. Interventions to prevent and modify or treat behavioural and externalising mental health conditions like Conduct Disorder, Early Onset Conduct Disorder and ADHD are multi sectorial and require systematic early identification, integrated care pathways and multi sectorial interventions.

There is a need to audit NICE evidence-based interventions in place in health but also in social care and educational settings in Kent where early intervention in behavioural disorders can be delivered, to understand the gaps, workforce requirements and impact on children and young people.

Access to children and young people with ADHD and conduct disorder particularly early onset conduct disorder, most likely to be amongst populations with the lowest socio-economic status, needs to be reviewed and interventions developed. These children are most likely to be identified in early year's settings and schools, may be in contact with the criminal justice system and engaged in substance misuse in early adolescence. The interventions needed for secondary prevention and treatment are problem solving groups and parent training. There is a need to review capacity and capability of parent training offer in Kent.

Given the increase in self-harm and PTSD particularly amongst girls aged 15 and 16-24, there is a need to ensure that there is a stepped increase in the awareness, identification and intervention for these disorders.

### **Improvements needs to be made to the transparency of the system of care for children and young people's emotional and mental health**

The system of emotional and mental health care needs to build confidence and effective communication with the wider children and young people's work force. The thresholds for services, age where diagnosis take place and clarity around the benefits of interventions need to be communicated.

### **Development of a children and young people's suicide and self-harm prevention strategy based on national and local evidence**

Evidence from national analyses of death by suicide recommends increasing access to mental health (including crisis) and substance misuse services, supporting vulnerable families, promoting mental health in schools, addressing bullying and on-line safety, increasing interventions for self-harm and awareness of the 'final straw' events in children and young people's lives. This learning needs to be incorporated into the Suicide Prevention Strategy.

**The prevention of adult mental health disorders needs to be understood in relation to the onset of mental health disorders in children and young people**

Any case for change in adult mental health needs to reference actions to improve children and young people's mental health.

**Children and young people's resilience, emotional health and resilience needs to be the business of the whole children and young people's workforce**

The whole children and young people's workforce needs to be engaged in the emotional and mental health system of care, in promoting emotional health and resilience, identifying at risk children and young people, intervening early and supporting children and young people to access treatment and to recover. The responsibility does not stop with the children and young people's workforce, adult services need to be engaged and understand the impact of adult behaviours on children and young people.

If the whole of the children and young people's workforce is to be engaged in children and young people's mental health, assessments of need are to be in place, like EHC and CIC plans and must be shared to enable care coordination.

**Children and young people's resilience, emotional health and resilience needs to be the business of the adult workforce:**

The adult workforce in social care and health also have a role in supporting parents and carers to understand and support their children and young people's resilience particularly when children and young people are exposed to adversity, parental separation and debt.

**A workforce audit is required to understand the current level of competencies and skills of the wider children and young people and adult workforce and to address gaps**

This will require a significant strategic commitment to understanding current levels of skills and competencies and developing the workforce over time.

**There is a need for focused work around the ability of children and young people's services to respond to familial issues and for parents and parents to engaged in emotional and mental health promotion, early intervention, prevention and treatment**

Efforts to improve children and young people's mental needs to be inclusive of parental mental health and the pressures on families including parental separation and debt.

There is a need to understand better from parents and carers of children and young people with mental health disorders what their needs are and how they can be better involved in their child's treatment.

There is a need to review and strengthen evidence based interventions in particular which promote attachment in line with NICE guidance, intervene to address attachment disorder and early onset conduct disorder.

**System improvement needs to a focus on promoting, intervening early, preventing and treating the emotional and mental health needs of children and young people with disabilities including with SLCN**

Children and young people with disabilities are a group which require particular attention for presentation and treatment because the high prevalence of mental health disorders amongst this group. These children are more likely to be outside of mainstream educational settings and due to high levels of speech language and communication need may not benefit from talking therapies.

There is a need to ensure an approach to emotional and mental health promotion, primary and secondary prevention and treatment which ensures that the children and young people with speech Language and Communication needs benefit.

**The lack of social and emotional support for children and young people who identify as LGBTQ needs to be addressed to enable emotional health promotion, early intervention and prevention as well as access to treatment**

Effort needs to be focussed on providing social and emotional support to LGBTQ children and young people in order build resilience and improve emotional health and increase access to support and specialist services as required.

Stakeholders report a lack of clarity regarding the support services and pathway in Kent for children and young people who are transgender or non-binary. There is a need for a multi sectorial integrated care pathway to be developed.

**There needs to be improvements in identification, assessment and access to interventions for children in need and in care**

Efforts need to be focused on improving mental health of children in care through the trialing of promising interventions including assessment and mental health practitioners integrated into specialist children's services.

There is a need to audit the assessment of mental health needs of children in care in Kent to ensure that SDQs which indicate need do result in referral to and engagement in treatment.

**There is a need to clarify the identification, assessment and access to interventions for children and young people involved in the criminal justice system and those who can be effectively diverted from the criminal justice system**

There is a need to confirm the model of mental health intervention and access to specialist treatment for young people in contact with the criminal justice system. Given the high levels of exposure to adversity and trauma it is likely that these young people would benefit from a trauma informed care approach, if piloted.

The pathway of support from custody to community has been historically problematic and needs to be examined in detail to ensure that continuity of care is supported through resettlement.

Street triage is a method of diverting young people from the criminal justice system at the point that they face arrest. The inclusion of young people in this service requires additional investigation.

**There is a need to ensure that young carers benefit from emotional health promotion and resilience, early intervention and prevention and treatment**

Social and emotional support services for young carers may offer the opportunity to build their resilience, coping strategies and improve access as appropriate.

**Emotional and mental health and substance misuse pathways require review and may benefit from greater integration:**

Pathways to behavioural interventions for under 15-year olds who present with problematic substance misuse need to be audited.

Pathways and joint working between substance misuse and mental health services need to be reviewed against best practice.

**Children and young people with long-term conditions and their parents and carers may benefit from emotional health promotion. The role that GPs, practice nurses and specialist children's nurses can play requires additional investigation**

There is a need to ensure that emotional health promotion and mental health awareness and intervention are incorporated into the management of children with long term conditions particularly as they enter adolescence.

**Public Health School Nursing has impact on emotional health and resilience needs be maximized**

Public Health School Health Services support to the whole school as well as individual pupils requires auditing to ensure that the resource is achieving the anticipated high impact and outcomes are being continuously improved.

**Variation in acute care presentations, admissions and representations require additional investigation and focused interventions to ensure children and young people receive the best possible care in community settings.**

There is variation across CCG and districts in presentations and admissions to acute care as a result of mental health disorder. This data needs to be understood in the context of guidance to Acute Trusts which indicates that young people who present at acute care should be admitted pending psychiatric assessment and the distribution and development of the psychiatric liaison service in Kent. This variation requires additional interpretation in order to confirm the actions required.

Repeat presentations and admissions for mental health disorders requires additional investigation. Some disorders repeated episodes that require presentation and admission may be anticipated.

Variation in planned and emergency admissions in acute settings for children and young people with eating disorders require additional investigation.

## | 4. Definitions

### For the purposes of this health needs assessment

**Emotional wellbeing** is the positive aspects of mental health, such as the feeling of happiness, confidence and functioning in each of the aspects of one's life.

**Mental health disorder is typically characterized as disordered thinking, emotions and behaviour. Mental health disorders may be mild, moderate or severe. Mental health disorders can be defined in relation to diagnostic categories defined in the ICD-10 Classification of Mental and Behavioural Disorders**

A person with a mild or moderate mental health disorder may be exhibiting some of the symptoms of that disorder but at a lower clinical threshold. This may include the symptoms being present for a short defined period i.e. symptoms of post-traumatic stress disorder (PTSD) in the first month after a traumatic event. This may include the symptoms being present in different settings i.e. ADHD diagnosis.

For the purposes of this health needs assessment, **mental health disorders are grouped as externalizing and internalizing mental health disorders**. Internalizing disorders include separation anxiety, specific phobia, social phobia, panic disorder, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD) and major depressive disorder (MDD). Externalising disorders include attention, deficit and hyperactivity disorder (ADHD), oppositional defiant disorder (ODD) and conduct disorder (CD) after Fabstein et al (2010), Achenbach (1978).

Broadly, externalising behaviours manifest outwardly, through problems with attention, self-regulation, and noncompliance, as well as antisocial, aggressive, and other under-controlled behaviours. Internalising behaviours are directed inwardly, through depression, withdrawal, and anxiety, as well as feelings of inferiority, self-consciousness, shyness, hypersensitivity, and somatic complaints (Bornstein et al 2010).

Internalising mental health conditions are also referred to as emotional health conditions.

**ADHD** is included as mental health disorder this health needs assessment as it is classified as an externalising behavioural mental health disorder in Fabstein et al 2010 and in the prevalence studies undertaken by Green (2004), Meltzer (1999) and Egger et al (2006). ADHD is also classified as a neurodevelopmental disorder. Autism, which is also a neurodevelopmental disorder, is not included.

**Specialist treatment** refers to a range of interventions which can be used to reduce symptoms below a clinical threshold and achieve goals defined by the child and young person which will support their recovery and emotional wellbeing.

**Resilience** is an adaptive capability that enables a person to thrive in the presence of adversity.

**Attention Deficit Hyperactivity Disorder (ADHD)** is defined as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. It is also understood to be a neurodevelopmental disorder.

The definition requires that symptoms:

- start before 12 years of age
- occur in two or more setting such as at home and school
- have been present for at least 6 months
- interfere with, or reduce the quality of social, academic or occupational functioning
- do not occur exclusively during the course of a psychotic disorder and are not better explained by another mental disorder (NICE 2016).

**Conduct disorder** is a persistent (several months or longer) pattern of antisocial behavior where a child or young person repeatedly carries out aggressive acts that upset other people. The presentation of conduct disorder varies with age.

Conduct disorders are usually diagnosed over the age of three years old. If antisocial behaviors occur:

- before 10 years of age this is referred to as 'early onset'
- after 10 years of age this is referred to as 'adolescent onset'.

Conduct disorder should be suspected, if maltreatment is not considered likely, and the child or young person presents with persistent, marked antisocial behaviors such as:

- Children aged three to seven years — usually present with general defiance of adults' wishes; disobedience of instructions; angry outbursts with temper tantrums; physical aggression to other people (especially siblings and peers); destruction of property; arguing; blaming others for things that have gone wrong; annoying, and provoking others.
- Children aged eight to 11 years — may present with any of the above as well as other behaviors such as swearing; lying about what they have been doing; stealing outside the home; persistent breaking of rules; physical fights; bullying other children; being cruel to animals, and setting fires.
- Young people aged 12 to 17 years — present with any of the above behaviors as well as more antisocial behaviors such as being cruel to and hurting other people; assault; robbery using force; vandalism; breaking and entering houses; stealing from cars; driving and taking away cars without permission; running away from home; truanting from school, and misusing alcohol and drugs (NICE 2017).

**Oppositional defiant disorder** is a sub-type and milder variation of conduct disorder seen in younger children.

**Anxiety disorders** are types of common mental health disorders (CMD). Anxiety disorders can include generalized anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder.

**Separation anxiety (SAD)** is ‘an abnormal reactivity to real or imagined separation from attachment figures which significantly interferes with daily activities and developmental tasks’ (Masi et al, 2001).

**Social anxiety disorder** is persistent fear of or anxiety about one or more social or performance situations that are out of proportion to the actual threat posed by the situation. (NICE 2015).

**Post-traumatic stress disorder can develop following an incident** such as a serious accident, a violent personal assault, or military combat). It can affect people of all ages and is characterized by:

- Re-experiencing symptoms — which may occur in the daytime when the person is awake (flashbacks, or intrusive images or thoughts) or as nightmares when asleep. This is the most characteristic symptom.
- Avoidance of people or places that remind the person of the event.
- Emotional numbing/negative thoughts, where the person expresses a lack of ability to experience feelings or feels detached from other people, or has negative thought about themselves.
- Hyperarousal/hyper reactivity, where the person is on guard all the time, looking for danger (hypervigilance), or the person has irritable behaviour or angry outbursts with little or no provocation.

A person is said to have post-traumatic stress disorder if a defined number of symptoms persist for more than one month after the major traumatic event.

The onset of symptoms is usually in the first month after the traumatic event. In a minority of people (15%) symptoms can be delayed by months or years, but they usually appear within six months. This figure is higher (38%) for people who have military or combat-related post-traumatic stress disorder:

- **Complex post-traumatic stress disorder** may develop after extreme prolonged or repeated trauma (such as repeated childhood sexual abuse or prolonged captivity involving torture (NICE 2005).
- **Oppositional Conduct Disorder** is characterized by recurrent obsessional thoughts or compulsive acts or, commonly, both (NICE, 2005).
- **Body Dysmorphic Disorder** is characterized by a preoccupation with an imagined defect in one's appearance, or in the case of a slight physical anomaly, the person's concern is markedly excessive.



- **Generalized Anxiety Disorder** is one of a range of anxiety disorders characterized by disproportionate, pervasive, uncontrollable, and widespread worry and a range of somatic, cognitive, and behavioral symptoms that occur on a continuum of severity.
- **Depression** is characterized by persistent low mood and or loss of pleasure in most activities and a range of associated emotional, cognitive, physical, and behavioral symptoms.

It is defined in the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by the presence of at least five out of a possible nine defining symptoms, present for at least two weeks, of sufficient severity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013).

**Subthreshold depressive symptoms** describe a situation when an individual has some of the nine defining symptoms of depression but they are insufficient in number or severity to meet the full criteria to diagnose depression (National Collaborating Centre for Mental Health, 2009).

**Persistent subthreshold depressive symptoms** are defined by the National Institute of Health and Clinical Excellence as persistence of subthreshold depressive symptoms for more than two years (NICE 2017).

**Bipolar disorder** is a potentially lifelong and disabling condition characterized by episodes of mania (abnormally elevated mood or irritability and related symptoms, with severe functional impairment or psychotic symptoms for seven days or more) or hypomania (abnormally elevated mood or irritability and related symptoms, with decreased or increased function for four days or more), alternating with episodes of depressed mood.

**Borderline personality disorder** is characterized by significant instability of interpersonal relationships, self-image and mood, and impulsive behavior (NICE 2009).

**Psychosis** and the specific diagnosis of **schizophrenia** represents a major psychiatric disorder or cluster of disorders that alter a person's perception, thoughts, mood and behaviour. The symptoms of psychosis are usually divided into 'positive symptoms', including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms' (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect (NICE 2016).

**Self-Harm** is intentional injury as a means of coping with or expressing overwhelming emotional distress. It includes cutting, pinching, hitting and poisoning.

**Suicide** is a death that received a conclusion of suicide or open verdict at coroner's inquest (NCISH 2016).

**Suicidal ideation, thoughts, feelings** are transient or frequent thoughts of, or a preoccupation with, suicide; this might include methods and developing a plan.

## | 5. Abbreviations

<b>ADHD</b>	Attention Deficit Hyperactivity Disorder
<b>APMS</b>	Adult Psychiatric Morbidity Study
<b>ASD</b>	Autistic Spectrum Disorder
<b>BDD</b>	Body Dysmorphia Disorder
<b>CAMHS</b>	Children and Adolescent Mental Health Services
<b>CD</b>	Conduct Disorder
<b>CMD</b>	Common Mental Health Problems
<b>DAWBA</b>	The DAWBA is a package of interviews, questionnaires and rating techniques designed to generate ICD-10 and DSM-IV or DSM-5 psychiatric diagnoses on 2-17 year olds.  The DAWBA covers the common emotional, behavioural and hyperactivity disorders, without neglecting less but sometimes more severe disorders
<b>DSM-IV</b>	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
<b>DSM-5</b>	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
<b>ED</b>	Eating Disorder
<b>EHC</b>	Education and Health Care Plan
<b>FAS</b>	Fetal Alcohol Syndrome
<b>GAD</b>	General Anxiety Disorder
<b>ICD-10</b>	International Classification of Disease Version 10
<b>LGBTQ</b>	Lesbian Gay Bisexual Transsexual, Queer and Questioning
<b>ODD</b>	Oppositional Defiant Disorder
<b>OSFED</b>	Other specified Eating Disorder/ Atypical eating disorder
<b>PTSD</b>	Post Traumatic Stress Disorder
<b>SDQ</b>	Strengths and Difficulties Questionnaire

## 6. Demographics

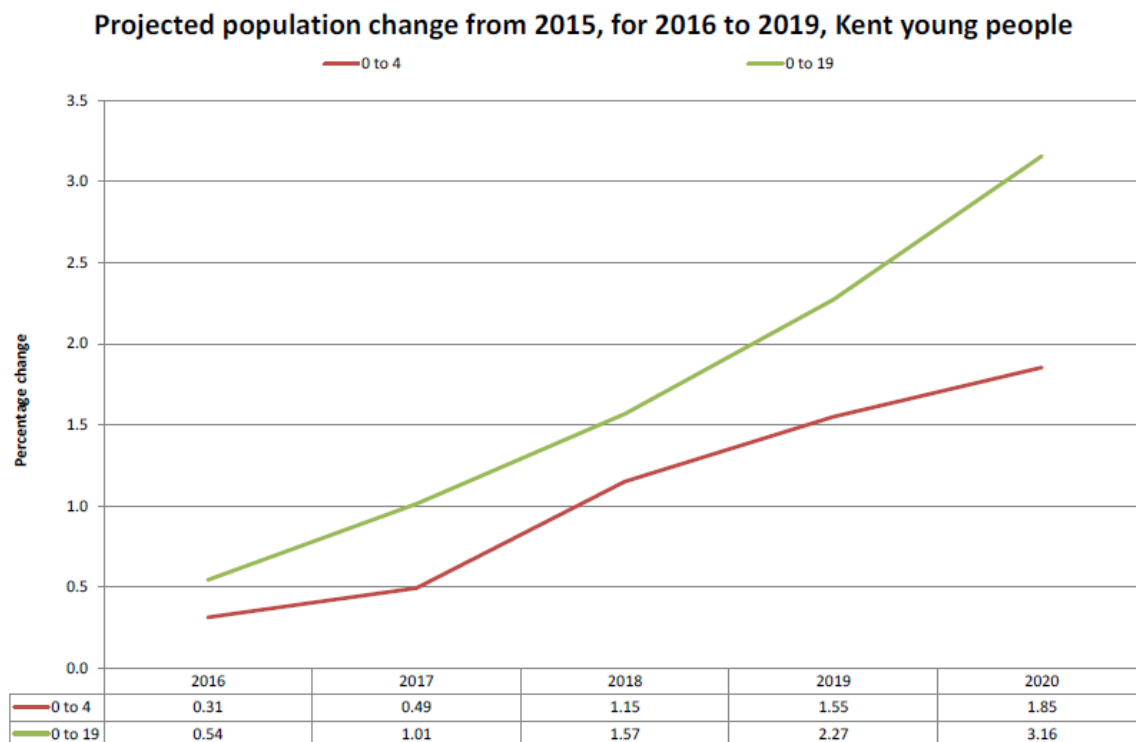
### Key Population and Indicators for Kent

In this section, demographic information is provided for the child population in Kent including the geographical distribution of at risk populations. Key indicators which impact on mental health are also provided. Indicators where Kent performs poorly compared to England are listed as well as comparisons between districts and Kent values. Together these provide contextual information which can be used to understand the distribution of need against the current and future demand for interventions and highlight indicators and populations which may need to be targeted in order to prevent mental health disorders.

#### Population Projections for Kent

In 2015 there were 367,400 children and young people aged 0-19 in Kent. This represents 24.1% of the population. The number is predicted to increase to 398,789 by 2025.

**Figure 1: Projected Population Change from 2015 for 2016 to 2019 for children and young people aged 0-4 years old and 0-19 years of age in Kent**



The percentage change in the population aged 0-4 and 0-19 is positive and increases from 2016 to 2020. The percentage change is greater amongst 0-19 year olds.

#### Key population and indicators for kent: public health england children and young people's mental health and wellbeing tool

The Public Health England's Children and Young People's Mental Health and Wellbeing Profiling Tool which can be found at: <https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh>. This provides a full set of benchmarked data on risk factors, prevalence, health and social indicators for Kent and Kent's districts. There is a time lag of up to two years for some indicators.

These indicators are significantly higher in Kent than England value. The source is provided in brackets for each indicator.

- % children aged <15 who provide unpaid care 2015/16 (National Census)
- % of 15 year olds with a long-term illness, disability or medical condition diagnosed by a doctor 2014/15 (What about YOUth?)
- Marital breakup: % of adults whose current marital status is separated or divorced 2015/16 (National Census)
- % of 15 year olds who are current smokers 2014/15 (What about YOUth?)
- % of 15 year olds who have taken cannabis in the last month 2014/15 (What about YOUth?)
- % of 15 year olds who have been bullied in the past couple of months 2014/15 (What about YOUth?)
- Rate of looked after children: per 10,000 population under 18 2015/16 (Social Care)
- Rate of children leaving care per 10,000 population under 18 2015/16 (Social Care)
- Rate of children in need due to socially unacceptable behavior 2015/16 (Social Care)
- Fixed period exclusion due to persistently disruptive behavior 2014/15 % of pupils (Pupil Census)
- Primary school fixed period exclusions % of pupils 2014/15 % of pupils (Pupil Census)
- Secondary school fixed period exclusions % of pupils 2014/15 (Pupil Census)
- School absence % of half days missed 2015/16 (Pupil Census)
- % children in need for more than two years: % of children who have been 'in need' for more than two years 2016 (Social Care)
- Abuse and neglect: Rate per 10,000 children subject of a child protection plan with initial category of neglect 2016 (Social Care)
- Repeat child protection cases: Percentage of children who became the subject of a child protection plan for a second or subsequent time 2016 (Social Care)
- Children started to be looked after due to family stress or dysfunction or absent parenting: rate per 10,000 <18 population 2016 (Social Care)
- Children in need due to family stress or dysfunction or absent parenting: per 10,000 resident children aged under 18 years 2016 (Social Care)
- % of 16-18 year olds not in education, employment or training 2015 (NEET).

Children and Young Persons Mental Health and Wellbeing Tool at Kent District Level

The following indicator data which measures risk factors is provided by Public Health England on risk factors for children and young people and mental health prior to it being updated in October 2016. Many of the indicators are taken from the Census in 2011.

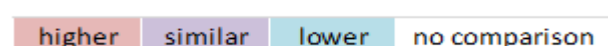
**Table 1: Children and Young Peoples Mental Health and Wellbeing Risk Factors England, Kent and Kent Districts**

Children and Young People's Mental Health and Well Being Risk Factors

Indicator	Time period	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells	Kent	England
Children providing care: Percentage of children aged <15 who provide unpaid care	2011	1.1	1.3	1.0	1.4	1.1	1.2	1.0	1.5	1.5	1.4	1.2	0.9	1.2	1.1
Children providing considerable care: Percentage of children aged <15 who provide 20+ hours of unpaid care per week	2011	0.2	0.2	0.2	0.3	0.2	0.2	0.1	0.3	0.4	0.2	0.2	0.1	0.2	0.2
Children under 16 in poverty: Percentage of children aged 0-15	2014	17.2	18.2	16.2	22.9	19.7	15.2	13.2	22.1	23.6	27.9	13.1	11.0	18.4	20.1
Families out of work: Percentage of households with dependent children where no adult is in employment	2011	3.7	3.6	4.1	3.8	4.5	3.5	2.4	4.0	5.1	5.3	3.0	2.8	3.8	4.2
Families with health problems: Percentage of households with dependent children where at least one person has a	2011	4.8	4.2	4.7	4.5	5.3	4.5	3.8	4.6	5.3	5.0	4.5	3.9	4.6	4.6
Lone parent households: Percentage of households	2011	7.1	6.5	7.8	6.3	7.4	6.7	4.9	6.4	8.0	8.3	6.3	5.2	6.8	7.1
Marital breakup: Percentage of adults	2011	12.3	10.7	11.7	13.7	11.6	11.8	10.7	14.0	13.2	15.2	11.8	11.7	12.3	11.6
Obese children (Reception year): Percentage of children	2015/16	10.6	6.3	10.7	11.6	10.5	9.0	6.3	10.6	8.6	10.0	7.7	9.4	9.2	9.3
Obese children (Year 6): Percentage of children	2015/16	19.1	16.5	21.1	21.5	22.1	18.6	14.4	20.6	19.6	21.4	15.5	13.5	18.7	19.8
Under 18 pregnancy: rate of conceptions per 1,000 females aged 15 - 17	2014	15.8	18.8	22.5	32.7	28.1	18.0	15.0	23.9	29.0	30.6	21.0	13.5	22.2	22.8
Underweight children (Reception year): Percentage of children	2015/16	0.6	1.6	0.5	*	1.1	0.6	0.4	0.8	0.7	*	*	0.5	0.6	1.0
Underweight children (Year 6): Percentage of children	2015/16	0.8	1.4	1.1	0.7	1.6	1.0	0.9	0.8	1.1	0.4	1.1	0.9	1.0	1.3
Young people providing care: Percentage of people aged 16-24 who unpaid care	2011	4.6	3.5	4.5	5.3	5.1	4.4	4.1	5.8	5.1	5.6	4.6	4.0	4.6	4.8
Young people providing considerable care: Percentage of people aged 16-24 who provide 20 hours + of unpaid care per	2011	1.3	0.7	1.2	1.4	1.6	1.1	1.2	1.9	1.9	1.8	1.0	0.9	1.3	1.3

<https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh/data#page/0/gid/1938132752/pat/102/par/E10000016/ati/101/are/E07000113/iid/90412/age/-1/sex/4>

**Compared to England benchmark:**



Canterbury (1.3), Dover (1.4), Shepway (1.5), Swale (1.5) and Thanet (1.4) have higher rates of children and young people providing unpaid care than the Kent (1.2) value.

Dover (22.9), Shepway (22.1), Swale (23.6) and Thanet (27.9) have higher percentage of children (aged under 16) in poverty than the Kent (20.1) value. These districts also have a higher percentage of families out of work than the Kent value.

The percentage of households that are lone parents are higher in Dartford (7.9), Gravesham (7.4), Swale (8.0) and Thanet (8.3) than the Kent (6.8) value.

Ashford (12.3), Dover (13.7), Maidstone (11.8), Shepway (14.0), Swale (13.2) and Thanet (15.2) have a higher percentage of adults who have experienced marital breakup than the Kent (12.3) and England (11.6) value.

Dover has a higher percentage of children (Year R) (11.6) who are obese than the Kent (9.2) value.

Gravesham has a higher percentage of children (Year 6) (22.1) than Kent (18.7) and England (19.8).

Dover (32.7), Swale (29.0) and Thanet (30.6) have higher rates of under 18 conceptions per 1,000 females 15-17 year olds than the Kent value.

Canterbury (1.6) has a higher percentage of underweight children (Year R) than the Kent value.

Dover (5.3), Shepway (5.8) and Thanet (5.6) have a higher percentage of young people aged 16-24 who provide unpaid care than the Kent (4.6) value.

Gravesham (1.6), Shepway (1.9), Swale (1.9) and Thanet (1.8) have a higher percentage of young people aged 16-24 who provide considerable unpaid care than the Kent (1.3) value.

Children who are subject to Child Protection Plans, Children in Need and Looked after Children: Kent and District

**Table 2 Count and Rate per 1,000 registered population of Children in Need (CIN) and Child Protection cases (CP) as at 31/12/2016 (snapshot data) by CCG**

CCG	Children in need		Child protection	
	Count	Rate per 1,000	Count	Rate per 1,000
NHS Ashford CCG	736	25.2	99	3.4
NHS Canterbury and Coastal CCG	1,038	26.0	96	2.4
NHS Dartford, Gravesham and Swanley CCG	1,317	22.1	186	3.1
NHS South Kent Coast CCG	1,473	36.4	235	5.8
NHS Swale CCG	782	31.1	107	4.2
NHS Thanet CCG	1,179	39.3	156	5.2
NHS West Kent CCG	1,868	17.4	220	2.1
<b>Kent</b>	<b>8,393</b>	<b>25.3</b>	<b>1,099</b>	<b>3.3</b>

Source: KCC MIU, PCIS

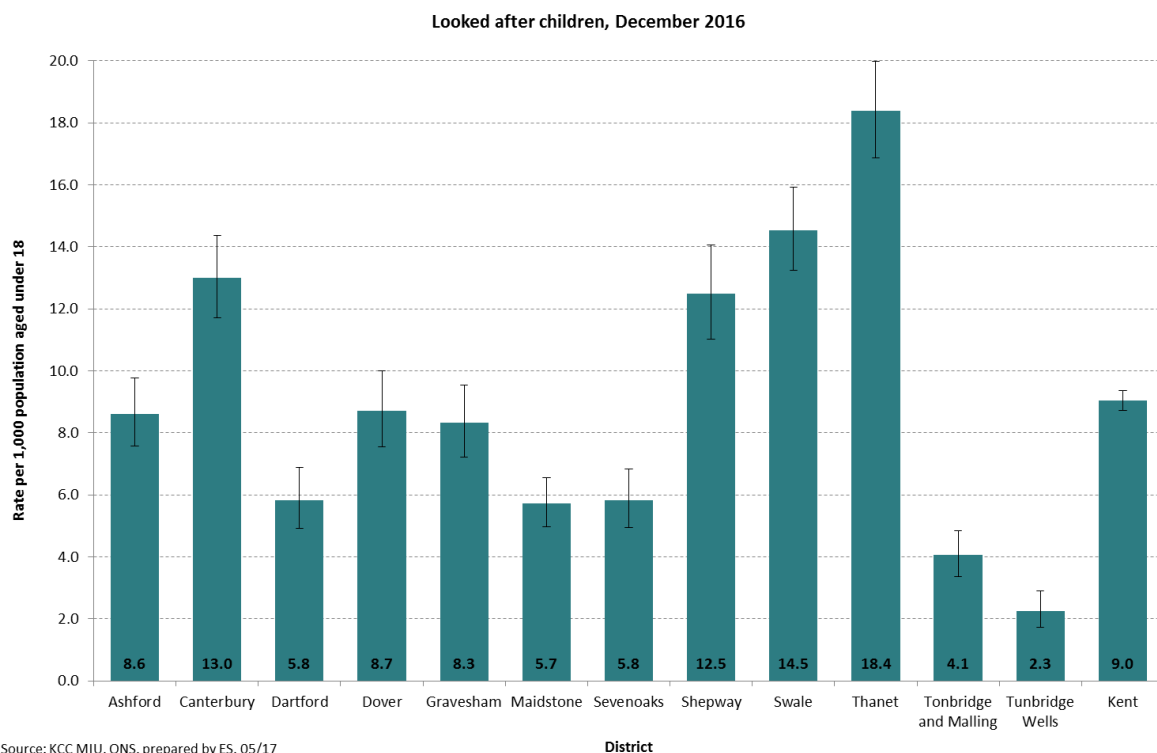
### Children in Need

Across Kent, there are 25.3 children in need per 1,000 population aged under 18. This ranges from 17.4 in West Kent CCG to 39.3 in Thanet CCG. West Kent CCG and Dartford, Gravesham and Swanley CCGs have significantly lower children in need rates compared to Kent, while South Kent Coast, Swale and Thanet CCGs have significantly higher rates (95% confidence intervals).

## Child Protection Plans

Across Kent, there are 3.3 children on child protection plans per 1,000-population aged under 18, ranging from 2.1 in West Kent CCG to 5.8 in South Kent Coast CCG. West Kent CCG and Canterbury and Coastal CCGs have significantly lower children on child protection plans compared to Kent, while South Kent Coast and Thanet CCGs have significantly higher rates (95% confidence intervals).

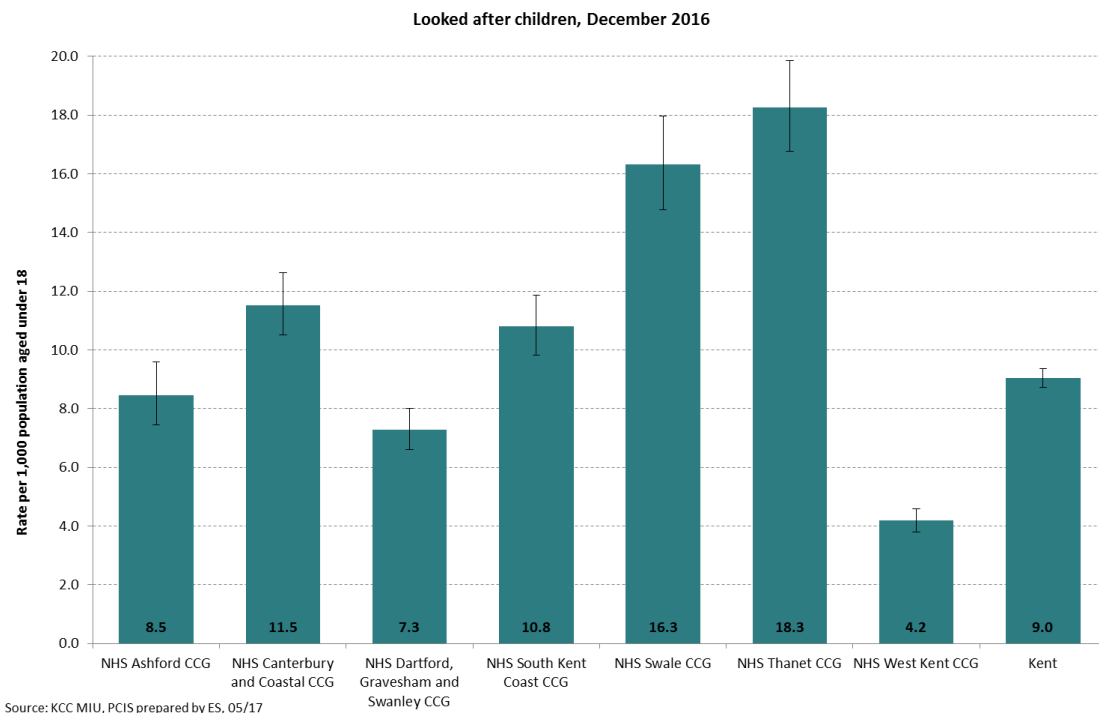
**Figure 2: Rate of Looked After Children per 1,000 population aged under 18 for Kent and Kent Districts**



Across Kent, there are 9.0 Kent looked after children per 1,000 resident population aged 0 to 17. This figure includes Kent children placed in Kent, and other local authority children placed in Kent districts. It does not include children placed in Medway, other local authorities or those placed in undisclosed locations. Canterbury (13.0), Shepway (12.5), Swale (14.5) and Thanet (18.4) had significantly higher rates than Kent (95% confidence intervals).

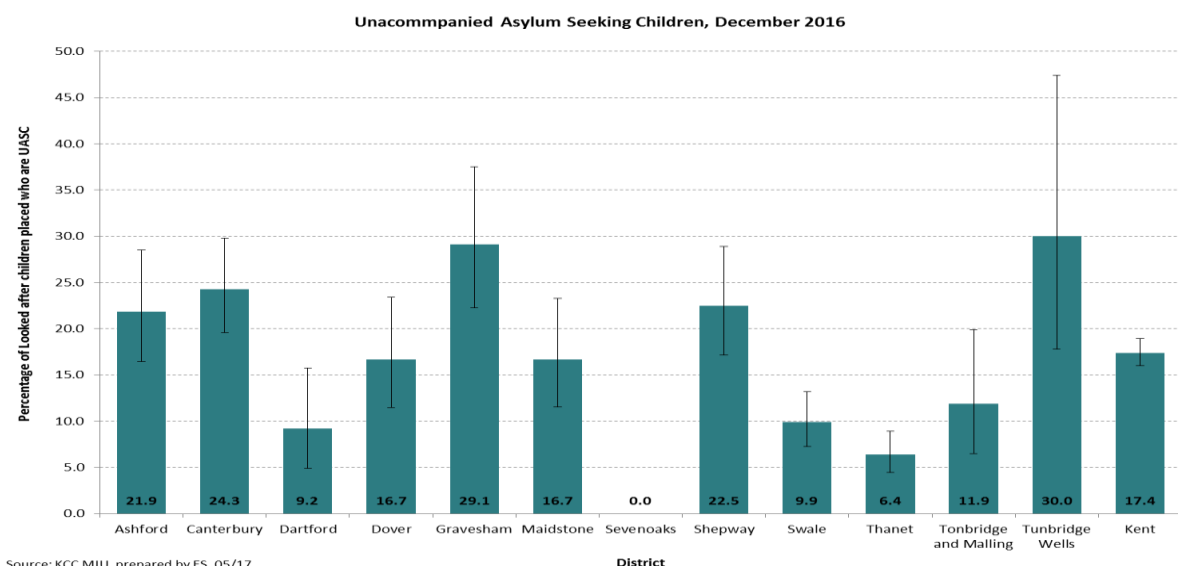
In total, there were 2,076 Kent looked after children, 1,686 of which were placed in Kent districts. A third (31.8%) of Kent looked after children were classified as Unaccompanied Asylum Seeking Children (UASC). A further 49 were placed in undisclosed locations, 171 in other local authorities and 170 in Medway. An additional 1,300 children from other local authorities were placed in Kent.

**Figure 3: Rate of Looked After Children per 1000 population aged under 18 for Kent and Kent CCGs**



Across Kent, there are 9.7 Kent looked after children placed per 1,000 registered population aged 0 to 17. Thanet (18.3), Swale (16.3) and Canterbury and Coastal (11.5) CCGs have significantly higher rates than Kent (95% confidence intervals).

**Figure 4: Percentage of Looked After Children who are Asylum Seeker Young People (UASC) for Kent and Kent Districts**



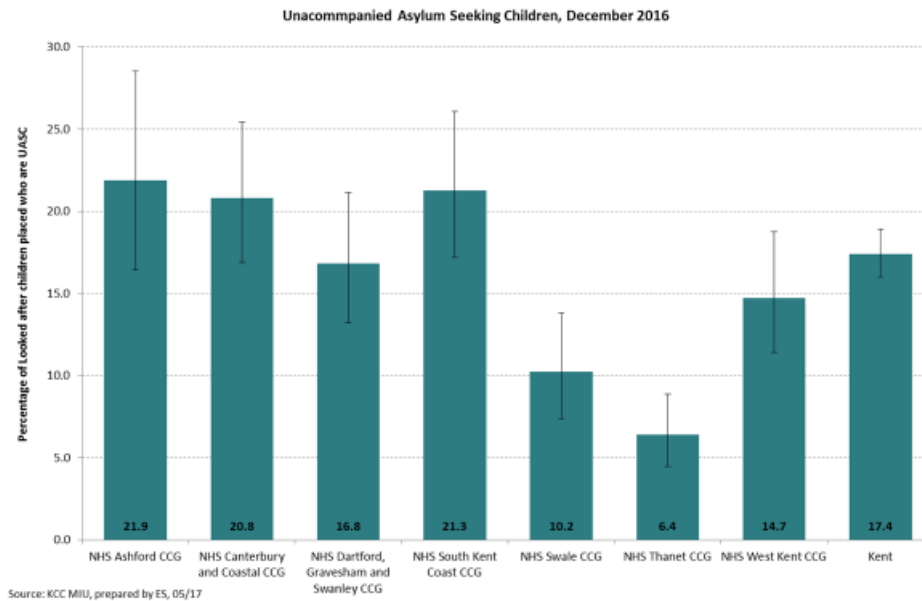
Across the Kent districts, the proportion of looked after children placed within Kent that are UASC ranges from 0% in Sevenoaks to 30.0% in Tunbridge Wells. Only Gravesham district (29.1%) has a significantly higher proportion than Kent (17.4%). Dartford (9.2%), Thanet



(6.4%) and Sevenoaks (0.0%) had a significantly lower proportion than Kent. In terms of numbers, Canterbury had the most UASC placements out of the Kent districts, with 92 at the end of December 2016.

### Unaccompanied Asylum Seeker Young People (UASC): CCG

**Figure 5: Percentage of Looked After Children who are Asylum Seeker Young People (UASC) for Kent and Kent CCGs.**



Across the Kent CCGs, the proportion of looked after children placed within Kent that are UASC ranges from 6.4% in Thanet to 21.9% in Ashford. None of the CCGs have a significantly higher proportion of UASC placements than Kent (17.4%). In terms of numbers, Canterbury and Coastal had the most UASC placements out of the Kent districts, with 96 at the end of December 2016, followed by South Kent Coast CCG with 93.

### Young Offenders

Young offenders are young people aged 10-17 who have entered the criminal justice system and received a court disposal. This may have received a community or a custodial sentence.

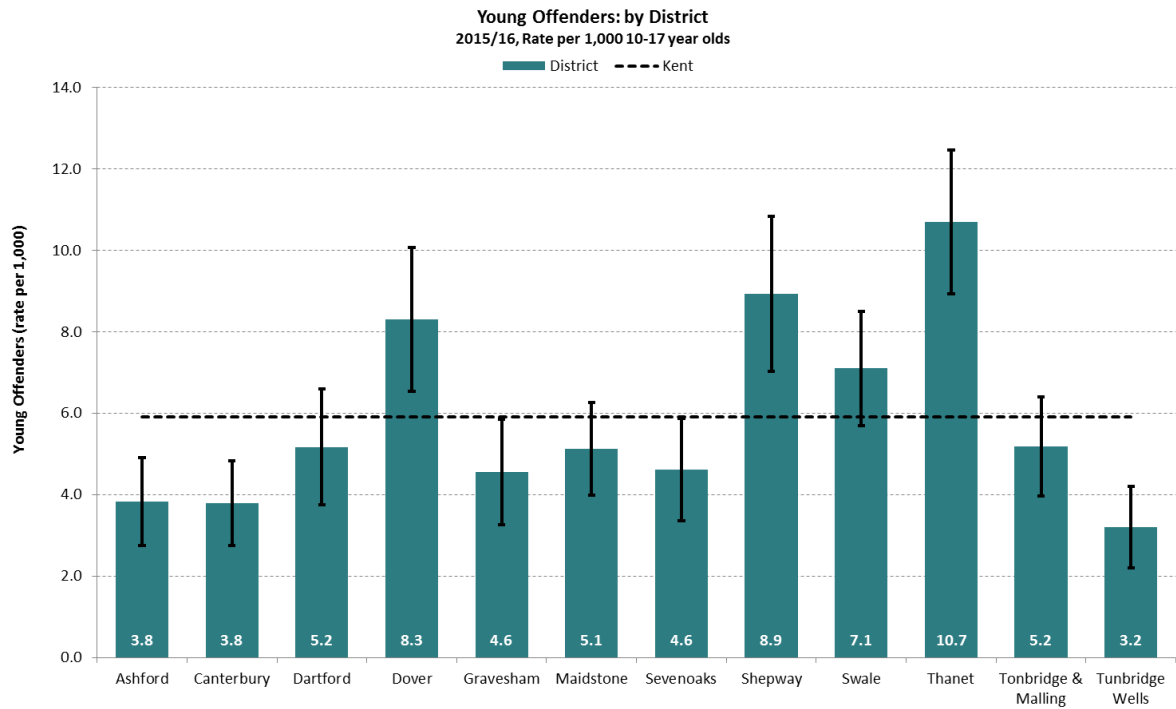
**Figure 6: Annual Rate of Young Offenders per 1,000 population aged 10-17 years from 2012/13 to 2015/16.**



**Figure 7: Annual Number of Young Offenders aged 10-17 years from 2012/13 to 2015/16**



**Figure 8: Rate of Young Offenders per 1,000 10-17 year olds for Kent and for each Kent District**

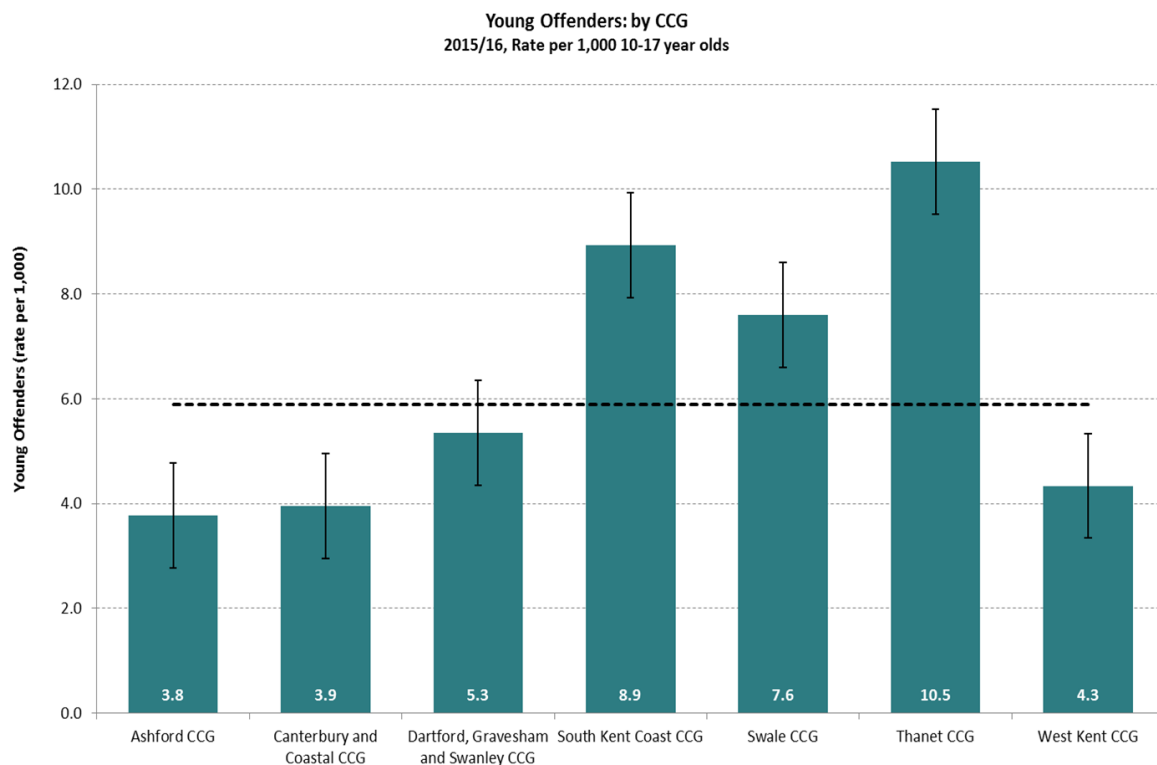


Source: KCC MIU, prepared by KPHO (RK), January 2017

In 2015/16, there were 852 Young Offenders in Kent which is a substantial reduction since 2012/13 (1,575). This reduction in offenders is replicated across the county and reflects the increase in diversion for lower level offences. At any one-time Early Help and Prevention will be working with 50 young people who have been involved in crime and antisocial behavior but who have been successfully diverted from court (KCC 2017). That said, the reduction in numbers belies an increase in the complexity of need amongst those young people.

## Young Offenders: CCG Level

**Figure 9: Rate of Young Offenders per 1,000 10-17 year olds for Kent and for each Kent CCG**

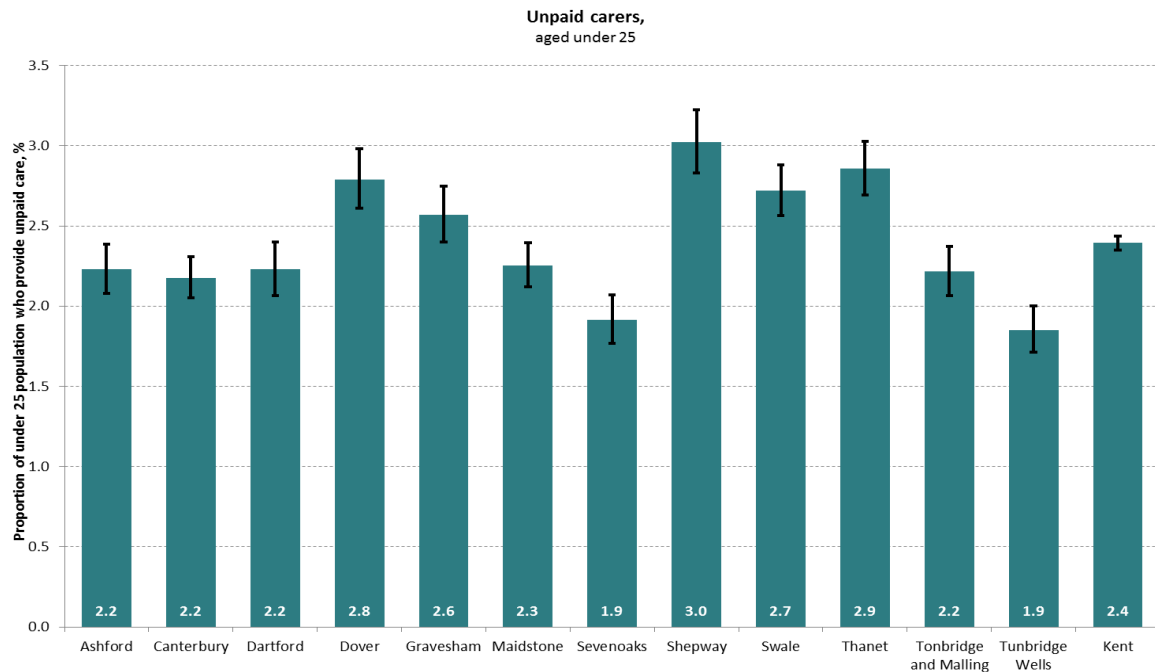


Source: KCC MIU, prepared by KPHO (RK), January 2017

In 2015/16, Thanet CCG had the highest rate of young offenders per 1,000 10-17 year olds at 10.5, followed by South Kent with 8.9 per 1,000. Both were significantly higher than the Kent rate of 5.9. Young offender rates were significantly lower than Kent in Ashford (3.8), Canterbury and Coastal (3.9) and West Kent (4.3) CCGs.

## Young Carers: Kent and District Level

**Figure 10: Proportion of the Under 25 Population who Provide Unpaid Care in Kent and in each Kent District**



Source: ONS (Census, 2011), prepared by ES, 06/17

Across Kent, 10,734 under 25s were classified as unpaid carers according to the 2011 Census, representing 2.4% of the population. Dover (2.8%), Shepway (3.0%), Swale (2.7%) and Thanet (2.9%) had significantly higher percentage of unpaid carers than Kent, while Canterbury (2.2%), Sevenoaks (1.9%) and Tunbridge Wells (1.9%) had significantly lower percentages.

### Lesbian, Gay, Bisexual and Transgender Young People 18-24

Across the adult population, it is estimated that 2.50% self-identify as lesbian, gay or bisexual. There is no data for children and young people but the percentage who self-identify in the 18-24 and 24-34 age group is highest at 4.73% and 7.74% respectively. There is a lack of data around the proportion of children and young people who identify as transgender or transsexual.

## | 7. Evidence Review

### **Resilience, trauma and emotional and mental health: what are they and how are they linked?**

There is some contention as to the definitions of emotional and mental health, whether they are part of the same continuum and whether the emotional wellbeing predicts a lack of mental health condition. In a recent large epidemiological study (n= 12,347) using longitudinal data for 11 year olds in the UK (Patalay and Fitzsimons 2016), there was a low correlation (r=0.2) between emotional wellbeing measures and mental illness measures. In addition, the predictors of emotional wellbeing and mental ill health differed. This study, despite its weaknesses, challenges us to ensure that a distinction is maintained between the two concepts.

### **Ecological Approaches to Mental Health**

In seeking to understand the predictors of mental health disorders conditions in order to prevent them, an ecological, risk and protective factors paradigm is often used. This recognises that risks, which can increase the likelihood that a child has a mental health disorder, and protective factors, which reduce the likelihood, exist at the level of the individual, family, school and community.

Patalay and Fitzsimons (2016) applied the ecological and risk and protective model empirically to data collected through longitudinal research in order to understand the differing and overlapping predictors of mental health illness and emotional wellbeing for children aged 11.

In their work, 47% of the variance of mental illness outcome scores was explained by the predictor variables. The main predictors of outcome were cognitive factors, home environment factors, parent health and social relationships. Twenty-six per cent of the variance of wellbeing scores was explained by the predictor variables.

The main predictors of the emotional wellbeing outcome were social relationships and the wider environment. The highest individual predictors of wellbeing were perceived school connectedness, liking school and being a victim of peer bullying.

At age 11, mental illness scores were significantly higher for children with:

- communication difficulties
- chronic illnesses
- peer relation problems
- frequent arguments with a parent.

Mental illness scores were significantly lower for children with:

- high family income.

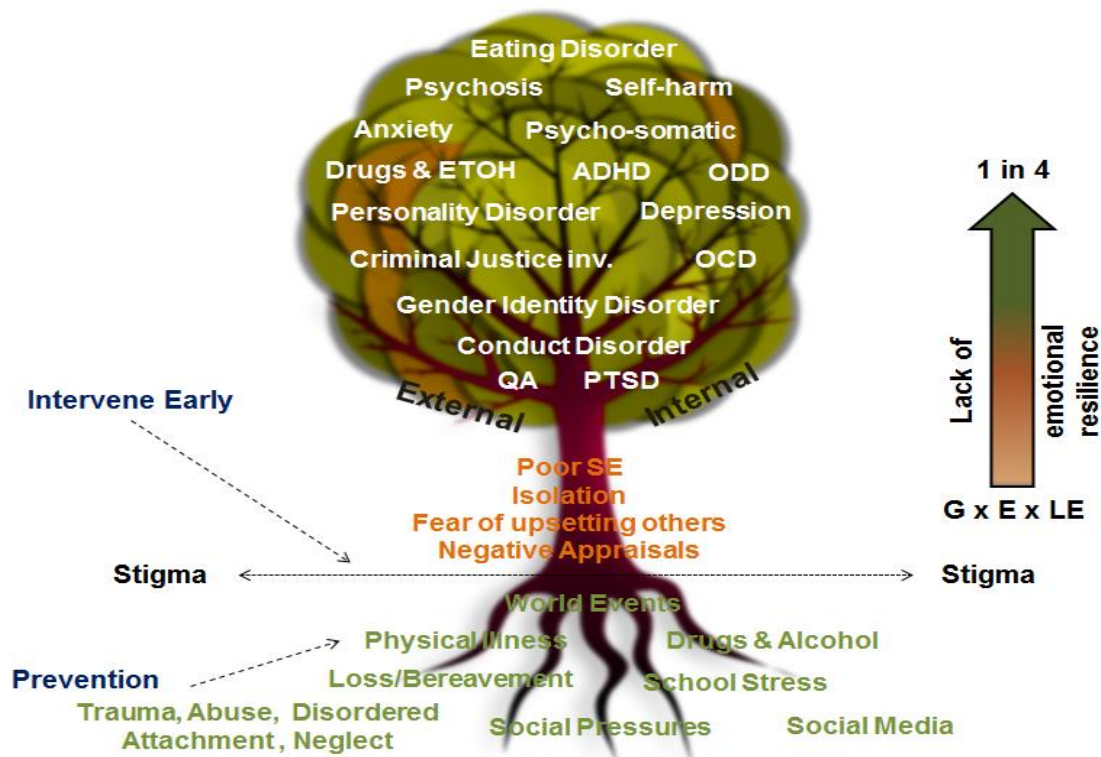
The Patalay and Fitzsimons study (2016) is a relatively rare longitudinal analysis of mental health conditions. This paucity of longitudinal studies within the field of mental health has meant that ‘little is known about the public health effects of early detection and treatment of child and adolescent mental illness on the later progression of these disorders (Kessler and Wang, 2008) in Pinhas and Bondy , 2011 ).

*\* The mental health score is an aggregated score for externalizing and internalizing mental health conditions. The measurements tools are used by both parents and children. Parents report on mental illness score using the SDQ and children self-report emotional wellbeing. The emotional wellbeing measure is self-reported and focused on school settings.*

### Root Causes of Mental Health and the Role that Emotional Resilience Can Play

The image below has been developed by Saqib Latif, Consultant Psychiatrist in North East London Foundation Trust (formally of Sussex Partnership Foundation Trust) to explain the rationale for preventing mental health disorders by addressing root causes or intervening early, and the role that emotional resilience can play in protecting children and young people from adversity.

**Figure 11: Conceptualisation of the Causation and Prevention of Mental Health Disorders**



### In this diagram:

G = Genetic influences

E = Environmental influences

LE = Adverse Childhood experiences (ACE)

QA = Quasi - Autism (where a child shows features similar to Autism, as a result of traumatic experiences)

ETOH = Alcohol use

SE = Social and Emotional

(see the glossary)

Saqib provides the following explanation:

*In order to support people with mental health problems, it is vital that we try to understand the root causes of those problems. Mostly mental illnesses do not come out of the blue, even if that appears to be. The tree is an illustration to highlight that as long as we keep focussing on their visible manifestations (branches), we will never be able to understand the entire complexity of the issue, and deal with it. Unless we tackle the root cause of mental health problems (roots) at individual and societal levels, the manifestations will keep changing from one form to another over time. Fortunately, we have now evidence for the common root causes for most mental and behavioural disorders, so we have begun to define the challenge. If we want to move towards a world with no major mental health problems, the aim should be to prevent those root causes from occurring in the first place.*

*The individual pathway to a mental or behavioural disorder varies, and the triggers effecting that can broadly be divided into Genetic (G) and Environmental (E) influences; the former we are born with and cannot be controlled for; the latter though are modifiable, and adults have a choice. Then there are stressors where a child is victim of trauma (Adverse Childhood Experiences or ACE). It is a complex interaction between these variables, which increases the propensity of someone experiencing a root cause factor to developing a mental illness. This is to say, lots of people experience trauma and abuse (about 1 in 4), but not every one of those will develop mental illness (less than 1 in 10). This is because of difference in the vulnerability they're born with (G), the environmental support they had or not (E) and the type of Adverse childhood experiences, which determine their presence / lack of Emotional resilience, i.e., their ability to bounce off after experiencing a trauma.*

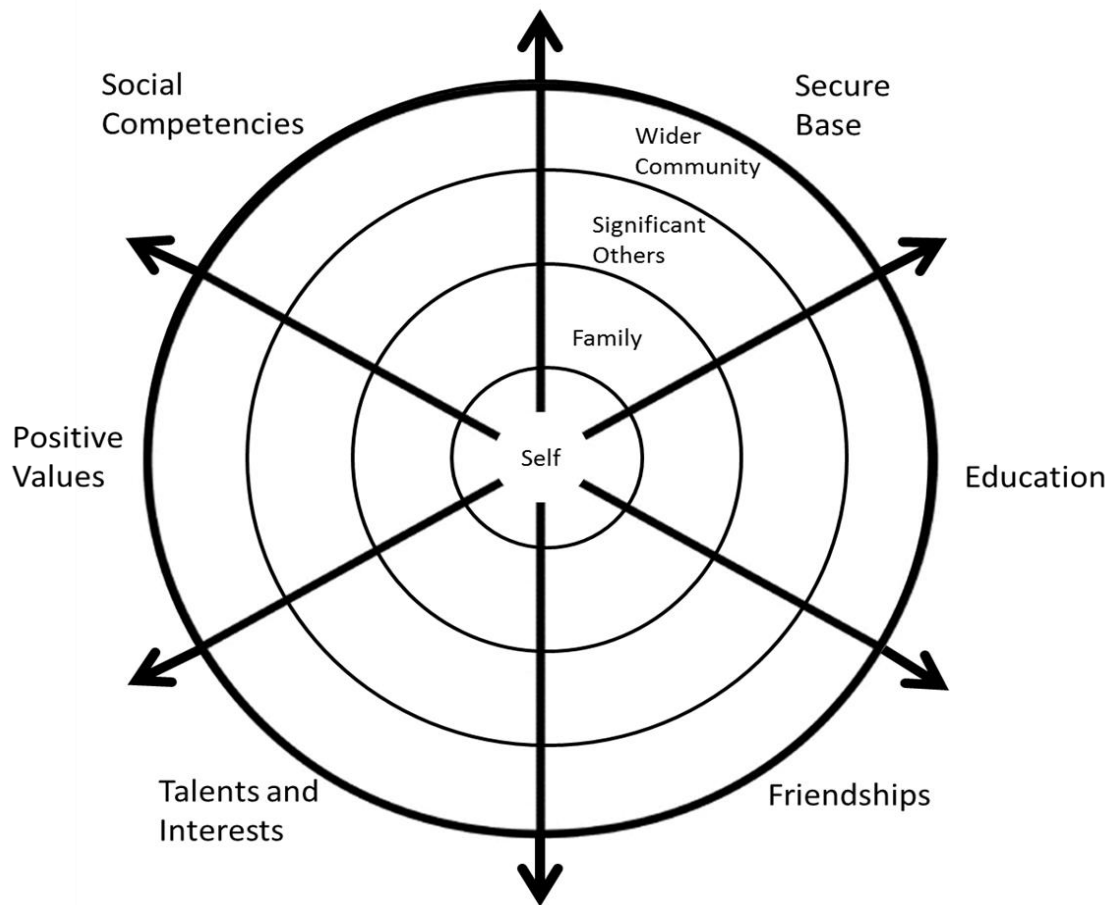
*There is evidence that intervening early improves all types of outcomes for people who have experienced root causes. Unfortunately, the common barrier in seeking this help is the stigma, derived both from self-perception, and from the society.*

### **Emotional Resilience**

Emotional resilience is an adaptive capability that enables a person to thrive in the presence of adversity. The capability to be resilient is understood to change over time. It is hypothesized that those children and young people who are able to be resilient in the face of adversity will be at less at risk of mental health disorders.



**Figure 12: The Ecological Approach and the Domains of Resilience Based on Empirical Research undertaken by Daniel and Wassell (2002).**



This figure can be used as a tool for mapping children and young people’s strengths and understanding where they may be vulnerable. The tool is being tested as part of the Kent Head Start programme in its third phase.

## | 8. Limitations of Published Studies

**Prevalence data for children and young people's mental health are limited by:**

- a lack of frequent systematic surveys, registries, longitudinal studies on children and young people's mental health;
- the difficulty in reporting / measuring mental health disorders including divergences between views of children, young people, parents and carers
- a lack of objective markers for some disorders
- the relative rarity of some disorders
- the complex interplay between patient and system behavior which results in difficulties in case identification (Pinhas and Brody, 2011).

The prevalence of mental health disorders in children under the age of 16 are largely based on survey of cohorts undertaken approximately 10 years apart. The last survey of this type was undertaken in 2004 and published in 2005 (Green 2005). An updated survey is currently being undertaken, the findings of which will be published in late 2018. Clearly the historic nature of the current prevalence data is a key limitation.

Few data sources are able to report whether individuals experience multiple co-morbid mental health conditions. Comorbidity of mental health conditions is common.

Appendix 2 provides a summary of the main sources of prevalence data used in this health needs assessment, what measures and the frequency of the survey. These studies are in the main point prevalence measures which underestimate prevalence compared to studies which look at prevalence over time.

### Prevalence of Disease/Illness

#### Comorbidity

Comorbidity is the rule rather than the exception in relation to children and young people's mental health disorders and can limit the accuracy of prevalence estimates.

Comorbidity can occur concurrently. Alternatively, symptomatology changes resulting in diagnoses changing over time but within the same episode of ill health. A preexisting condition increases risk of developing mental health conditions. This is more marked in girls than boys (Costello et al, 2003).

Comorbidity can also make diagnosis more complex. For example, bipolar disorder is particularly difficult to diagnose in children and young people because of the nature of its presentation and complex comorbidities such as anxiety disorders, substance misuse, personality disorders and attention deficit hyperactivity disorder (NICE 2015)

## Prevalence of Mental Health Disorders

One in ten children between the age of 5 and 15 have a diagnosable mental health disorder and one in five of these have more than one of the main types of mental health disorder (Green 2005).

Prevalence of Mental Health Conditions in Kent: for Children aged two - five years old

It is estimated that 19.6% of children aged two - five years old present symptoms of common mental health disorders (Egger et al, 2006).

**It is estimated that there are 14,745 children aged two to five years inclusive living in Kent have a mental health disorder** with a focus on the five most common emotional and behavioral disorders, attention deficit hyperactivity disorders, oppositional defiant and conduct disorders, anxiety disorders, and depressive disorders. (Egger et al, 2006). It is understood that within this age group mental health conditions are likely to be behavioural rather than emotional. This is based on local authority mid-year resident population estimates for 2014 from Office for National Statistics.

Prevalence of mental health disorders: 5-10, 10-16,

Prevalence of mental health disorders vary by age and sex.

Children and young people aged 11 to 16 years olds are more likely (11.5%) than five to ten year olds (7.7%) to experience mental health problems (Green et al 2005).

Boys aged 11 to 16 are more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%) (Green et al 2005).

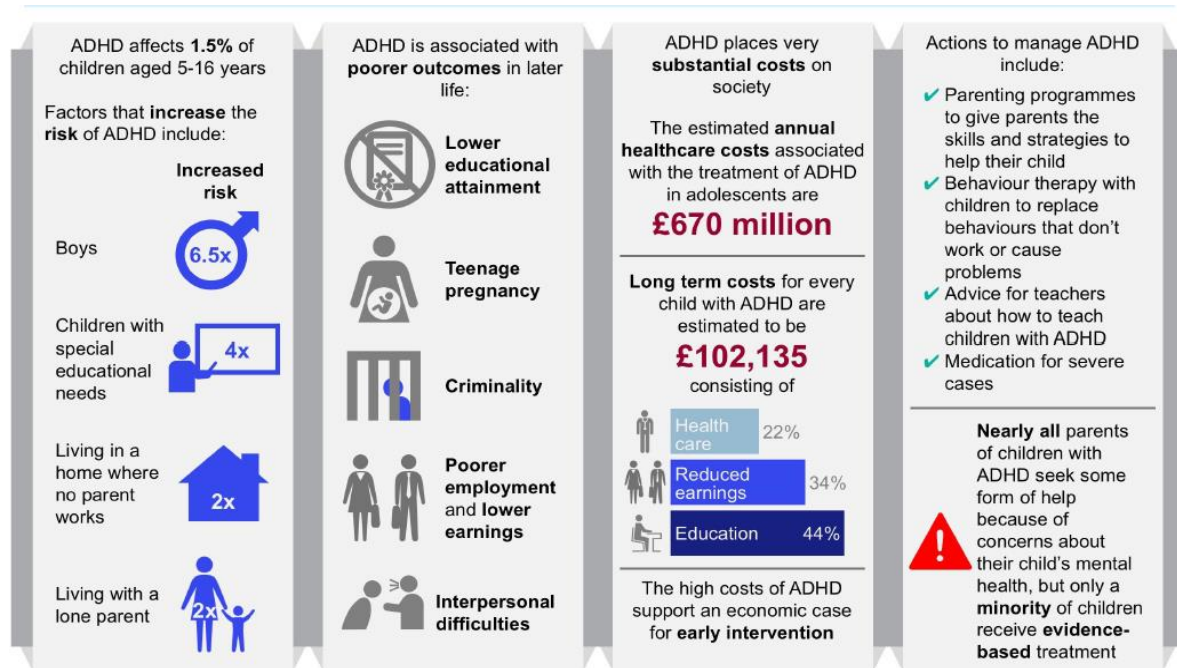
### The Prevalence of Externalising and Internalising Mental Health Disorders

Mental health disorders can be categorised into externalizing mental health disorders, which are sometimes referred to as behavioural disorders and internalising mental health disorders, which are sometimes referred to as emotional disorders. The following section provides prevalence estimates for externalising and internalising mental health disorders. These prevalence estimates are based on Green (2005) and Meltzer (1999) who applied the DAWBA tool to measure the prevalence of three main categories of mental disorder: conduct disorders, emotional disorders and hyperkinetic disorders and on the specific conditions which fall into these categories, based on ICD-10 (International Classification of Diseases, tenth revision) and DSM-IV (Diagnostic and Statistical Manual, fourth revision) criteria. Self-harm and suicide is then considered.

Appendix 3 provides the estimated prevalence of a range of mental health conditions for children and young people in Kent. The estimates are provided for 2017 and projected to 2012 using ONS (2014) mid-year population estimates. The estimates are provided for Kent and for each CCG.

## Prevalence of Externalising Mental Health Disorders

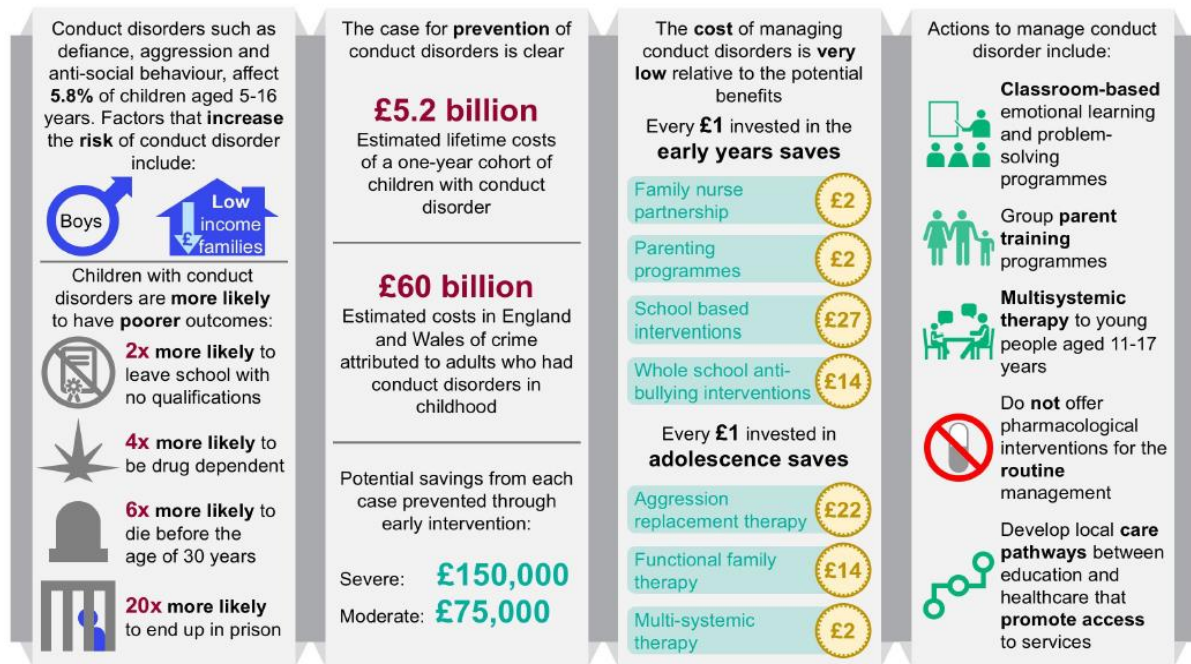
Figure 13: Prevalence, Outcomes, Costs and Evidence-based Actions for ADHD:



Source: PHE 2016

**Prevalence:** The prevalence of attention deficit hyperactivity disorder (ADHD) varies among studies, and is estimated to be around 2.4% of children and young people in the UK. Typically, ADHD is diagnosed in children 3–7 years of age, but it may not be recognized until much later in life. It is more commonly diagnosed in boys than girls (depending on the population studied, the ratio ranges vary from 9:1 to 2.5:1. (NICE 2016).

**Figure 14: Prevalence, Outcomes, Costs and Evidence-based Actions for Conduct Disorders (CD), Oppositional Defiant Disorder (ODD): Prevalence:**



Source: PHE (2016)

**Conduct disorders are the most common mental health disorders of childhood** (Pilling et al, 2013). Green et al (2005) estimates that approximately 5% of children and young people aged between five and 15 years old met the diagnostic criteria for conduct disorders. Nearly 40% of children who are being 'looked after' (for example in foster care or children's homes), or who have been abused, or who are on the child protection or safeguarding register, meet the criteria for conduct disorders.

## The Definition and Prevalence of Internalising Conditions

### Anxiety

Anxiety disorders can have a lifelong course of relapse and remission. They commonly occur together, or with other problems such as depression or substance misuse (NICE 2015).

### Separation Anxiety (SAD): Prevalence

Separation anxiety is estimated to be 4- 5 % in the child and young people's population (Masi et al, 2001). It is strongly associated with socio economic deprivation with 50% of children and young people with the disorder coming from low income households. SAD is reported in 80% of children and young people who are school refusers.

Psycho educational, behavioural, cognitive behavioural, family and psychodynamic therapy is considered effective for children and young people with SAD, with CBT the best proven approach (Masi et al, 2001). (Masi et al, 2001).

### **Social Anxiety Disorder: Prevalence**

Social anxiety disorder has an early median age of onset (13 years) and is one of the most persistent anxiety disorders. Despite the extent of distress and impairment, only about half of those with the disorder ever seek treatment, and those who do generally only seek treatment after 15–20 years of symptoms. A significant number of people who develop social anxiety disorder in adolescence may recover before reaching adulthood. However, if the disorder has persisted into adulthood, the chance of recovery in the absence of treatment is modest when compared with many other common mental health problems (NICE 2015).

### **Post-Traumatic Stress Disorder: Prevalence**

The British National Survey of Mental Health (of over 10,000 children and young people) reported the incidence of post-traumatic stress disorder in the UK to be 0.2% for children and young people 5–15 years of age.

The APMS 2014 reported that 12.6% of females aged between 16- 24 screened positive for PTSD and then declined with age. This contrasted with males for whom 3.6% 16-24 screen positive for PTSD which then remains fairly constant over subsequent age bands. Females age 16-24 also report significantly more exposure to trauma in the 16-24 aged group than males (McManus et al 2014).

In the UK, the incidence is common (up to 30%) in children and young people following attendance at emergency departments for a traumatic injury (NICE 2005).

### **Obsessive-Compulsive Disorder (OCD): Prevalence**

The prevalence of obsessive-compulsive disorder (OCD) is thought to be around 0.8–3.0% in adults, and 0.25–2.0% in children and young people. The mean age of onset is in late adolescence in men, and early twenties in women, but OCD may present at any age (Heyman et al, 2006).

### **Body Dysmorphic Disorder (BDD): Definition and Prevalence**

BDD is characterized by time-consuming behaviours such as mirror gazing, comparing particular features to those of others, excessive camouflaging tactics to hide the defect, skin picking and reassurance seeking.

It is thought that 0.5–0.7% of the whole population have BDD (NICE 2005).

### **Generalized Anxiety Disorder (GAD): Prevalence**

Anxiety disorders are the most common psychiatric disorder in adults. GAD is more common in people aged between 35 and 55 years of age (NICE, 2011).

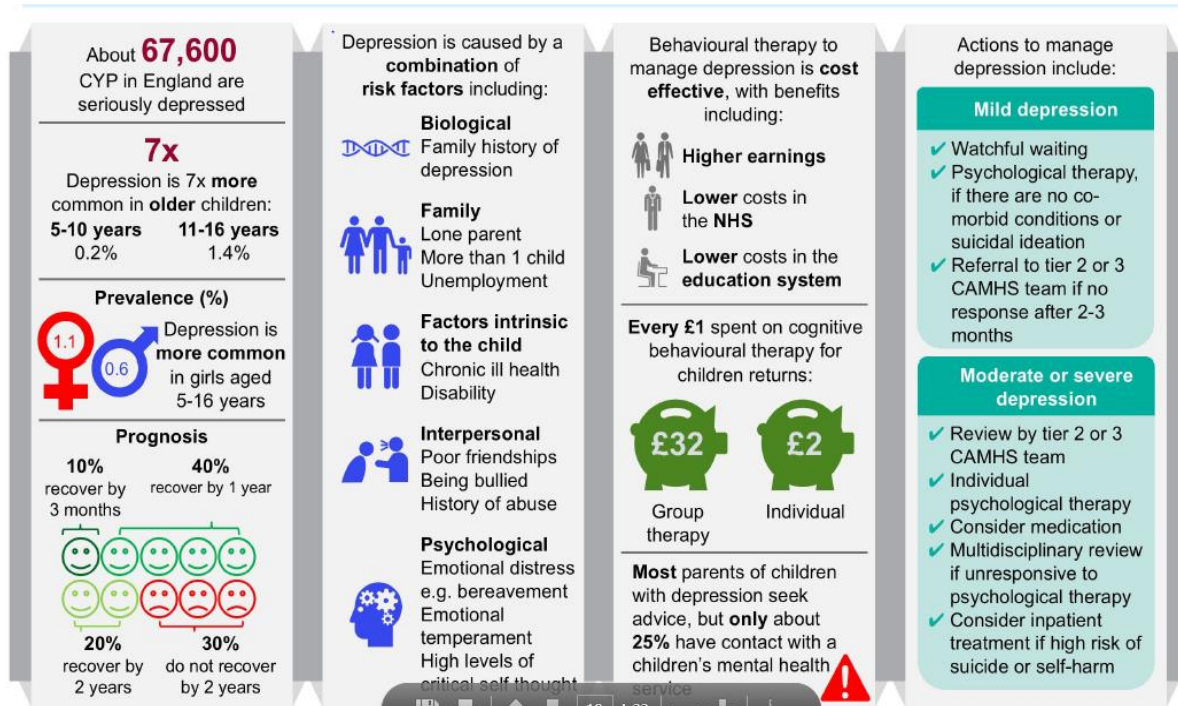
Anxiety disorders are diagnosed according to the DSM-V classification:

- Onset of symptoms are insidious, often unremitting and can be lifelong.

- While some people will present with obvious anxiety, others will initially present with somatic symptoms such as muscle tension and insomnia (NICE 2015).

## Major Depressive Disorder

Figure 15: Prevalence, Outcomes, Costs and Evidence-based Actions for Major Depressive Disorder



Source: PHE 2016

## Bipolar Disorder: Prevalence

Prevalence data for children and young people are limited. The peak age of onset is 15–19 years, and the condition is rare in children under 12 years. There is often a substantial delay between onset and first contact with mental health services (NICE 2015).

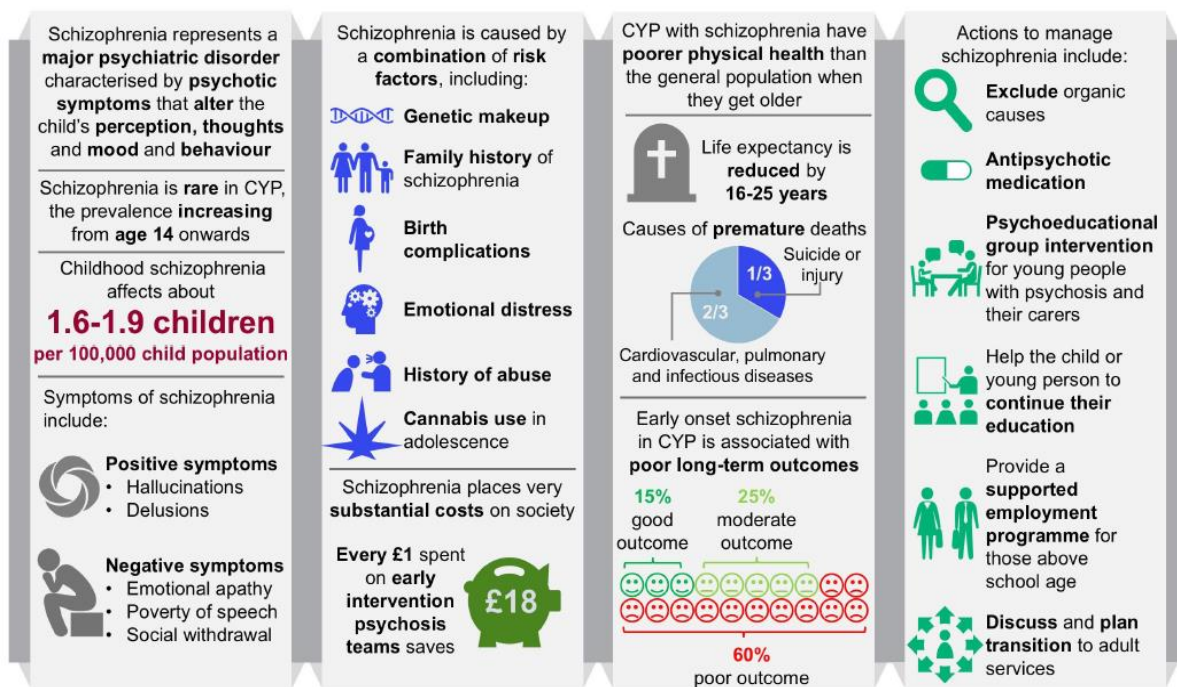
The prevalence of Borderline Psychiatric Morbidity is 5.7% in the 15-24 population.

## Borderline Personality Disorder: Prevalence

Borderline personality disorder is often not formally diagnosed before the age of 18, but the features of the disorder can be identified earlier. Borderline personality disorder is present in just under 1% of the whole population, and is most common in early adulthood. The prevalence of Borderline Psychiatric Morbidity is 5.7% in the 15-24 population (NICE 2009).

## Psychosis and Schizophrenia

**Figure 16: Prevalence, Outcomes, Costs and Evidence-based Actions for Psychosis and Schizophrenia**



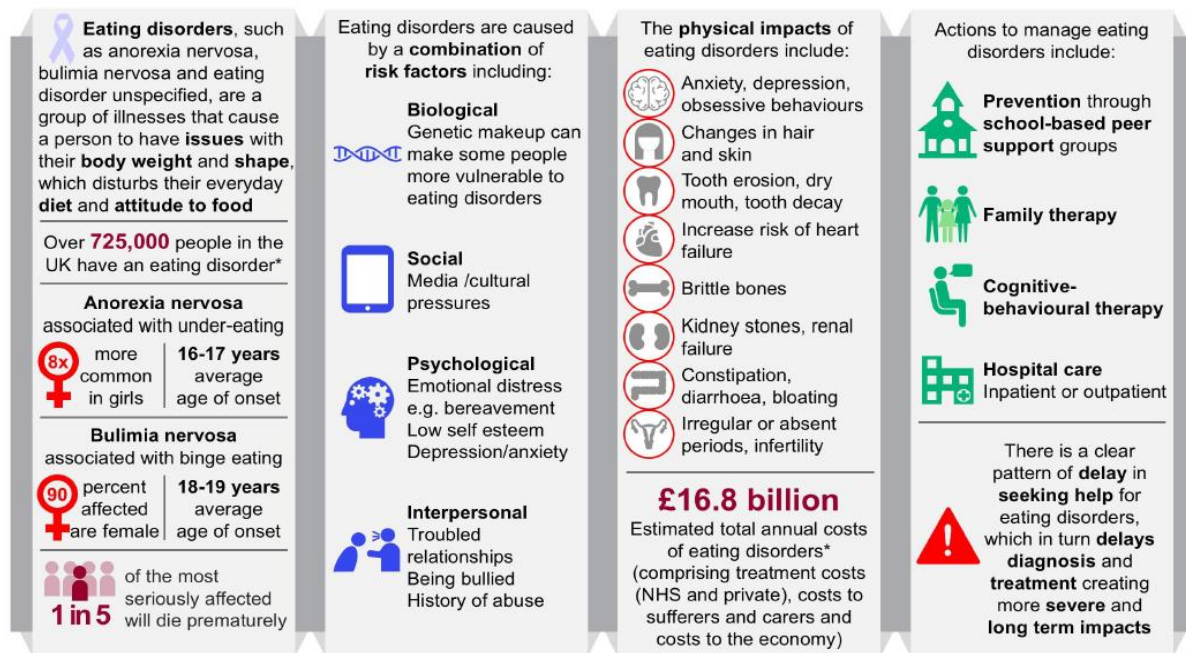
Source: PHE 2016

The prevalence of psychotic disorders in children and young people aged between 5 and 18 years has been estimated to be 0.4%. Schizophrenia is very rare in pre-pubertal children. Incidence increases significantly from 15 years onwards (NICE 2016).



## Eating Disorders

Figure 17: Prevalence, Outcomes, Costs and Evidence-based Actions for Eating Disorder



Source: PHE 2016

An eating disorder is characterized by a persistent disturbance of eating or eating related behaviour that results in altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning (NICE 2017).

The main types of eating disorders are

**Anorexia Nervosa** - a syndrome in which the person maintains a low body weight as a result of a preoccupation with weight, construed as either a fear of fatness or a pursuit of thinness.

**Bulimia Nervosa** - characterized by recurrent episodes of binge eating and compensatory behaviour (any one or a combination of vomiting, fasting, or excessive exercise) in order to prevent weight gain.

**Binge Eating Disorder** - characterized by recurring episodes of eating significantly more food in a short period of time (usually less than 2 hours) than most people would eat under similar circumstances. These episodes are marked by feelings of lack of control. Compensatory behaviour (for example vomiting, fasting, or excessive exercise) is absent.

**Atypical Eating Disorder (or Other Specified Feeding or Eating Disorder (OSFED))** - characterized by symptoms of an eating disorder such as anorexia nervosa, or bulimia nervosa, but does not meet the precise diagnostic criteria for them. For example, all of the criteria for anorexia nervosa are met, there is significant weight loss, but the person's weight is within or above normal range.

These different types of eating disorders have many features in common and the person can move between the different diagnostic categories.

Obesity may also fulfil some of the criteria of an eating disorder, but it is not usually managed by eating disorder services.

Eating disorders are rare in the general population; however they are relatively common in teenagers and young women (Yeo and Hughes, 2011). They are thought to be the third most common chronic illness (after asthma and obesity) in adolescent females (Yeo and Hughes, 2011). Atypical eating disorders are the most common presentation, followed by binge eating disorders, and bulimia nervosa. Anorexia nervosa is the least common (AED, 2014).

### **Atypical Eating Disorders**

The incidence of atypical eating disorders is 40 to 50 in 1,000 people, adults, children and young people per year. It is more common in females than males. For every male with an atypical eating disorder there are four females. Atypical Eating Disorder presents during adolescence or young adulthood.

### **Binge Eating Disorder**

The incidence of binge eating disorders is 16 in 1,000 females per year (American Psychiatric Association, 2013). Around 35 in 1,000 females will experience binge eating disorder at some point in their life.

For men, approximately eight out of 1,000 are affected per year and 20 out of 1,000 are affected throughout their lives.

Binge eating presents during adolescence or young adulthood.

### **Bulimia Nervosa**

The incidence of bulimia nervosa has been estimated to be between 10 to 15 in 1,000 females per year (American Psychiatric Association, 2013).

Bulimia nervosa is less common in males than females: for every male with bulimia, there are 10 females. Typically presents during mid to late adolescence.

### **Anorexia Nervosa**

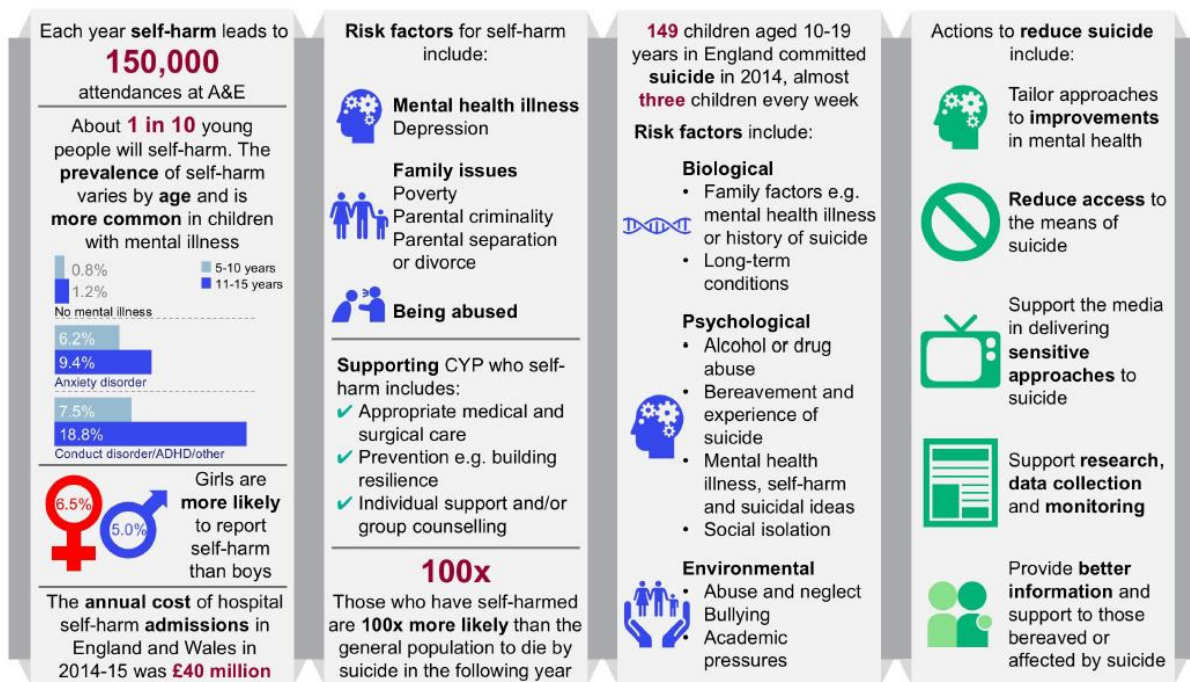
The incidence of anorexia nervosa is 0.4 in 1,000 females per year, and around nine in 1,000 females will experience anorexia at some point in their lives (American Psychiatric Association, 2013).

It is less common in males than females: for every male with anorexia there are 10 females.

Onset usually occurs during early to mid-adolescence (AED, 2014).

## Suicide, Suicidal Thoughts, Suicidal Attempts and Self-Harm

Figure 18: Prevalence, Outcomes, Costs and Evidence-based Actions for Suicide, Suicidal Thoughts, Suicidal Attempts and Self-Harm



Source: PHE 2016

### Self-Harm

Females self-harm more than males. Analysis of the Health Behavior in School-aged Children Survey for England (2014) shows that 22% of 15 year olds reported they had ever self-harmed. With three times as many girls (32%) reporting self-harm than boys (11%). Comparisons with other studies indicate that it is increasing. Self-harm is associated with lower family affluence (PHE 2017).

The Psychiatric Morbidity Survey includes those aged 16 and over and shows the proportion of females aged 16-24 who have self-harmed is greater at 27% than those for males, at 10%. It reports that the difference in the rate has increased over time (McManus 2014).

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

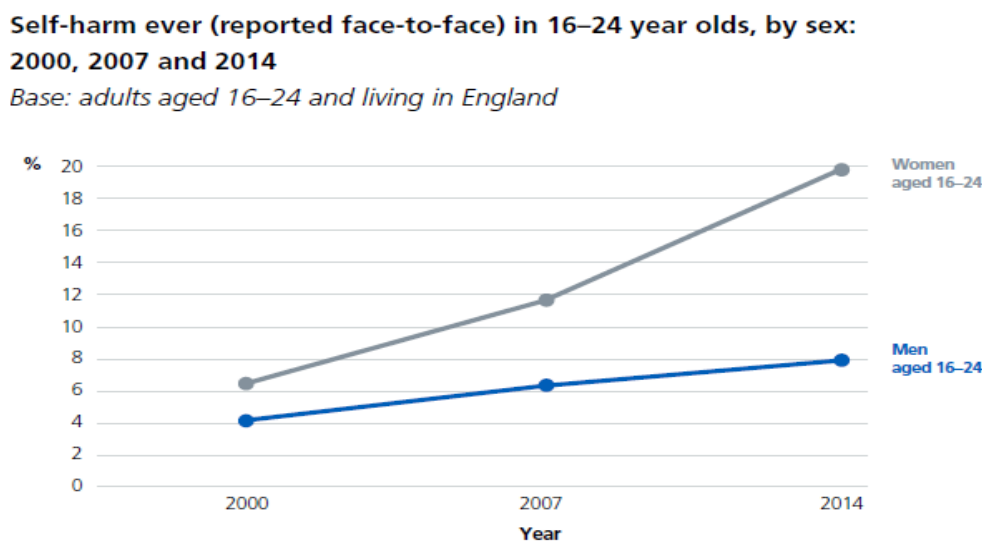
Hawton identified that repetition of self-harm was frequent (53.3 % had a history of prior self-harm and 17.7 % repeated within a year) (Hawton 2012).

With regard to any associations with ethnicity, South Asian young women in the United Kingdom seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors (Hawton 2005).

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

### Self-Harm prevalence measured through the Adult Psychiatric Morbidity Study (APMS)

**Figure 19: Percentage of 16-24 in England who Report that they have ever Self-Harmed in the APMS in 2000, 2007 and 2014 by sex**



**Source:** PHE 2016

This figure shows that the percentage of 16-24 who report that they have ever self-harmed has increased from 2000 to 2014. The increase has been greatest in young women.

Many psychiatric problems, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol use disorders, are associated with self-harm.

### Suicidal Ideation, Thoughts, Feelings and Suicide Attempts

Self-harm is a significant predictor of suicidal ideation. Suicidal ideation is a significant predictor of suicide (Evans 2016) but many young people who die by suicide do not express recent ideation and an absence of suicidal ideas cannot be assumed to show lack of risk (NCISH 2016).

McManus et al 2009 (based on self-reports) indicate that lifetime suicidal thoughts are more prevalent than self-harm in the 16-24 age group. Suicidal attempts are less prevalent than both self-harm and suicidal thoughts. Self-harm, suicidal thoughts and suicide attempts are all more prevalent in young women than young men. However, more young men die by suicide which suggests that first suicide attempts are more common in young men than in young women (McManus 2009).

In cross national studies lifetime prevalence of suicidal ideation is estimated to be 9.2% and suicide attempts at 2.7% (Nock 2008).

In adolescents aged 15-16 who participated in the European ESPAD survey, the median prevalence of any lifetime self-reported suicide attempt was 10.5% (range 4.1%-23.5%). The median of frequent self-harm thoughts (at least five times) was 7.4% (range 2.1%-15.3%).

Suicide attempts are more than three times as likely in children and young people placed in care compared to non-care populations (Evans 2017).

## **Suicide**

In England, the suicide rate in children and young people is lower than 10 years ago but this fall occurred in the early 2000s and there has been no fall since around 2006 (NCISH 2016).

Analysis of suicides by children and young people in England, from January 2014 and April 2015 in England by the NCISH (2016) found the following 10 common themes associated with suicide by children and young people:

- family factors such as mental illness
- abuse and neglect
- bereavement and experience of suicide
- bullying
- suicide-related internet use
- academic pressures, especially related to exams
- social isolation or withdrawal
- physical health conditions that may have social impact
- alcohol and illicit drugs
- mental ill health, self-harm and suicidal ideas.

(NCISH 2016)

However, NCISH note that ‘numerous experiences and stresses contribute to suicide—it is rarely caused by one thing. We found several antecedents that are likely to have contributed to risk in the children and young people in this study. For many, longstanding family adversity seems to have been followed by difficulties in other areas of life, and complicated by mental health problems. This pattern of cumulative risk may then lead to a “final straw” event, often a broken relationship or exam stresses ‘In over a quarter (28%), an experience of bereavement was recorded—this had usually occurred more than three months earlier. 13% of suicides by children and young people were preceded by the suicide of a family member or friend’.

Over a third (36%) of the children and young people who died had a physical health condition, usually long-term. The most common conditions were acne and asthma: both could lead to withdrawal from social activities (although acne is common in young people aged 18) but in these cases it had been severe enough to lead to medical attention. We found that academic pressures, especially related to exams, were common antecedents.

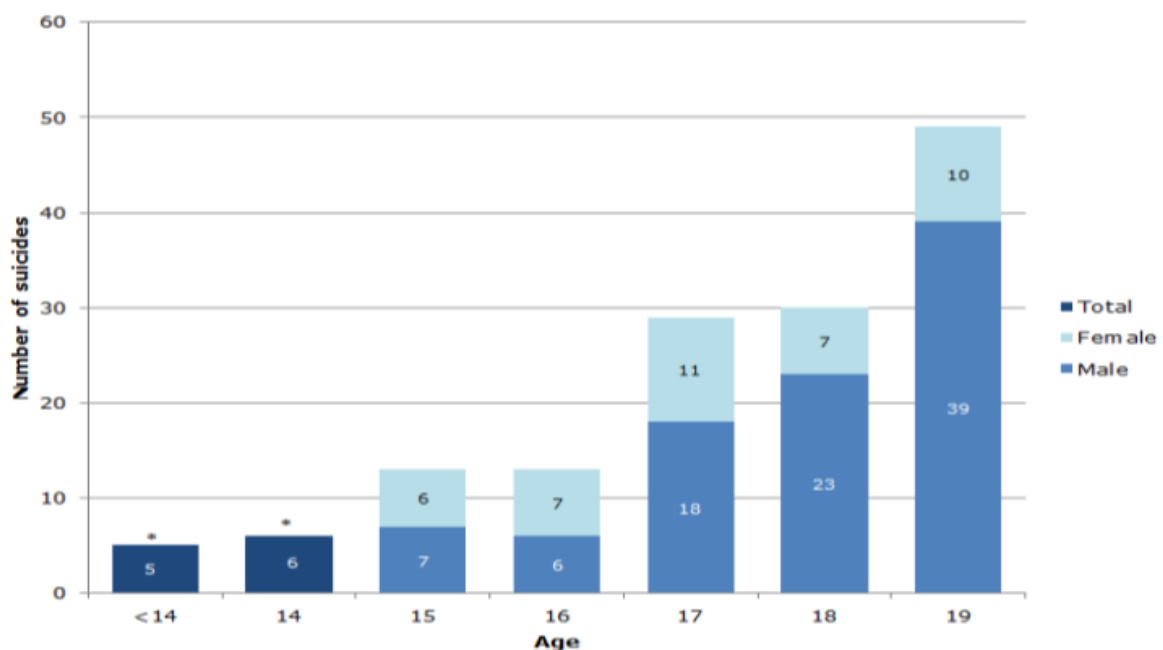
Although this study cannot demonstrate cause and effect, almost a third (29%) of those in education were facing exams or exam results at the time of death and four died on the day of an exam or the following day' (NCISH 2016).

Many of the antecedents of suicide are more common in females than males, including bullying, bereavement, physical health conditions and exam pressures. Females were more likely to have self-harmed in the past and had contact with mental health and social care services. Young men more often had no recent contact.

Windfuhr, 2008 reports the following findings from their study of suicides in the UK from 1997-2003.

- Three times as many young men as young women aged between 15 and 19 committed suicide.
- Only 14% of young people who committed suicide were in contact with mental health services in the year prior to their death, compared with 26% in adults.
- Looking at the difference between sexes, 20% of young women were in contact with mental health services compared to only 12% of young men.
- (CHIMAT CAMHS HNA)

**Figure 20: Number of Suicides by Age and Gender for the Period January 2014 and April 2015 in England (NCISH 2016)**



The figure shows that from the age of 15 the number of suicides by females remained stable in contrast to males where the number increased from 17 onwards.

Prevalence of self-harm, self-harm thoughts and suicide and suicidal thoughts are higher in transgender children and young people than the cisgender children and young people. In a

survey of transgender young people aged 16-25, 72% had ever self-harmed and 27% had ever attempted suicide (METRO 2013 in Hablin 2016).

NCISH's extended study of death by suicide in under 25s identified the following at risk groups:

- young people who are bereaved, especially by suicide, who need bereavement support services to be widely available.
- Students in universities and colleges who would benefit from a greater focus on prevention, e.g. staff vigilance for warning signs, as well as access to counselling and primary care.
- Looked after children, especially aged under 20, who need stable accommodation on leaving care, and access to mental health care.
- LGBT groups especially aged under 20, who may have fears over disclosure of their gender identity and may face bullying (NCISH 2017).

### **Associations between Suicide, Suicidal Ideation, Self-Harm and Mental Health Disorder**

Self-harm is a significant predictor of suicidal ideation. Suicidal ideation is a significant predictor of suicide (Evans 2016) but many young people who die by suicide do not express recent ideation and an absence of suicidal ideas cannot be assumed to show lack of risk (NCISH 2016).

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

Those with a diagnosable mental health condition are ten times more likely to self-harm or attempt to kill themselves (based on parent report) and five times more likely to self-harm (based on their own report). Those with diagnosable conduct disorder are nine times as likely to self-harm or attempt to kill themselves (parent report) or four times as likely to harm, hurt or attempt to kill themselves (based on their own report). Those with a diagnosable hyperactivity condition were six times as likely to harm, hurt or attempt to kill themselves according to their parents report and four times as likely according to their own report. Those with ASD were 13 times more likely to harm, hurt or attempt to kill themselves.

NCISH (2016) analysis of death by suicide for children and young people between the found 39% (n=51) had a diagnosis of mental illness. Affective disorder (bipolar affective disorder or depression) was the most common diagnosis. 15% (n=20) people were receiving anti-depressants, and in 13% (n=17) these were selective serotonin reuptake inhibitors (SSRI).

## Preventing Suicide

Agencies that work with young people can contribute to suicide prevention by recognizing the pattern of cumulative risk and “final straw” stresses that leads to suicide.

NCISH (2016) conclude that:

- improved services for self-harm
- improving access to CAMHS are crucial to addressing suicide
- involving schools, primary care, social services, and youth justice.

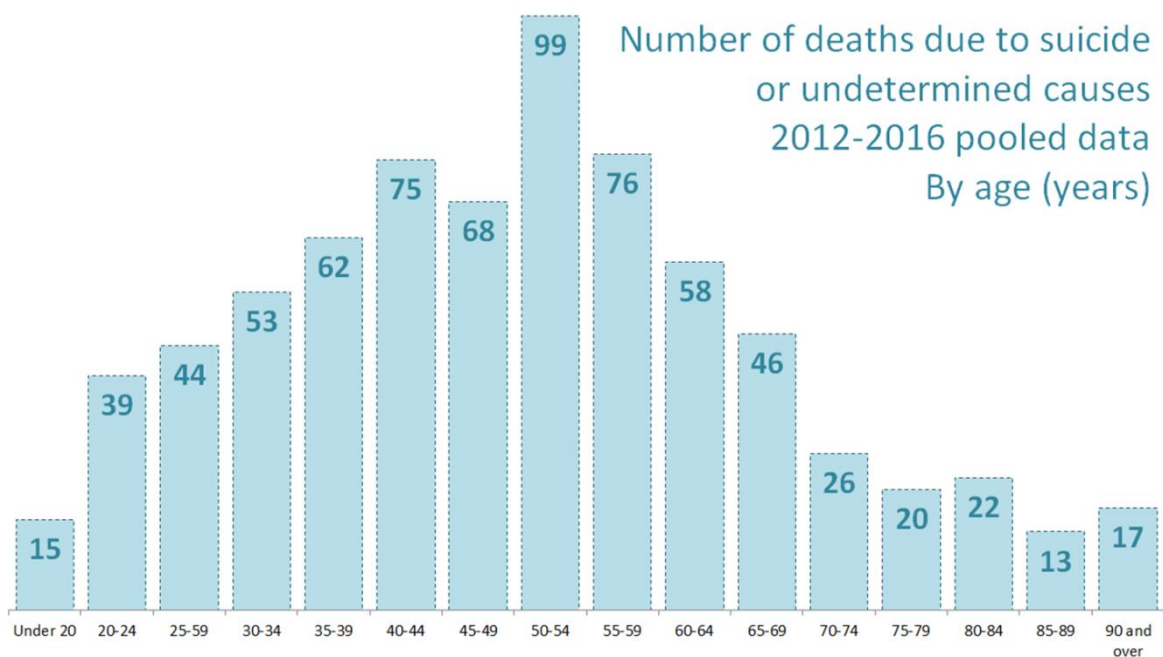
NCISH’s subsequent study in 2017, which analyzed death by suicide in under 25 year olds supported these findings but made some additional recommendations for prevention:

- Supporting vulnerable children and young people and their families
- Promoting mental health in schools to address bullying and online safety
- Services for self-harm and alcohol and drug misuse in young people
- Healthy workplace and campus initiatives
- Crisis services (NCISH 2017).

## Suicide in Kent

Between 2012 and 2016, there were 733 deaths due to suicide or undetermined causes among Kent residents. Of these, 7% (54) of individuals were aged under 25. One in 100 deaths due to suicide or undetermined causes was for under 18s.

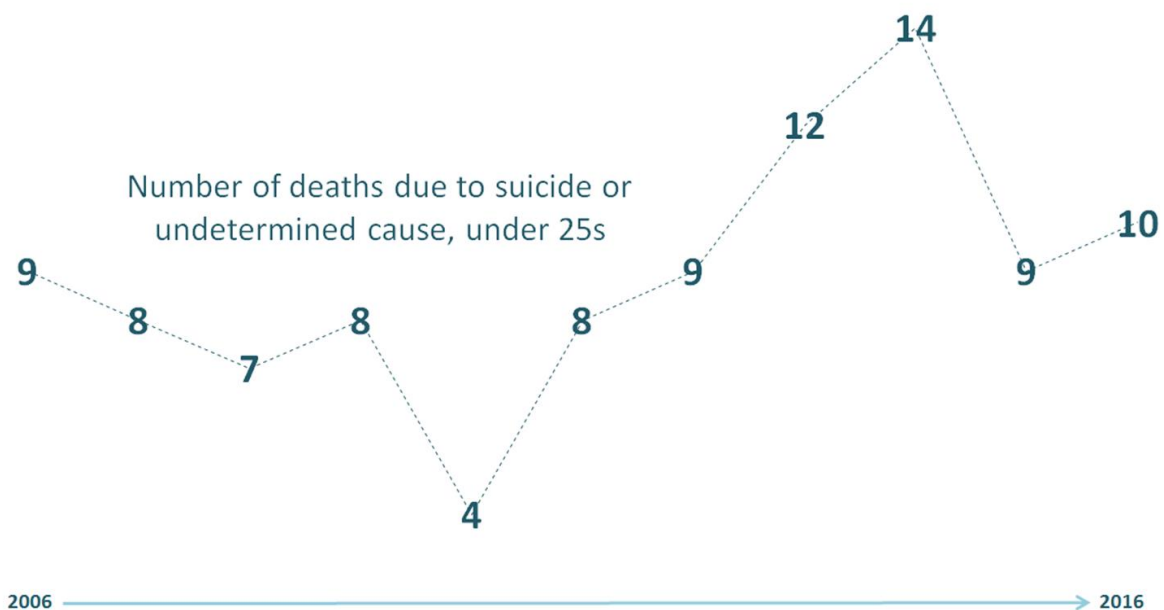
**Figure 21: Number of Deaths to Suicide or Unintended Causes 2012-2016 By Age**



The figure shows that 15 people under the age of 20 committed suicide or underdetermined causes in the period 2012-2016. Death by suicide increases with age and peaks at 50-54 years of age before declining.



**Figure 22: Number of Deaths Due to Suicide or Undetermined Cause for under 25 year olds**



Over the last 11 years, there have been 98 deaths from suicide or undetermined causes among Kent residents aged under 25. This has ranged from 4 in 2010 to 14 in 2014. Across all ages, there has been 1,430 suicide or undetermined deaths between 2012 and 2016.

Under 18

18 to 24 years

8 46

Between 2012 and 2016, 54 people aged under 25 died due to suicide or undetermined causes. 8 people were aged under 18

**Source:** PHE 2016

In the past five years, 54 people aged 24 and under died due to suicide or undetermined causes. Of these, 8 (16%) were aged under 18. The number of people under 18 who die from suicide or undetermined causes remains low, with an average of 2 per year between 2006 and 2016.

### Children and Young People in Kent with a Learning Disability

Children and young people with learning disabilities have a higher risk and prevalence of mental health disorders. Emmerson and Hatton’s analysis of Metzler (2000) and Green (2005) led them to conclude that the prevalence of psychiatric disorders was 36% among children and young people with intellectual disability and 8% among children and young people without (OR¼6.5). Children and young people with Intellectual disabilities accounted

for 14% of all children and young people with a diagnosable psychiatric disorder. Increased prevalence was particularly marked for those children and young people with autistic spectrum disorder (OR¼33.4), hyperkinesia (OR¼8.4) and conduct disorders (OR¼5.7). Cumulative risk of exposure to social disadvantage was associated with increased prevalence (Emmerson and Hatton 2007).

For this research Emmerson and Hatton (2007) applied the following criteria to identifying children with learning or intellectual disabilities.

The child’s primary carer reported that the child had ‘learning difficulties’ and the child’s teacher reported that either they had marked difficulty in all three areas of scholastic attainment assessed (reading, maths, spelling) or their estimated developmental quotient (DQ) fell two or more standard deviations below the sample average. Child DQ was calculated by dividing the child’s mental age (as estimated by their teacher) by chronological age.

The child’s primary carer did not report that the child had ‘learning difficulties’ but the child’s teacher reported that they had marked difficulty in all three areas of scholastic attainment assessed and their DQ fell two or more standard deviations below the average DQ.

No information was available from the child’s teacher but the child’s primary carer reported that the child had ‘learning difficulties’ and that they had been concerned about the child’s speech development in the first three years of life (Emmerson and Hatton 2007: 494).

**Table 3: Estimated Number of Children and Young People in Kent with a Learning Disability and Mental Health Disorder aged 0-25 by Age Band and Gender**

Age band	Gender		
	Male	Female	Persons
0-4	30	18	48
5-9	205	128	337
10-14	437	290	737
15-19	524	359	891
20-24	542	358	898
Under 25	1737	1154	2911

Source: Emmerson & Hatton (2004), People with LD in the UK (2011), PCIS (registered population, December 2016)

This table shows that there are estimated to be a total of 2911 persons under the age of 25 with a learning disability and a mental health disorder in Kent.

**Table 4: Estimated number of Children and Young People in Kent by CCG with a Learning Disability and Mental Health Disorder Aged 0-25 by Age Band**

CCG	Age band					
	0-4	5-9	10-14	15-19	20-24	Under 25
NHS Ashford CCG	4	29	65	76	69	243
NHS Canterbury And Coastal CCG	5	39	93	163	229	529
NHS Dartford, Gravesham And Swanley CCG	9	62	128	140	139	477
NHS South Kent Coast CCG	6	41	90	110	101	347
NHS Swale CCG	4	26	54	62	61	207
NHS Thanet CCG	4	31	66	78	73	252
NHS West Kent CCG	15	109	241	264	226	855
Kent	48	337	737	891	898	2911

Source: Emmerson & Hatton (2004), People with LD in the UK (2011), PCIS (registered population, December 2016)

This table shows the greatest estimated number of persons under the age of 25 with a learning disability and a mental health disorder are in West Kent CCG, which reflects that West Kent CCG has the greatest population of all the CCGs.

**Table 5: Projected Estimate of the Number of Children and Young People in Kent by CCG with a Learning Disability and Mental Health Disorder 2017-2021**

CCG	2017	2018	2019	2020	2021
NHS Ashford CCG	246	247	249	251	252
NHS Canterbury And Coastal CCG	528	534	539	545	550
NHS Dartford, Gravesham And Swanley CCG	481	484	487	490	492
NHS South Kent Coast CCG	347	347	346	345	345
NHS Swale CCG	208	209	209	210	211
NHS Thanet CCG	258	258	258	258	258
NHS West Kent CCG	858	863	868	873	879
Kent	2928	2942	2957	2972	2987

Source: Emmerson & Hatton (2004), People with LD in the UK (2011), PCIS (December 2016 and registered popula

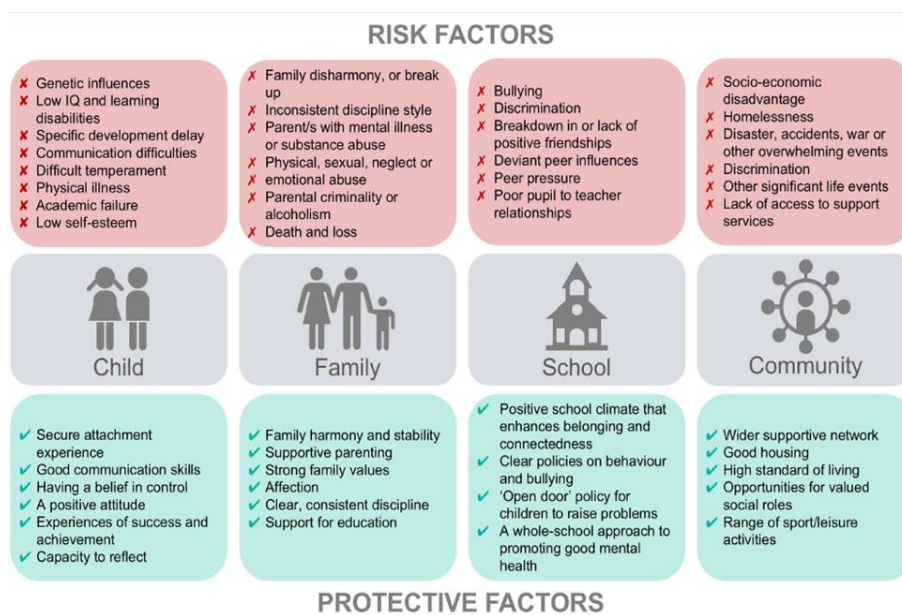
This table shows that the estimated number of persons under the age of 25 with a learning disability and a mental health disorder will increase over the period 2017-2021.

## 9. Risk Factors for Children and Young People’s Mental Health

The relationship between risk factors and outcomes for young people’s mental health is complex, with the two influencing each other. The likelihood of a child experiencing mental health problems increases dramatically as the number of risk factors increases.

A combination of risk factors tends to increase their adverse effects, though this is not always the case for all children and young people. Not all children and young people experiencing the same risk factors will develop mental health disorders as some are more resilient, due to the protective factors.

**Figure 23: Risk and Protective Factors for Mental Health at the Level of Child , Family , School and Community**



### Age

Age is a significant risk factor for mental illness. Most people with a lifetime mental illness develop their disorder in childhood and adolescence (Kessler et al 2008, Pinhas and Body, 2011). The incidence of mental health conditions vary with age. This may be influenced by child development or diagnostic criteria.

The widening gap between physical maturity (that is, at the end of puberty) and attaining adult social and financial independence has been postulated to explain growing mental health problems and behavioral disorders among adolescents and young adults. Some disorders occur in adolescence and their incidence is lower in the adult population. For example, obsessive-compulsive disorder, post-traumatic stress disorder, ADHD and eating disorders have the highest occurrence in those aged 16 to 24 compared with other adult age groups. This age group also has the highest percentage of comorbidity (experiencing two or more mental health disorders).

That said, early onset disorders tend to become chronic or relapsing and forecast a wide range of psychosocial and vocational impairments, resulting in accumulative of risk over an extended period (KMPHO 2013). This is particularly true of behavioral disorders. Late starting behavioral disorders do not have the same poor long-term outcomes as early onset behavioral disorders. This is explained by neurological development, which stabilizes for the late onset group with age (Khan 2016).

### **Risk Factors: Gender**

There is an association between gender and emotional wellbeing and the prevalence of mental health disorders in boys and girls.

Girls report lower levels of subjective wellbeing than boys, with the gap appearing to widen throughout adolescence. They express lower satisfaction with themselves and their appearance (The Children's Society 2016).

Mental health problems are more frequently identified in school age boys than girls and boys are more likely to have multiple difficulties. The gender gap in diagnosable mental health conditions begins to narrow in adolescence, as emotional problems become more common in girls. By early adulthood, women are more likely to be diagnosed with a mental health condition than men (Hablin 2016).

Girls and young women are more likely to have depressive and anxiety disorders than boys and young men. Conduct disorders, the most common mental health disorder in childhood is more prevalent in boys and young men. Young women are more likely to self-harm than young men but boys and young men are more likely to die by suicide (Hablin 2016).

Young women have been identified as an at risk group for mental health disorders based on comparison of self-reporting from the Adolescent Psychiatric Morbidity Study 2007 to 2014 (McManus 2014).

### **Gender- Trans and Non-binary Children and Young People**

Non-binary or transgender young people are disproportionately affected by depression, anxiety, eating disorders, self-harm and suicidality; their mental health is significantly undermined by transphobic victimization (Hablin 2016).

The prevalence of self-harm, self-harm thoughts and suicide and suicidal thoughts are higher in transgender children and young people than the cisgender children and young people. In a survey of transgender young people aged 16-25, 72% had ever self-harmed and 27% had ever attempted suicide (METRO 2013 in Hablin 2016).

### **Risk Factors: Ethnicity**

There is some dispute about the prevalence of mental health conditions in ethnic minority communities. Green et al (2005) was limited by small BME sample sizes but reported for children and young people aged 5-16 years, 9.2% of children and young people from black backgrounds, 7.8% of children and young people from Pakistani and Bangladeshi

backgrounds, and 2.6% of children and young people from Indian backgrounds had a mental disorder compared to 10.1% of children and young people from white backgrounds. There are some differences by gender; for instance, in girls aged 11-16, 7.6% of those from black backgrounds, and 7.5% of those from Pakistani and Bangladeshi backgrounds, had an emotional disorder, compared to 6.2% of girls from white backgrounds; while a high prevalence of boys from black backgrounds were diagnosed with a conduct disorder.

Goodman et al (2002) systematic review compared the population-based prevalence of child mental disorders between ethnic groups in Britain, and related these findings to ethnic differences in mental health service use. They found that the prevalence of common mental health problems in the main minority ethnic groups in Britain seemed to be similar or lower than that of white British children and young people but there is a lack of evidence for several small minority groups.

Research has suggested that there is a high prevalence of self-harm in young South Asian women aged 16-24 years and that the time of onset and how they manage the condition is different to white women. For instance, young South Asian women are less likely to attend A&E with repeat episodes of self-harm (NICE 2012).

It is important to recognize the exposure to racism is recognized as being a risk factor for mental health conditions (Lavis 2014).

### **Risk Factors: Health Inequalities and Socio-Economic Status**

Socio economically disadvantaged children and young people are up to three times more likely to have a mental health problem than their better off peers (Green et al 2005, Reiss 2013).

Low household income and low parental education as measures of social economic status are the factors known to be the strongest predictor of mental health problems in children and young people (Roberts et al, 2016).

Inequality is associated with increased mental health problems in the population. Children and young people are particularly vulnerable to poor health as a result of inequality. If inequality continues to rise so will mental health conditions (Roberts et al, 2016). Persistent poverty and current poverty have differential associations with mental health conditions with persistent poverty being associated with internalizing conditions and current poverty being associated with externalizing conditions (Roberts et al, 2016).

The conceptual frameworks used to explain this association includes:

- Family investment model – whereby families do not have the resources to invest in protective factors
- Family stress model – whereby the stress of living on low socio-economic circumstances places stress on the parenting and therefore result in exposing the child to risk

- Social selection theory- whereby epigenetics explain the underlying vulnerability of people with low SES to have poor health when exposed to adverse environment (Roberts et al, 2016).

Low household income and low parental education as measures of social economic status are the factors known to be the strongest predictor of mental health problems in children and young people.

Self-harm is associated with lower social economic status aged 15 (PHE 2017).

### **Risk Factors: Family Context**

Risk factors which are associated with a higher prevalence of mental health disorders in children and young people with:

- Lone-parent (16%) compared with two-parent families (8%)
- Reconstituted families (14%) compared with families containing no stepchildren (9%).
- Low education of parent (17%) compared with those who had a degree-level qualification (4%)
- Parental work situation; families with neither parent working (20%) compared with those in which both parents work (8%) (KPHO 2013).
- In Kent, the percentage of adults who experience a marital breakup, 12.3%, is higher than the England value which is 11.6% according to the 2011 Census data.

Family risk factors also include adverse childhood experiences (ACE) like exposure to domestic abuse, parental mental health and substance misuse which impact on attachment and childhood trauma (see below). Parenting styles also impact on mental health. Parenting can be modified in order to manage behaviour.

### **Risk Factors: Adverse Childhood Experiences (ACE)**

Adverse Childhood Experiences (ACE) are a group of experiences which include physical, sexual and emotional abuse, living with a parent / carer who is substance misusing, has mental health problems, is a victim of domestic violence, experiencing bereavement, a parent/ carer being imprisoned, exposure to violence in the local community or collective violence which results in leaving one's home.

Exposure to these adversities in childhood is associated with mental health conditions and low mental wellbeing in childhood and physical and mental health conditions in adulthood. ACEs are associated with socio economic deprivation (SES). There is a dose response effect which means the more the exposure to ACE the greater the risk of ill health in adulthood.

Bellis et al (2013) undertook the first study of ACE in Britain and found of the surveyed population, 47.1% reported at least one ACE, 12.3% reported 4 plus. Having 4 plus ACE strongly associated with higher deprivation. There was a significant association between ACE and low mental wellbeing AOR 3.48 (2.40-5.04). There was a graded and increasing

association between all health outcomes with an increasing ACE, apart from heroin and crack cocaine use where the strength of association was greatest amongst those with 4 plus ACE odds ratio (9.69). These associations were independent of deprivation, age and ethnicity.

Explanations for the associations are influenced by the following perspectives:

- social learning theory
- attachment theory
- parenting styles.

### **Domestic Abuse**

The trauma of exposure to domestic abuse in childhood is associated with emotional and behavioural issues in children and young people. The short-term impact varies with age and gender. All children and young people can develop symptoms of PTSD, young children may show symptoms of separation anxiety, and older young people may have symptoms of anxiety and depression, with boys more likely to show issues of externalizing disorders, although this may be due to the higher prevalence of externalizing disorders in the wider population. That said, some young people will not show symptoms in the short-term and may be resilient to their exposure (Bedi and Goddard, 2007).

Much of the evidence on the impact of exposure to domestic abuse and risk of mental health disorders comes from cross sectional studies. It is therefore important to note that these children and young people may also be exposed to other adversities. For example, although the prevalence is contested, and may be an underestimate, it has been estimated that 40% of children and young people exposed to domestic abuse will also have experienced sexual abuse (Goddard and Hiller, 1993 in Bedi and Goodard, 2007).

### **Parental Mental Health**

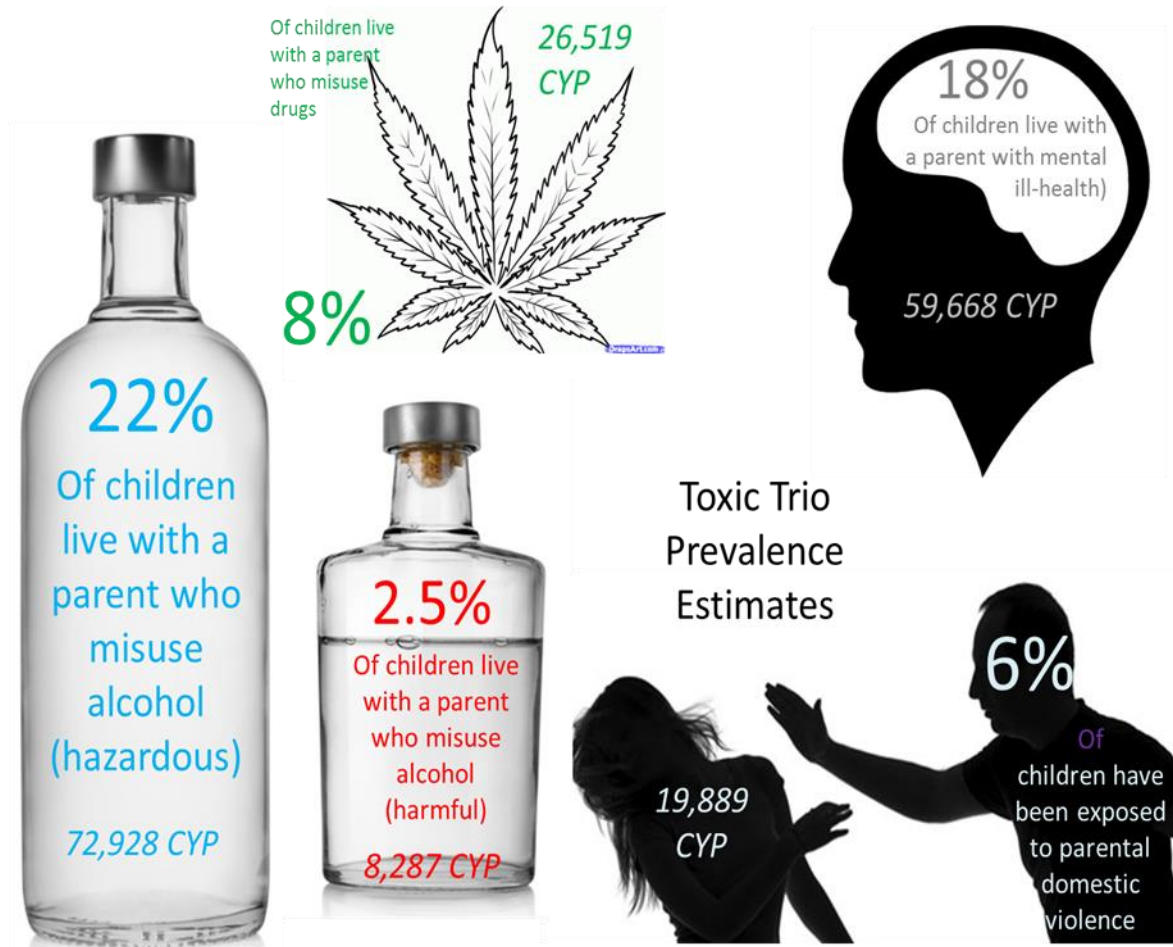
There is a well-documented association between parental mental health and child and young people's mental health. In Rutter and Quinton (1983) study of the children of psychiatric patients; they found these children and young people had an increased rate of persistent emotional/ behavioural disturbance, which tended to involve disorders of conduct. The psychiatric risk to the children and young people was greatest in the case of personality disorders associated with high levels of exposure to hostile behavior'.

The association between the quality of the relationship between the child and parent can be impacted on by parental mental health (but also parental domestic abuse, substance misuse and child abuse) and externalizing behaviors are widely reported with an assumption in most research that there is a 'dose-response' connection between poor parenting environment and antisocial related outcomes. The more extreme the parenting environment, the worse the child outcome and greater the likelihood of clinical disturbance. This association is also true of parent-child relationships and depression, anxiety and other 'internalizing' symptoms (such as somatic complaints and social withdrawal). Over



protectiveness may also be associated with internalizing symptoms (O'Connor and Scott, 2007).

**Figure 24: Prevalence of Parental Substance Misuse, Domestic Violence and Mental Ill Health (Toxic Trio) in Kent in 2015**



Source: SBDI (KCC), ONS MYE

**Sexual Abuse and Child Sexual Exploitation:**

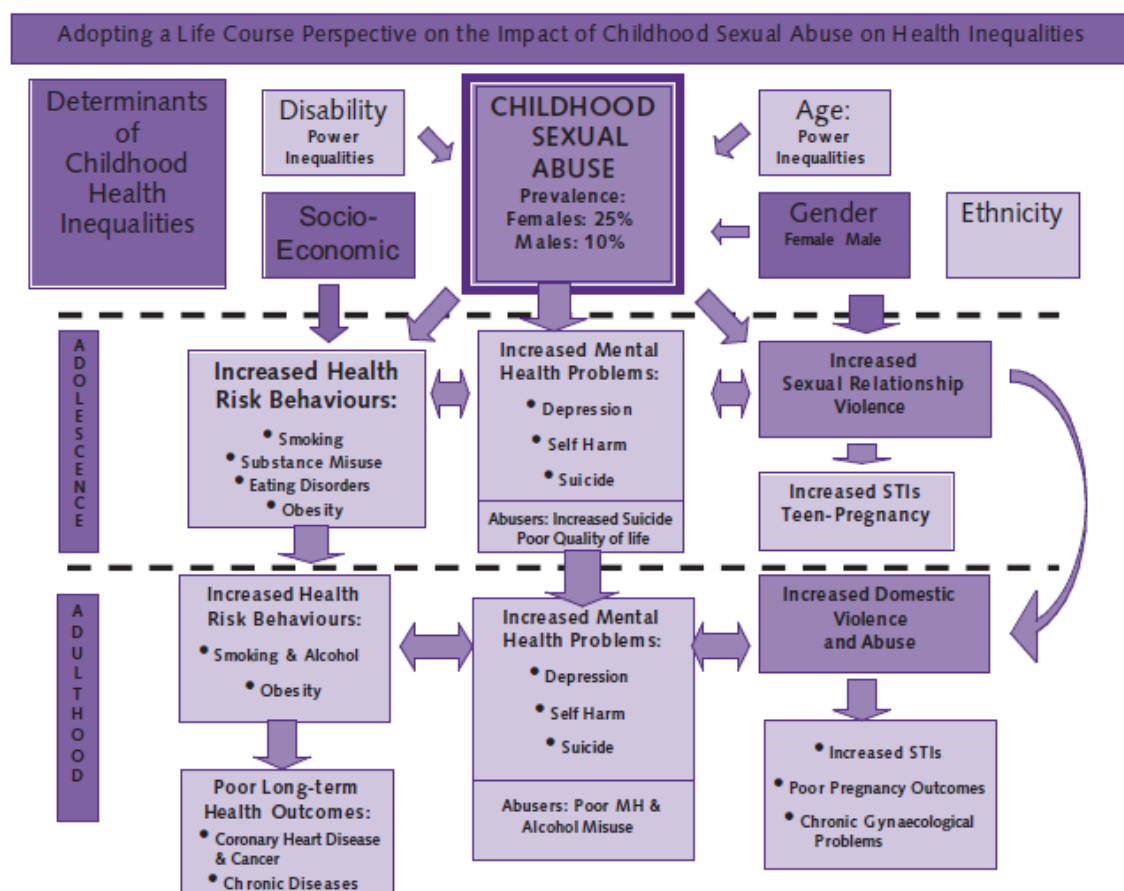
It is estimated that 1 in 20 children and young people have been sexually abused in the UK (Radford, 2011).



Spataro et al's (2004) prospective study found that sexual abuse is associated with mental illness in childhood and adulthood and significantly higher rates of psychiatric treatment than general population controls (12.4% v. 3.6%).

Rates were higher for childhood mental disorders, personality disorders, anxiety disorders and major affective disorders, but not for schizophrenia. Male victims were significantly more likely to have had treatment than females (22.8% v.10.2%) despite sexual abuse being more prevalent amongst females than males.

**Figure 25: Conceptualization of the Comorbidity of Sexual and Domestic Abuse and the Consequences for Health including Mental Health in Adolescence and Adulthood (Itzin 2006)**



(Adapted from Nurse, J. et al 2005)

### Bereavement

Akerman and Statham's (2011) rapid review of the literature on childhood bereavement found that most children and young people do experience some negative impact on psychological wellbeing in the short-term, but, for the majority, these difficulties do not persist or require specialist intervention.

In the short-term children and young people may experience an increase in anxiety and mild depression which may persist for up to a year. Their study reports that only one in five bereaved children and young people are likely to need a specialist service (Dowdney, 2000) most likely to be as a result of depression or dysphoria (a combination of sadness and crying or irritability). Symptoms may also include anxiety, depressive symptoms, fears, angry outbursts, and regression regarding developmental milestones. The majority of children and young people however, do not experience serious problems (Haine et al. 2008). They say that 'even among children and young people bereaved by parental suicide and cancer, most children and young people reported low levels of psychological distress, suggesting a considerable degree of resilience (Ratnarajah and Schofield, 2007 in Akerman and Stratham, 2011).

That said, bereavement may impact differently on children and young people who have already faced adversity. NCISH (2016) analysis of suicides amongst children and young people identified bereavement in the last three months to be a common factor. It is known that cumulative exposure to adversity, including bereavement, is associated with mental health problems in childhood and in adulthood.

Analysis of data from the Office for National Statistics survey of mental health among 5-16 year-olds suggests that bereaved children and young people are approximately one-and-a-half times more likely than other children and young people to be diagnosed with any mental disorder (Fauth 2009 in Ackerman 2011). The analysis did not indicate whether these conditions were present before bereavement and so was not able to comment on whether the bereavement caused the mental ill health. The report found that children and young people whose parent or sibling had died were more likely to have problems with anxiety, drinking, whereas children and young people who had experienced the death of a friend were more likely to display conduct problems, use substances, and engage in troublesome acts such as staying out late or truanting from school. This study did not find higher rates of 'clinical levels' of depression among bereaved children and young people, although this is a high threshold and so milder forms are likely to have remained hidden. While the initial grief responses tended to decline over time, mental health and other problems can persist or even increase. There could also be fluctuations over time. Delayed grief reactions may be triggered when subsequent life changes occur, such as the remaining parent re-marrying or the bereaved person having their own child (Raveis, 1999). Any negative events that follow the death, and the child's resources for coping with these, seem to be significant for the long-term (Haine 2008). However, the difficulty of disentangling the impact of bereavement from other factors increases with the passage of time since the death, so drawing conclusions about long-term impact is problematic.

### **Learning Disability**

People with learning disabilities are more likely to experience mental health problems (Emerson et al, 2008). Children and young people with learning disabilities are 'over six

times more likely to have a diagnosable psychiatric disorder than their peers who do not have learning disabilities' (Bond, 2015: 5).

Emerson et al (2004) calculated prevalence in children and young people with learning disabilities for different age groups as follows: five to nine years: 0.97%; 10 to 14 years: 2.26%; and 15 to 19 years: 2.67%.

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

Mental health problems may be worse for those with greater support needs particularly those who have difficulties communicating their feelings and their distress and may be overlooked particularly if those young people have high levels of medical need (Bond 2015: 5).

Children and young people with learning disabilities are:

- 33 times more likely to have an AS disorder than the general population
- 8 times more likely to have ADHD
- 6 times more likely to have conduct disorder
- 4 times more likely to have an emotional disorder
- 3 times more likely to experience schizophrenia
- 1.7 times more likely to have a depressive disorder (Emerson and Hatton, 2007 in BOND 2015: 11).

Children and young people with Neurodevelopmental Disorders: Autistic Spectrum Disorder (ASD)

- 70% of children and young people with ASD will have a mental health concern at some point in their life and 40 % will have 2 or more (BOND 2015: 12)
- 1 in 10 of the children and young people who use CAMHS have autism (National Autistic Society, 2010).

Children and young people with Foetal Alcohol Syndrome (FAS)

- this is a an umbrella term for a range of preventable alcohol related birth defects, which are a result of pre-natal alcohol exposure
- 90% of all people with FAS will also have some form of mental health issue (TACT 2010 in BOND 2015:13).

### **Speech, Language and Communication**

There is a high incidence and prevalence of speech, language and communication needs associated with mental health disorders in children and young people. (Enderby et al, 2009,

Patalay, 2016). Both speech, language and communication needs are co-morbid with ADHD and with learning disabilities.

Selective mutism is a specific childhood anxiety disorder, which frequently co-occurs with a social phobia and has a high comorbidity with developmental delays and delays in speech and language development and psychiatric disorders (Enderby et al, 2009).

### **LGBQ (see also section on transgender and non-binary)**

School-aged LGBQ young people experience higher levels of emotional distress than other children and young people, including being twice as likely to have depressive symptoms, suicidal thoughts and to attempt suicide (Safren and Heimberg, 1999; Fergusson et al, 1999 in Khan, 2016). This may in part be associated with their experience of bullying. In 2012, Stonewall, in partnership with the University of Cambridge, surveyed 1,600 LGBT young people in British schools (a survey repeated every four years). This study found that:

- 55% of LGBT children and young people reported being subjected to homophobic bullying.
- One in six reported being subjected to physical abuse.
- 6% reported being subjected to death threats.
- Just under half who experience homophobic bullying skipped school because of it; one in seven had skipped school more than six times.
- More than half of LGBT children and young people don't feel there is an adult at school who they can talk to about being gay.
- A quarter don't have an adult to talk to at school, home or elsewhere; Seven out of ten LGBT girls and six out of ten LGBT boys had experienced suicidal thoughts; boys from BME communities had the highest rate of suicidal thoughts affecting nearly eight out of ten.
- These children and young people were around three times as likely as other children and young people to have tried to take their own life at some point. More than half deliberately harmed themselves, which can include cutting or burning themselves (Statham et al., 2012 in Khan 2016).

### **Disengagement from School, Excluded from School, NEET**

Children and young people with a diagnosable mental health condition have much higher likelihood of being excluded (Green, et al., 2005). There is debate between educationalists and mental health specialists regarding the extent to which the behaviour of excluded children and young people reflects any underpinning mental health diagnosis (Cole, 2015).

The health of home schooled children and young people is not well evidenced. However, a national survey of local authorities undertaken by the Association of Directors of Children's Services in 2016 indicated that the reasons given by parents and carers for opting for home education included bullying, SEND, anxiety and school phobia, and emotional and behavioural difficulties (ADCS, 2016).

## Substance Misuse

There is a strong association between substance misuse and emotional and mental health in children and young people. The relationship is complex. It is explained by the clustering of similar risk factors for substance misuse and mental health, the use of substances as a means of medicating against poor emotional health, using substances as a form of self-harm or as a prelude to a suicide attempt and finally the negative impact on mental health of exposure to substances.

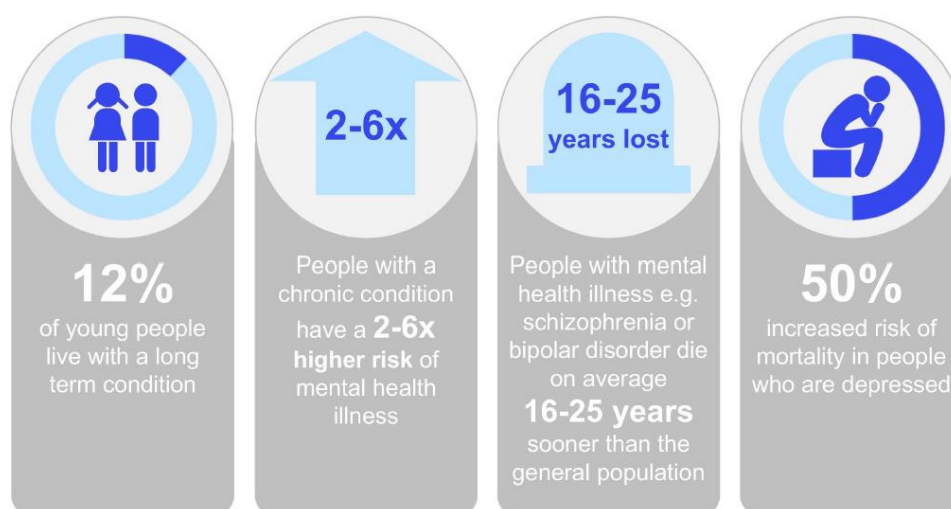
The early onset of substance misuse (under the age of 15) is associated with behavioural issues in childhood and drug dependence in adulthood. Children and young people affected by attention deficit (hyperactivity) disorder (ADHD) and conduct disorder (CD) are reported as a high-risk group for drug use (EMCDDA 2007).

Although there is a decline in the use of substances amongst young people in the UK, there is an acknowledgement that the introduction of New Psychoactive Substances (NPS) may have introduced inaccuracies in the use of substances over time. This is particularly relevant to the Adult Psychiatric Morbidity Survey (APMS) which surveys mental health and substance misuse and so can inform understanding of their comorbidity (McManus 2014).

The APMS reports that among 16–24 year olds, 23.7% of men and 16.2% of women had used cannabis in the past year, followed by ecstasy, cocaine, ketamine and mephedrone (McManus 2014) .

The coexistence of mental health disorders and problematic substance misuse, referred to as dual diagnosis, has long presented challenges to effective treatment, resulting in the development of guidelines and dual diagnosis integrated pathways.

**Figure 26: Prevalence of Long Term Conditions (LTC) and Comorbidity of Mental Health Conditions amongst Children and Young People**



Source: PHE 2016

Long-term conditions, also known as chronic conditions, are health conditions which require management over a number of years or possibly over a person's lifetime. Common long-term conditions in children and young people include: asthma, epilepsy, diabetes and anaphylaxis. The association between mental ill health and the long-term condition is two directional. The long-term condition may limit children and young people's life such that their emotional health declines, conversely periods of stress may trigger episodes of ill health.

The impact of adolescence, a period of vulnerability for mental ill health may also result in changes in treatment compliance which in itself may increase risks of mental health conditions. An example of this is diabulimia, which is an eating disorder affecting individuals with type 1 diabetes. The term 'diabulimia' has been used to identify type 1 diabetics who omit or reduce their insulin in order to lose weight.

### **Diabulimia**

Diabulimia is closely associated with feelings of shame and embarrassment, negative body image, low self-esteem, depression and anxiety. Specific characteristics associated with diabulimia include unexplained fluctuations in blood glucose, frequent diabetic ketoacidosis, improved control only when in hospital, refusal to let others observe injections, and anxiety about being overweight (Criego and Jahraus, 2009). Complications of diabulimia include blindness, limb loss, neuropathy blindness and fatality (SLAM NK).

Prevalence estimates for diabulimia vary widely; however, it is typically thought that between 30 and 40% of adolescent and young female diabetics reduce or omit insulin regularly in order to lose weight (Davidson 2014).

Based on the GP event table within the KID, 4,397 individuals aged under 25 have a read code of type 1 diabetes. Of these, 2,045 individuals are female. It is estimated that between 30 and 40% of young women with type 1 diabetes reduce or omit insulin regularly in order to lose weight, which would suggest between 614 and 818 individuals with an eating disorder and type 1 diabetes.

The NICE guidance for eating disorders (NICE 2017) contains recommendations specific to diabetic patients with an eating disorder. Key recommendations are around joint working and good communication between the mental health and diabetes teams, and also with the carer or parent of the patient. There is an emphasis on education about the consequences of reducing or omitting insulin, and the implementation of a treatment plan monitoring both food and insulin intake is recommended for people misusing insulin. For individuals with expected hyperglycaemia, recommendations are made for when to test blood glucose and blood ketones, and for monitoring of symptoms of glucose toxicity, insulin resistance, ketoacidosis and oedema. There is a lack of research into the effectiveness of treatments for people with diabulimia; the emphasis has been on establishing prevalence figures and the likelihood and complications (Philpot 2013).

## **Bullying and Cyberbullying**

Bullying has a significant negative impact on children and young people's mental and emotional health. Victimization through bullying (face to face and cyber bullying) increases risk of emotional health disorders including self-harm.

In Kent, 59.9% of 15 year olds questioned in the 'What About YOUth survey' reported that they had been bullied recently. This is higher than the England value of 55%.

Schools play a leading role in preventing bullying through the development and implementation of school policies and promotion of online safety.

'Cyber-bullying', or bullying through digital media, is increasingly recognized as the most common type of bullying. According to publications from 2008 to 2011, between 8% and 34% of young people in the UK have been cyber-bullied, with girls twice as likely to be victims of persistent cyber-bullying (Munro 2007). Analysis of the 2014 HBSC study indicated that 17.9% of 11-15 year olds reported being cyberbullied in the two months prior to being surveyed. Cyberbullying increased with age, almost doubling between the ages of 11 and 15. Girls were twice as likely as boys to report being cyberbullied. Cyberbullying was associated with socio-economic status. Young people from more affluent families were more likely to report being victims of cyberbullying. Young people who reported positive family communication, especially with a father, were less likely to experience cyberbullying. Positive perceptions of the school environment were associated with lower levels of cyberbullying as were feelings of safety in one's own community (PHE 2017).

While evidence is limited and contradictory on the potential negative effects of the emergent digital culture on children and young people, such effects may include increased physiological arousal, decreased attention, hyperactivity, aggression, antisocial or fearful behavior, social isolation and excessive use or 'technological addiction' (Williams and Guerra, 2007).

Websites that normalize unhealthy behaviors such as anorexia and self-harm may give rise to more direct harm (Andrist, 2003; Luxton et al, 2012, Whitlock et al, 2006). Schools play a leading role in preventing bullying through the development and implementation of school policies and teaching online safety.

## **Gang Affiliation**

PHE's (2015) report on the mental health of gang affiliated young people reports that the young people who have poor mental health can be vulnerable to being drawn into gangs and that involvement in gangs increases young people's risks of mental ill-health.

Young people with poor mental wellbeing can be drawn to gang-affiliation:

- Evidence shows that young people who have already faced adversity and lack familial and social support are vulnerable to gang affiliation because it provides them



with a sense of belonging. Gangs may offer a source of support to isolated young people who lack strong family or social relationships.

- Fear and anxiety may draw young people into gangs for the purpose of protection.
- Gang activities may appeal to young people with traits such as impulsivity, sensation seeking and externalizing behaviours – which can be markers of conditions including attention deficit hyperactivity disorder (ADHD) and conduct disorders.
- Gang affiliation may result in increased status for young people who have low self-esteem.

Gang affiliation can negatively impact mental health

- Gang-involved young people are at increased risk of violence as victims, perpetrators and witnesses. This exposure increases the risk of mental ill health, particularly repeated exposure.
- Gang involved young women are at risk of sexual violence. Sexual violence is a risk factor for mental ill health.
- Gang involvement may result in a need for young people to suppress their emotions.
- Gang activity can increase young people's risks of arrest and conviction which is anxiety inducing.
- Substance use is often part of gang affiliation and can increase the risk of mental ill health (PHE 2015).

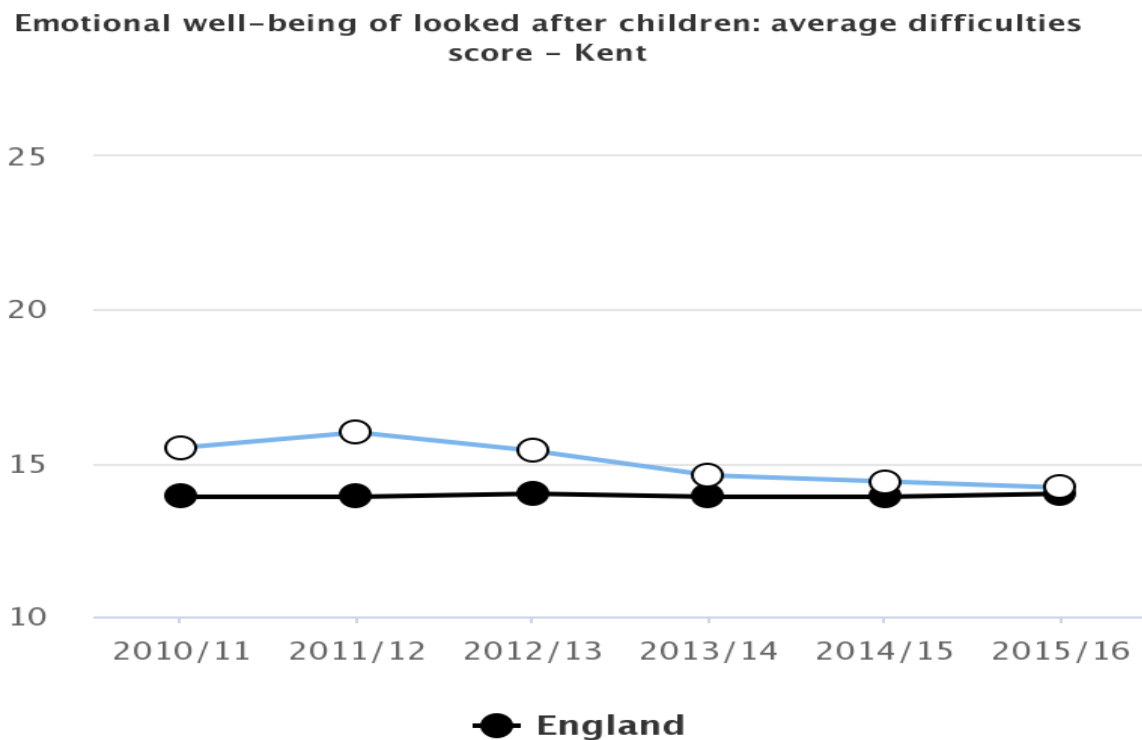
### **Children in care, looked after children and children who are children in need and subjects of a child protection plan**

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

Variation was shown depending on the type of placement with two-thirds of children and young people living in residential care found to have a mental health disorder compared with four in ten of those places with foster-carers or their birth parents (CHIMAT NK)

The high rate of mental health and behavioural disorders among looked after children is understood to be an interaction between pre-existing mental health conditions, exposure to maltreatment, the length of that exposure and biological risk and resilience (Hablins 2008) shows that mental health and behavioural disorders were already present in 72% of cases at entry into care.

**Figure 27: The average annual STQ score for Children in Care in Kent compared to England for the period 2010/11 to 2015/16**



The figure shows that the average score in Kent has declined and is now in line with the England value.

A score below 13 is considered normal, a score of 14-16 is borderline and above 17 is cause for concern. Department of Education data shows that for the period 2011- 2014, the percentage of children and young people who scored above 17, who are of concern was higher than Kent’s statistical neighbours and higher than England. Kent’s percentage of eligible children and young people for whom an SDQ was submitted was also higher than its statistical neighbours and England.

Ninety per cent of referrals to CAMHS were initiated by social workers. The average waiting time is five weeks. One hundred and seventy three (65%) of appointments attended are face to face.

The annual SDQ provides a systematic means of assessing symptoms, although with limitations. This should be supplemented through integrated working between schools, CIC nurses, and specialist CAMHS, SCS and foster carers.

Although SDQ scores for children in care in Kent are currently in line with the England benchmark, there is evidence that a pathway is not currently in place for those children and young people whose score indicates a clinical need and who may benefit from services.

There is an absence of systematic identification of emotional and mental health needs amongst Children in Need, who are at greater risk of adversity.

The Institute of Social Care Excellence has developed a programme of work to improve the mental health of looked after children. A call to evidence in 2016 identified evidence of the following promising practice:

Dedicated multi-agency teams supporting LAC mental health and wellbeing which included a consultancy model to support the professional network and key relationships around the child or young person as the first line of involvement, including informal 'drop in' models, provision of training for carers and other professionals, delivery of direct interventions including therapeutic support for children and young people and their carers as needed. The impact of these teams included positive impacts on outcomes such as child wellbeing and behaviour, quality of relationships, and carer confidence and stress. Both children and young people and practitioners and carers provided positive feedback on this model of delivery.

Screening and identification of need through the monitoring of SDQ scores, including through multi-agency meetings for the purposes of care planning, the use of DAWBA as an initial screening for all looked after children, and screening for under five's leading to an intervention. There was no evidence submitted which indicated that there was an impact on identification at this stage but feedback from carers and practitioners was positive.

Training and support for foster carers was provided through multi-disciplinary teams or third sector organizations commissioned by the local authority and included: Fostering Changes Programme, Head Heart Hands; Incredible Years; KEEP; Nurturing Attachments Mentalisation-Based Treatment for Fostering, Reflective Fostering, TEND, a specialist foster carer support scheme. Evidence of positive impacts on outcomes were reported including parental sensitivity, quality of parenting, child behaviour, emotional distress and child development for some interventions. Some interventions had also received positive feedback from carers and practitioners.

Approaches and models in residential care included providing comprehensive training to staff based on a common conceptual or therapeutic model, and provision of therapeutic interventions to children and young people. In one area, a reduction in SDQ scores for children and young people involved with the service was reported. Two further examples reported positive feedback from children, young people and staff in residential homes about the approaches.

Training and support for adoptive parents through Family Futures is a neurophysiological psychotherapy (NPP) intervention for children and young people who have experienced significant trauma in their early life and through Adopt, a group-based parenting programme for adoptive parents which aims to develop parenting techniques that help to address the difficulties that adopted children and young people may experience. These examples included evidence of improved outcomes as well as positive feedback from children and young people and adoptive parents.

The programme is progressing to further test some of these approaches.

The NSPCC has developed a whole systems approach, which incorporated many of the areas of practice identified by the SCIE. They have identified the following priorities:

1. Improving the assessment and monitoring of looked after children's emotional wellbeing and mental health.
2. Improving early intervention to support looked after children's emotional wellbeing and mental health.
3. Building children's resilience through a holistic understanding of children's wellbeing.
4. Building the emotional intelligence of the workforce.
5. Improving training and support for carers and other professionals to promote placement stability.
6. Ensuring young people's voices are heard throughout their time in care.
7. Enabling children in care to develop a coherent sense of their identity.
8. Sustaining young people's emotional resilience as they leave care (NSPCC 2015).

### **Young Offenders**

Young offenders are estimated at having three times higher levels of mental ill health than the general non-offending population. Contact with the criminal justice system increases mental ill health.

Forty-three per cent of children and young people on community orders have emotional and mental health needs, and between a third and a half of children and young people in custody have a diagnosable mental health disorder such as depression, which is particularly prevalent in girls. Sixty per cent of children and young people who offend have communication difficulties and, of this group, around half have poor or very poor communication skills (Prison Reform Trust 2013).

Seventy-two per cent of young offenders have experienced abuse, 53% have experienced significant loss and 35% have experienced abuse and loss (Beyond Youth Custody, 2016).

The Chief Medical Officer noted that 40% of children and young people on Community Orders have emotional and mental health needs. Approximately the same proportion have experienced neglect, abuse or homelessness, and half have themselves been a victim of crime (CMO, 2012).

In a health audit of young offenders in Kent undertaken by KCC Early Help and Prevention officers with reference to ASSET and their case notes (n=60) in 2014, 8% of the young people's cases audited had a diagnosis of conduct disorder. A quarter of the cases showed that the young person has a diagnosis of ADHD. This is significantly higher than the general population and higher than the national evidence. Just 12% were in receipt of medication for ADHD, 8% of the young people's cases audited showed that the young person has a diagnosis of anxiety, 6% of the young people's cases audited that the young person has a diagnosis of depression. None of the cases audited showed the young person has a diagnosis of psychosis. Five per cent of the young people's cases audited showed the young person has a diagnosis of post-traumatic stress disorder.

Taken together and assuming there is no comorbidity between diagnoses, of the young people's cases audited, 27% had a diagnosable mental health disorder. This is in line with the 25% of cases who were receiving an intervention from specialist treatment services but is lower than the national prevalence figure of 25-77%. Thirty-six per cent of the cases had sadness and irritability or anxiety, 13% of the cases felt hopeless about the future, 10% of the cases currently see and hear things that other people do not, 33% have longstanding symptoms of over activity, inattention and impulsivity in multiple settings, 5% of the cases had current thoughts of self-harm or suicide - this is probably lower than we would expect even within a predominantly male population.

The number of young offenders in Kent is declining but their needs are becoming more complex. Young offenders, of whom around 40% are Children in Care, are at high risk of mental ill health particularly externalizing mental health conditions. Those with early onset conduct disorder will have a particularly poor prognosis.

Their exposure to adversity and trauma may result in them being hard to engage and complex to diagnose and treat.

### **Unaccompanied Asylum Seeking Children (UASC)**

Unaccompanied children and young people are also at high risk of mental illness as a result of their exposure to risks and adversities prior to, during and after migration. The prevalence of symptoms consistent with a mental illness in unaccompanied children and young people has been reported as up to 48%. The most common mental illnesses reported in unaccompanied children and young people are post-traumatic stress disorder (PTSD), mood disorders and agoraphobia. It is important to note that unaccompanied children and young people may show delayed presentations of mental illness, necessitating ongoing surveillance and repeat assessment (KCC 2015).

Sanchez-Cao et al (2012) surveyed 71 UASC and identified high levels of psychological distress via self-report, with 66% at high risk for PTSD and 12% at high risk for depressive disorder. However, only 17% were in contact with MHS, and this was predicted by depressive symptoms and time spent in the UK.

In an analysis of Initial Health Assessment for UASC in Kent (n=154) psychological symptoms were reported in 41% of children and young people. The most common psychological symptoms noted were of Post-Traumatic Stress Disorder (PTSD), anxiety, and depression (KPHO 2017).

### **Young Carers**

Surveys of young carers found substantial numbers reporting stress, anxiety, low self-esteem and depression (Frank et al., 1999; Dearden & Becker, 2000; Banks et al., 2001 in Khan, 2016). Poor mental health may arise from children and young people's caring roles a role which may also increase barriers for those children and young people accessing mental health services. Young Carers groups provide critical social and emotional support for young

carers and an opportunity to reduce stigma and improve access to mental health services if needed.

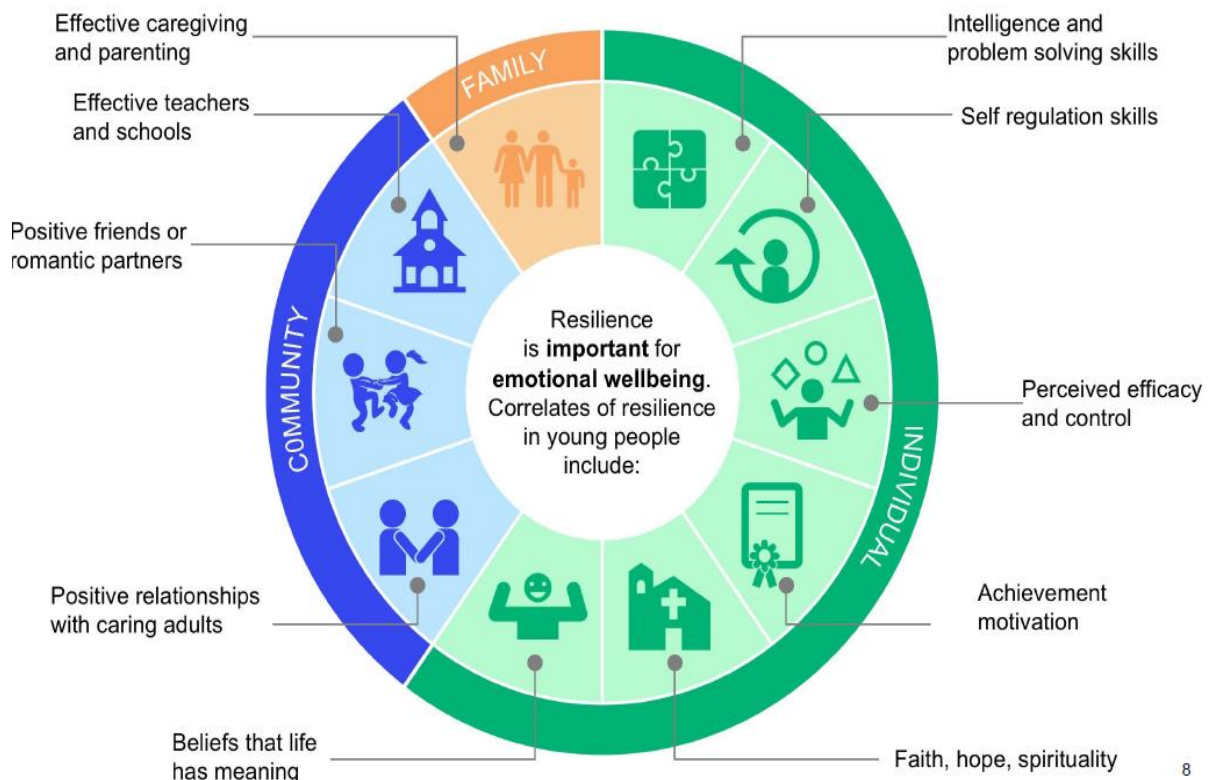
## 10. Preventing, Treating and Recovery from Mental Health Disorders

### Evidence Based Approaches

This section provides an indication of interventions which provide universal prevention, secondary prevention, treatment and recovery for emotional health and for externalising and internalising mental health disorders. It is largely based on NICE guidance and is supported by evidence where additional good evidence is available. It goes on to report on promising interventions some of which have been developed and trialled in Kent.

In implementing interventions for children and young people’s mental health, it should be recognised that comorbidity is the norm rather than an exception. That said, Ollendick et al’s (2008) review examining whether the comorbidity of the most common childhood disorders (anxiety, ADHD, affective disorders, ODD and CD) had an impact on treatment outcomes found that comorbidity did not affect treatment outcomes.

**Figure 28: Conceptualisation of Resilience**



### Social and Emotional Wellbeing

Good social, emotional and psychological health helps protect children and young people against emotional and behavioural problems, violence and crime, teenage pregnancy and

the misuse of drugs and alcohol ('Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education' (Adi et al. 2007, Colman et al. 2009; Graham and Power 2003 in NICE 2009).

### **Social and Emotional Health in the Early Years**

Social and emotional learning in the early years (0-5) plays a critical role in later behavioural and emotional health (NICE 2012). It is impacted upon by attachment provided by the mother and by exposure to adversity like parental substance misuse, domestic abuse and poor parental mental health. The early years provide an opportunity to have a positive impact on social and emotional learning particularly those children who live in more disadvantaged households and who are at greater risk of these adversities.

Access to early years education including that provided through children's centres and to intensive health visiting support as well as parenting skills courses are key to identifying and intervening to improve social and emotional health.

### **Attachment Disorder**

Attachment disorder describes a range of emotions and behaviors, which a child or young person who have been exposed to a lack of attachment to their primary care giver in infancy feels or displays. Reactive attachment disorder is a severe form of attachment disorder.

Attachment is a type of behavior displayed by children to draw their primary caregiver towards them at moments of need or distress. Children whose caregivers respond sensitively to their needs at times of distress and fear in infancy and early childhood develop secure attachments to them. They have better outcomes than non-securely attached children and young people in social and emotional development, educational achievement and mental health. Early attachment relations are thought to be crucial for later social relationships and for the development of capacities for emotional and stress regulation, and self-control. Children and young people who have had insecure attachments are more likely to struggle in these areas and to have emotional and behavioural difficulties (NICE 2016).

Attachment can also be assessed indirectly by examining the primary caregiver's sensitivity to the child, particularly in response to the child's distress or fear. A significant association has been found between maternal sensitivity and child security of attachment.

Attachment difficulties are typically assessed using structured interviews with carers, and may be supplemented by questionnaires and direct observation of the child or young person's behaviour.



## Quality Standards and Implementation

### **Statement 1: Children and young people who may have attachment difficulties, and their parents or carers, have a comprehensive assessment before any intervention programme.**

Service providers (providers of attachment interventions) ensure that systems are in place so that children and young people who may have attachment difficulties, and their parents or carers have a comprehensive assessment before any intervention programme.

Health and social care practitioners (groups delivering attachment interventions) ensure they undertake comprehensive assessments for children and young people who may have attachment difficulties before any intervention programmes commence.

Commissioners (clinical commissioning groups and local authorities) ensure that services providing intervention programmes for attachment difficulties undertake comprehensive assessments on children and young people who may have attachment difficulties before initiation of a programme.

### **Statement 2. Children and young people with attachment difficulties have an up-to-date education plan setting out how they will be supported in school.**

Education providers (schools and other settings such as early year's providers) ensure that systems are in place for children and young people with attachment difficulties to have education plans setting out how they will be supported in school. Providers ensure staff involved in the design and development of education plans has had training in supporting children with attachment difficulties.

Education staff (such as designated teachers, virtual school heads and other identified teachers) work with health and social care practitioners to develop and maintain education plans for children and young people with attachment difficulties. Teachers, through the framework of core content for initial teacher training (ITT) should have an awareness of the importance of emotional development such as attachment issues and mental health on pupils' performance.

Local authorities ensure that education providers have and maintain an education plan for children and young people with attachment difficulties that set out how they will be supported in school.

### **Statement 3. Parents and carers of preschool-age children with or at risk of attachment difficulties are offered a video feedback programme.**

Service providers (health and social care providers) ensure that they have a video feedback programme available to offer the parents and carers of preschool aged children with or at risk of attachment difficulties.

Health and social care practitioners (such as mental health professionals in multi-agency services, health visitors and social workers) ensure that they offer a video feedback

programme to parents and carers of preschool aged children with or at risk of attachment difficulties.

Commissioners (clinical commissioning groups and local authorities) ensure that they commission services that can offer parents and carers of preschool aged children with or at risk of attachment difficulties a video feedback programme

**Statement 4. Health and social care provider organisations provide training, education and support programmes for carers of school aged children and young people with attachment difficulties.**

Service providers (health and social care providers) ensure that carers of school aged children and young people with attachment difficulties can have training, education and support before and during a placement. Service providers should offer a range of training and support programmes appropriate for different age groups of children.

Health and social care practitioners (Child and Adolescent Mental Health Services [CAMHS], specialist paediatricians, and social care practitioners) ensure that they consider training, education and support programmes for carers of school aged children and young people with attachment difficulties before and during a placement.

Commissioners (local authorities) ensure they commission training and support programmes for carers of school aged children and young people with attachment difficulties before and during placements. Programmes should be appropriate to different age groups:

- Video feedback programme
- Parental sensitivity and behaviour training
- If the early years child has experienced maltreatment or is at risk of maltreatment
- Consider parent–child psychotherapy for parents who have maltreated or are at risk of maltreating their child to improve attachment difficulties, ensuring that safeguarding concerns are addressed
- Consider delivering PTSD assessment and interventions for a school aged child or young person.

Consider a group-based training and education programme for foster carers, special guardians and adoptive parents to maintain stability in the home and help transition to a new school environment combined with a group-based training and education programme for late primary and early secondary school-age children and young people in the care system, subject to special guardianship orders and adopted from care to improve social skills and maintain positive peer relationships

**Social and Emotional Health of Primary Aged Children**

NICE (2008) is clear in its recommendation to develop a children and young people’s plan which ensures all primary schools adopt a comprehensive, 'whole school' approach to children's social and emotional wellbeing. All primary schools should:

- Create an ethos and conditions that support positive behaviors for learning and for successful relationships, through programmes like SEAL
- Provide an emotionally secure and safe environment that prevents any form of bullying or violence
- Support all pupils and, where appropriate, their parents or carers (including adults with responsibility for looked after children)
- Provide specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems
- Include social and emotional wellbeing in policies for attaining National Healthy Schools status and reaching the outcome framework targets
- Offer teachers and practitioners in schools training and support in how to develop children's social, emotional and psychological wellbeing (NICE 2008).

Put in place and evaluate coordinating mechanisms to ensure primary schools have access to the skills, advice and support they need to deliver a comprehensive and effective programme that develops children's social and emotional skills and wellbeing.

Schools and local authority children's services should work closely with child and adolescent mental health and other services to develop and agree local protocols. These should support a 'stepped care' approach to preventing and managing mental health problems. The protocols should cover assessment, referral and a definition of the role of schools and other agencies in delivering different interventions, taking into account local capacity and service configuration.

### **Social and emotional health of secondary aged children and young people**

#### **Strategic Framework:**

- What action should they take?
- Enable all secondary education establishments to adopt an organisation-wide approach to promoting the social and emotional wellbeing of young people. This should encompass organisation and management issues as well as the curriculum and extra-curriculum provision.
- Encourage the appropriate local authority scrutiny committee to assess the progress made by secondary education establishments in adopting an organisation-wide approach to social and emotional wellbeing.
- Help secondary education establishments to develop the necessary organisational capacity to promote social and emotional wellbeing. This includes leadership and management arrangements, specialist skills and resources.
- Help secondary education establishments to share practical advice on how to promote the social and emotional wellbeing of young people.
- Ensure secondary education establishments have access to the specialist skills, advice and support they require. This may be provided by public, private, voluntary and community organisations. It may involve working with local authority advisory

services, personal, social, health and economic (PSHE) education services, educational psychology and child and adolescent mental health services.

- Ensure policies and arrangements are in place to promote the social and emotional wellbeing of those who work with young people in secondary education.
- Head teachers, governors and teachers should demonstrate a commitment to the social and emotional wellbeing of young people. They should provide leadership in this area by ensuring social and emotional wellbeing features within improvement plans, policies, systems and activities. These should all be monitored and evaluated.
- Foster an ethos that promotes mutual respect, learning and successful relationships among young people and staff. Create a culture of inclusiveness and communication that ensures all young people's concerns can be addressed (including the concerns of those who may be at particular risk of poor mental health).
- Provide a safe environment which nurtures and encourages young people's sense of self-worth and self-efficacy, reduces the threat of bullying and violence and promotes positive behaviours.
- Systematically measure and assess young people's social and emotional wellbeing. Use the outcomes as the basis for planning activities and evaluating their impact (informed by Ofsted guidance on social and emotional wellbeing).
- Ensure young people have access to pastoral care and support, as well as specialist services, so that emotional, social and behavioural problems can be dealt with as soon as they occur. (Specialist services include child and adolescent mental health services)
- Provide a curriculum that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying. This can be achieved by integrating social and emotional skills development within all areas of the curriculum. Skills that should be developed include: motivation, self-awareness, problem-solving, conflict management and resolution, collaborative working, how to understand and manage feelings, and how to manage relationships with parents, carers and peers.
- Tailor social and emotional skills education to the developmental needs of young people. The curriculum should build on learning in primary education and be sustained throughout their education.
- Reinforce curriculum learning on social and emotional skills and wellbeing by integrating relevant activities into all aspects of secondary education. For example, such skills might be developed through extra-curricular activities, using projects set for homework or via community-based and individual voluntary work.
- Work in partnership with parents, carers and other family members to promote young people's social and emotional wellbeing.
- To help reinforce young people's learning from the curriculum, help parents and carers develop their parenting skills. This may involve providing information or

offering small, group-based programmes run by appropriately trained health or education practitioners.

- Ensure parents, carers and other family members living in disadvantaged circumstances are given the support they need to participate fully in activities to promote social and emotional wellbeing. This should include support to participate fully in any parenting sessions (for example, by offering a range of times for the sessions or providing help with transport and childcare). This might involve liaison with family support agencies
- Develop partnerships between young people and staff to formulate, implement and evaluate organisation-wide approaches to promoting social and emotional wellbeing.
- Introduce a variety of mechanisms to ensure all young people have the opportunity to contribute to decisions that may impact on their social and emotional wellbeing.
- Provide young people with opportunities to build relationships, particularly those who may find it difficult to seek support when they need it. This could involve developing a peer education or peer mediation approach. Note, young people who act as peer supporters need training and the support of staff and other professionals.
- Provide young people with clear and consistent information about the opportunities available for them to discuss personal issues and emotional concerns. Any support offered should take account of local community and education policies and protocols regarding confidentiality. Make young people aware of their rights on confidentiality.
- Involve young people in the creation, delivery and evaluation of training and continuing professional development activities in relation to social and emotional wellbeing
- Integrate social and emotional wellbeing within the training and continuing professional development of practitioners and governors involved in secondary education.
  - Ensure practitioners have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing. Training may cover:
    - listening and facilitating skills and the ability to be non-judgmental
    - how to manage behaviours effectively, based on an understanding of the underlying issues
    - identifying and responding to the needs of young people who may be experiencing emotional and behavioural difficulties
    - how to access pastoral care based in secondary education or specialist services provided by other agencies, such as child and adolescent mental health services
    - the issues in relation to different medical conditions (such as diabetes, asthma and epilepsy) to ensure young people with these conditions are not bullied, inappropriately excluded from school activities or experience any undue emotional distress

- opportunities to reflect upon and develop their own social and emotional skills and awareness.

## ADHD

### ADHD Diagnosis

A diagnosis of ADHD should only be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, on the basis of:

- A full clinical and psychosocial assessment of the person; this should include discussion about behaviour and symptoms in the different domains and settings of the person's everyday life.
- A full developmental and psychiatric history.
- Observer reports and assessment of the person's mental state.

As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health. For children and young people, there should also be an assessment of their parents' or carers' mental health (NICE 2008)

### ADHD: Secondary Prevention

If the child or young person's behavioural and/or attention problems suggestive of ADHD are having an adverse impact on their development or family life, healthcare professionals should consider:

- A period of watchful waiting of up to 10 weeks.
- Offering parents or carers a referral to a parent-training/education programme (this should not wait for a formal diagnosis of ADHD). [2008]
- If the behavioural and/or attention problems persist with at least moderate impairment, the child or young person should be referred to secondary care (that is, a child psychiatrist, paediatrician, or specialist ADHD CAMHS) for assessment.
- If the child or young person's behavioural and/or attention problems are associated with severe impairment, referral should be made directly to secondary care (that is, a child psychiatrist, paediatrician, or specialist ADHD CAMHS) for assessment. [2008]
- Group-based parent-training/education programmes are recommended in the management of children and young people with conduct disorders [1]. [2008].

Treatment: Children in their Early Years with ADHD

Parent-training/education programmes are the first-line treatment for parents or carers of pre-school children. Group-based parent-training/education programmes, developed for the treatment and management of children with conduct disorders [3], should be fully accessible to parents or carers of children with ADHD whether or not the child also has a formal diagnosis of conduct disorder. [2008]

Individual-based parent-training/education programmes are recommended in the management of children with ADHD when:

- A group programme is not possible because of low participant numbers
- There are particular difficulties for families in attending group sessions (for example, because of disability, needs related to diversity such as language differences, parental ill-health, problems with transport, or where other factors suggest poor prospects for therapeutic engagement)
- A family's needs are too complex to be met by group-based parent-training/education programmes.

When individual-based parent-training/education programmes for pre-school children with ADHD are undertaken, the skills training stages should involve both the parents or carers and the child

### **Treatment: children and young people of school age with adhd and moderate impairment**

Group-based parent-training/education programmes are usually the first-line treatment for parents and carers of children and young people of school age with ADHD and moderate impairment (see criteria for early years parenting programme).

This may also include group psychological treatment (cognitive behavioural therapy [CBT] and/or social skills training) for the younger child. For older age groups, individual psychological treatment may be more acceptable if group behavioural or psychological approaches have not been effective, or have been refused.

Drug treatment is not indicated as the first-line treatment for all school-age children and young people with ADHD. It should be reserved for those with severe symptoms and impairment or for those with moderate levels of impairment who have refused non-drug interventions, or whose symptoms have not responded sufficiently to parent-training/education programmes or group psychological treatment (NICE 2008)

### **Treatment: Older Adolescents**

For older adolescents with ADHD and moderate impairment, individual psychological interventions (such as CBT or social skills training) may be considered as they may be more effective and acceptable than group parent-training/education programmes or group CBT and/or social skills training. (NICE 2008)

### **Treatment: Children and young people with learning disability with ADHD**

For children and young people (including older age groups) with ADHD and a learning disability, a parent-training/education programme should be offered on either a group or individual basis, whichever is preferred following discussion with the parents or carers and the child or young person.

### **Treatment: Discharge from secondary care and integrated working**

Following successful treatment with a parent-training/education programme and before considering discharge from secondary care, the child or young person should be reviewed, with their parents or carers and siblings, for any residual problems such as anxiety, aggression or learning difficulties. Treatment plans should be developed for any coexisting conditions.

Following treatment with a parent-training/education programme, children and young people with ADHD and persisting significant impairment should be offered drug treatment.

Healthcare professionals should contact the child or young people's teachers to share the assessment and suggest behavioural interventions which trained teachers can provide. (NICE 2008)

### **Treatment: School age children and young people with severe ADHD (hyperkinetic disorder) and severe impairment**

The first-line treatment for school-age children and young people with severe ADHD (hyperkinetic disorder) and severe impairment is drug treatment. If the child or young person wishes to refuse medication and/or the parents or carers reject it, a psychological intervention may be tried but drug treatment has more benefits and is superior to other treatments for this group.

In school-age children and young people with severe ADHD, drug treatment should be offered as the first-line treatment. Parents should also be offered a group-based parent-training/education programme.

Drug treatment should only be initiated by an appropriately qualified healthcare professional with expertise in ADHD and should be based on a comprehensive assessment and diagnosis. Continued prescribing and monitoring of drug therapy may be performed by general practitioners, under shared care arrangements (NICE2008).

### **ADHD: Management around significant transitions**

Healthcare professionals should work with children and young people with ADHD and their parents or carers to anticipate major life changes (such as puberty, starting or changing schools, the birth of a sibling) and make appropriate arrangements for adequate personal and social support during times of increased need. The need for psychological treatment at these times should be considered.

Following a diagnosis of ADHD, healthcare professionals should consider providing all parents or carers of all children and young people with ADHD self-instruction manuals, and other materials such as videos, based on positive parenting and behavioural techniques.

Healthcare professionals should stress the value of a balanced diet, good nutrition and regular exercise for children, young people and adults with ADHD. (NICE 2008)



### **ADHD: Support to families**

Healthcare professionals should ask families or carers about the impact of ADHD on themselves and other family members, and discuss any concerns they may have.

Healthcare professionals should:

- Offer family members or carers an assessment of their personal, social and mental health needs.
- Encourage participation in self-help and support groups where appropriate.
- Offer general advice to parents and carers about positive parent– and carer–child contact, clear and appropriate rules about behaviour, and the importance of structure in the child or young person's day.
- Explain that parent-training/education programmes do not necessarily imply bad parenting, and that their aim is to optimise parenting skills to meet the above-average parenting needs of children and young people with ADHD. (NICE 2008).

### **ADHD: Transition**

A young person with ADHD receiving treatment and care from CAMHS or paediatric services should be reassessed at school-leaving age to establish the need for continuing treatment into adulthood. If treatment is necessary, arrangements should be made for a smooth transition to adult services with details of the anticipated treatment and services that the young person will require. Precise timing of arrangements may vary locally but should usually be completed by the time the young person is 18 years. [2008]

During the transition to adult services, a formal meeting involving CAMHS and/or pediatrics and adult psychiatric services should be considered, and full information provided to the young person about adult services. For young people aged 16 years and older, the care programme approach (CPA) should be used as an aid to transfer between services. The young person, and when appropriate the parent or carer, should be involved in the planning. [2008]

### **Conduct Disorder (CD)**

Conduct Disorder (CD): Identification of at Risk Children and Young People and Primary Prevention

Services should establish robust methods to identify children and young people at risk of developing conduct problems, integrated when possible with the established local assessment system. These should focus on identifying vulnerable parents, where appropriate antenatally, including:

- Parents with other mental health problems, or with significant drug or alcohol problems.

- Mothers younger than 18 years, particularly those with a history of maltreatment in childhood.
- Parents with a history of residential care.
- Parents with significant previous or current contact with the criminal justice system.

### **Early Years Settings and Primary Schools**

Offer classroom-based emotional learning and problem-solving programmes for children aged typically between 3 and 7 years in schools where classroom populations have a high proportion of children identified to be at risk of developing oppositional defiant disorder or conduct disorder. Typically the programmes should consist of up to 30 classroom-based sessions over the course of 1 school year (NICE 2017)

### **Conduct Disorder and ODD: Indicated/ Secondary Prevention and Specialist Treatment**

Indicated prevention refers to interventions targeted to high-risk individuals who are identified as having detectable signs or symptoms that may lead to the development of conduct disorders but who do not meet diagnostic criteria for conduct disorders when offered an intervention

### **Parent Training Programmes**

Offer a group parent training programme to the parents of children and young people aged between three and 11 years who:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder.
- Have oppositional defiant disorder or conduct disorder.
- Are in contact with the criminal justice system because of antisocial behaviour.

Group parent training programmes should involve both parents if this is possible and in the best interests of the child or young person, and should:

- Typically have between 10 and 12 parents in a group.
- Be based on a social learning model, using modelling, rehearsal and feedback to improve parenting skills.
- Typically consist of 10 to 16 meetings of 90 to 120 minutes' duration.

Adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme.

Offer an individual parent training programme to the parents of children and young people aged between three and 11 years who are not able to participate in a group parent training programme and whose child:

- Has been identified as being at high risk of developing oppositional defiant disorder or conduct disorder.
- Has oppositional defiant disorder or conduct disorder.

- Is in contact with the criminal justice system because of antisocial behaviour.
- Individual parent training programmes should involve both parents if this is possible and in the best interests of the child or young person.
- Be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills.
- Typically consist of 8 to 10 meetings of 60 to 90 minutes' duration.
- Adhere to a developer's manual [5] and employ all of the necessary materials to ensure consistent implementation of the programme (NICE 2017).

Manualized programmes include Incredible Years which have been evidenced to reduce, although not totally stop the ODD behaviors (Hobbel et al 2011).

### **Conduct disorder and ODD: Indicated/ secondary prevention and specialist treatment group work programmes for 9-14 year olds**

Offer group social and cognitive problem-solving programmes to children and young people aged between nine and 14 years who:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder.
- Have oppositional defiant disorder or conduct disorder.
- Are in contact with the criminal justice system because of antisocial behaviour.
- Group social and cognitive problem-solving programmes should be adapted to the children's or young people's developmental level.
- Be based on a cognitive-behavioural problem-solving model.
- Use modelling, rehearsal and feedback to improve skills.
- Typically consist of 10 to 18 weekly meetings of 2 hours' duration.
- Adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme.

### **Conduct Disorder: Treatment multimodal interventions**

Offer multimodal interventions, for example, multi-systemic therapy, to children and young people aged between 11 and 17 years for the treatment of conduct disorder.

Multimodal interventions should involve the child or young person and their parents and carers and should:

- Have an explicit and supportive family focus.
- Be based on a social learning model with interventions provided at individual, family, school, criminal justice and community levels.
- Be provided by specially trained case managers.
- Typically consist of three to four meetings per week over a three- to five-month period.

- Adhere to a developer's manual [5] and employ all of the necessary materials to ensure consistent implementation of the programme.

## Depression

### Depression: Universal Primary Prevention:

**Table 6: Stepped Approach to Depression**

Focus	Action	Responsibility
Detection	Risk profiling	Tier 1
Recognition	Identification in presenting children or young people	Tiers 2-4
Mild depression (including dysthymia)	Watchful waiting Non-directive supportive therapy/group cognitive behavioural therapy/guided self-help	Tier 1 Tier 1 or 2
Moderate to severe depression	Brief psychological therapy +/- fluoxetine	Tier 2 or 3
Depression unresponsive to treatment/recurrent depression/psychotic depression	Intensive psychological therapy +/- fluoxetine, sertraline, citalopram, augmentation with an antipsychotic	Tier 3 or 4

Cairns et al (2014) undertook a systematic review to identify risk factors which adolescents could modify to reduce the risk of depression and identified the following modifiable behaviours which could inform self-help and health education campaigns:

#### Reduce

- substance use (alcohol, tobacco, cannabis, other illicit drugs and poly drug use);
- Reduce dieting
- Reduce negative coping strategies

#### Promote

- Healthy weight;
- Healthy diet
- Sleep patterns

### **Depression: Universal Secondary Prevention**

Risk profiling, identification and support through watchful waiting and active listening, non-directive support therapy, group CBT, guided self-help.

In response to a single event i.e. bereavement, separation divorce an assessment of risks of depression should be undertaken and a plan progressed to coordinate professionals and parental responses. Single life events are unlikely to lead to depressive illness. If a child is at high risk of depression (exposed to two or more risk factors) and presenting self-harm then a referral should be made to Tier 2/3.

If children and young people who have previously recovered from moderate or severe depression begin to show signs of a recurrence of depression, healthcare professionals in primary care, schools or other relevant community settings should refer them to CAMHS tier 2 or 3 for rapid assessment (NICE 2015).

The most evaluated intervention for depression is the Penn State Resilience Programme (Ahlen 2015).

Ahlen (2015) estimates an effect size of .11 and .13 for universal prevention interventions for anxiety symptoms and depression respectively.

### **Depression: Treatment of Mild Depression**

- Watchful waiting
- Following a period of up to 4 weeks of watchful waiting, offer all children and young people with continuing mild depression and without significant comorbid problems or signs of suicidal ideation individual non-directive supportive therapy, group cognitive behavioural therapy (CBT) or guided self-help for a limited period (approximately 2 to 3 months).
- If no progress is made, assessment and referral to Tier 3 for moderate, severe depression (NICE 2015).

### **Depression: Treatment of Moderate and Severe Depression**

- Moderate and Severe
- A specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months
- Consider combined therapy (fluoxetine [2] and psychological therapy) for initial treatment of moderate to severe depression in young people (12–18 years)
- If unresponsive after 4 to 6 treatment sessions multi-disciplinary review followed by alternative psychological therapy for child and additional therapy for parent/ carer
- offer fluoxetine [3] if moderate to severe depression in a young person (12–18 years) is unresponsive to a specific psychological therapy after 4 to 6 sessions.

### **Severe**

Following multidisciplinary review, the following should be considered:

- An alternative psychological therapy which has not been tried previously (individual CBT, interpersonal therapy or shorter-term family therapy, of at least 3 months' duration).
- Systemic family therapy (at least 15 fortnightly sessions).
- Individual child psychotherapy (approximately 30 weekly sessions).

### **Unresponsive to Treatment**

Following multidisciplinary review, the following should be considered:

- An alternative psychological therapy which has not been tried previously (individual CBT, interpersonal therapy or shorter-term family therapy, of at least 3 months' duration).
- Systemic family therapy (at least 15 fortnightly sessions).
- Individual child psychotherapy (approximately 30 weekly sessions)

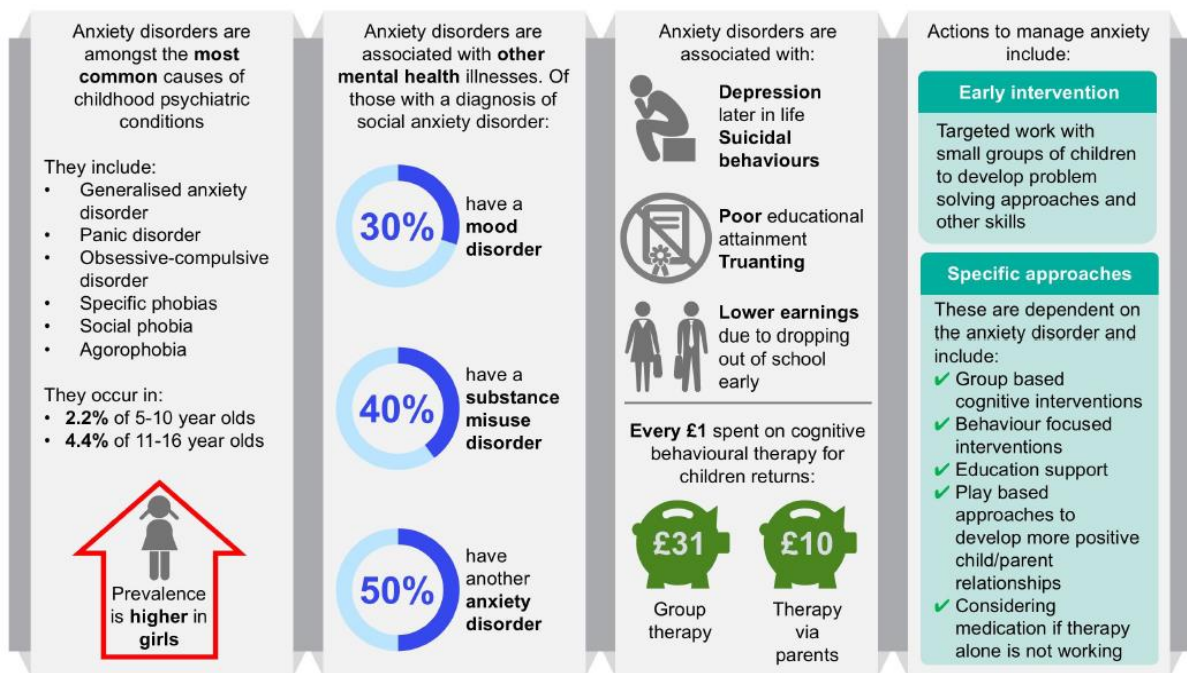
### **Tertiary Prevention/ Recovery**

Follow-up psychological therapy sessions to reduce the likelihood of, or at least detect, a recurrence of depression should be considered for children and young people who are at a high risk of relapse (for example individuals who have already experienced two prior episodes, those who have high levels of sub syndrome symptoms, or those who remain exposed to multiple-risk circumstances) (NICE, 2005).

CAMHS specialists should teach recognition of illness features, early warning signs, and subthreshold disorders to tier 1 professionals, children or young people with recurrent depression and their families and carer(s). Self-management techniques may help individuals to avoid and/or cope with trigger factors. (NICE 2015).

## Anxiety

Figure 29: Prevalence, Outcomes, Costs and Evidence-based Actions for Anxiety



Source: PHE 2016

### Universal Prevention: Anxiety

The most robustly evaluated intervention for the prevention of anxiety is the Penn State Resilience Programme (Ahlen 2015).

Ahlen (2015) estimates an effect size of .11 and .13 for universal prevention interventions for anxiety symptoms and depression respectively.

### Social Anxiety Disorder: Recovery/Tertiary Prevention

OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list (NICE 2013).

### OCD and BDD Specialist Treatment

Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.

Following multidisciplinary review, for a child (aged 8–11 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment may be considered. Careful monitoring should be undertaken, particularly at the beginning of treatment.

Following multidisciplinary review, for a young person (aged 12–18 years) with OCD or BDD with moderate to severe functional impairment if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment should be offered. Careful monitoring should be undertaken, particularly at the beginning of treatment.

All children and young people with BDD should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment (NICE 2005)

## **Post-Traumatic Stress Disorder (PTSD)**

### **PTSD: Secondary Prevention and Treatment**

Families and carers have a central role in supporting people with PTSD.

However, depending on the nature of the trauma and its consequences, many families may also need support for themselves. Healthcare professionals should be aware of the impact of PTSD on the whole family.

A number of sufferers with PTSD may recover with no or limited interventions. However, without effective treatment, many people may develop chronic problems over many years. The severity of the initial traumatic response is a reasonable indicator of the need for early intervention, and treatment should not be withheld in such circumstances.

### **Watchful Waiting**

Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by individual sufferers, should be considered by healthcare professionals. A follow-up contact should be arranged within 1 month.

Trauma-focused cognitive behavioural therapy should be offered to older children and young people with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.

Where the event has taken place over 3 months ago trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy or eye movement desensitization and reprocessing should be offered (NICE 2015)



**Treatment for severe post traumatic symptoms or with severe PTSD**

Trauma-focused cognitive behavioural therapy should be offered to older children and young people with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.

Where the event has taken place over 3 months ago trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy or eye movement desensitization and reprocessing should be offered.

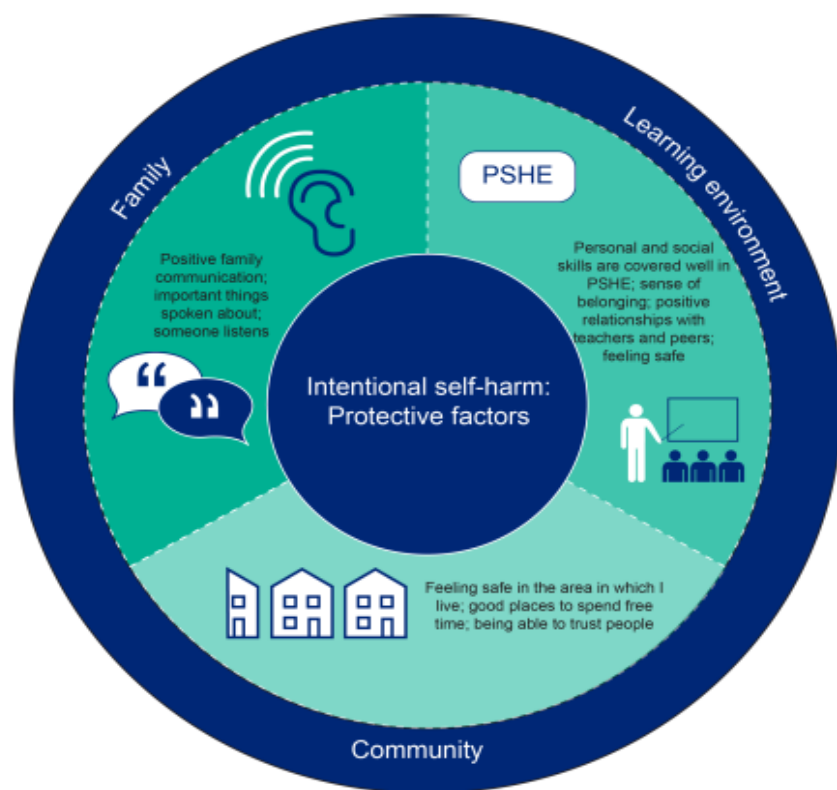
**PTSD where symptoms have been present for more than 3 months after a trauma**

Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused cognitive behavioural therapy adapted appropriately to suit their age, circumstances and level of development.

The duration of trauma-focused psychological treatment for children and young people with chronic PTSD should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are usually necessary (for example, 90 minutes). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person (NICE 2015).

## Self-Harm

Figure 30: Prevalence, Outcomes, Costs and Evidence-based Actions for Self-Harm



### Self-Harm: Secondary Prevention and Treatment

Offer an integrated and comprehensive psychosocial assessment of needs and risks to understand and engage people who self-harm and to initiate a therapeutic relationship in Tier 2 or Tier 3 CAMHS services.

Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition:

The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.

### Harm Reduction

If stopping self-harm is unrealistic in the short term:

- Consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible.

- Consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team.
- Advise the service user that there is no safe way to self-poison (NICE 2004)

### Self-Harm: Crisis Care

- All children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day before discharge or further treatment and care is initiated.
- A paediatrician would normally have oversight of the case.
- A mental health assessment by the CAMHS team should be conducted (NICE 2014).

## Eating Disorders (ED)

### Eating Disorder: Identification and Assessment

Although eating disorders can develop at any age, the risk is highest for young men and women between 13 and 17 years of age.

Do not use screening tools (for example, SCOFF) as the sole method to determine whether or not people have an eating disorder. When assessing for an eating disorder or deciding whether to refer people for assessment, take into account any of the following that apply:

- An unusually low or high BMI or body weight for their age
- Rapid weight loss
- Dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or carers, or professionals
- Family members or carers report a change in eating behaviour
- Social withdrawal, particularly from situations that involve food
- Other mental health problems
- A disproportionate concern about their weight or shape (for example, concerns about weight gain as a side effect of contraceptive medication)
- Problems managing a chronic illness that affects diet, such as diabetes or coeliac disease
- Menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms
- Physical signs of:
  - Malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor
  - Compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise
  - Abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition
  - Unexplained electrolyte imbalance or hypoglycaemia
  - Atypical dental wear (such as erosion)

- whether they take part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling).
- Present with faltering growth (for example, a low weight or height for their age) or delayed puberty.

## **Anorexia Nervosa**

### **Treating Anorexia Nervosa**

- Provide support and care for all people with anorexia nervosa in contact with specialist services, whether or not they are having a specific intervention.
- Include psychoeducation about the disorder.
- Include monitoring of weight, mental and physical health, and any risk factors.
- Be multidisciplinary and coordinated between services.
- Involve the person's family members or carers (as appropriate).

### **Psychological treatment for anorexia nervosa in children and young people**

Consider anorexia-nervosa-focused family therapy for children and young people (FT-AN), delivered as single-family therapy or a combination of single- and multi-family therapy. Give children and young people the option to have some single-family sessions: separately from their family members or carers and together with their family members or carers

If FT-AN is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN)

#### **Psychological treatment for anorexia nervosa in children and young people**

- Consider anorexia-nervosa-focused family therapy for children and young people (FT-AN), delivered as single-family therapy or a combination of single- and multi-family therapy. Give children and young people the option to have some single-family sessions.
- Separately from their family members or carers.
- Together with their family members or carers.
- If FT-AN is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN) (NICE 2017).

## **Binge Eating**

Offer a binge-eating-disorder-focused guided self-help programme to adults with binge eating disorder.

Binge-eating-disorder-focused guided self-help programmes for adults should:

- •use cognitive behavioural self-help materials
- •focus on adherence to the self-help programme

- supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first)
- focus exclusively on helping the person follow the programme.

If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, offer group eating-disorder-focused cognitive behavioural therapy (CBT-ED).

### **Bulimia Nervosa**

Offer bulimia-nervosa-focused family therapy (FT-BN) to children and young people with bulimia nervosa.

If FT-BN is unacceptable, contraindicated or ineffective for children or young people with bulimia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN) (NICE 2017).

### **Tier 4 Eating Disorder**

When deciding whether day patient or inpatient care is most appropriate, the following should be taken into account:

- The person's BMI or weight, and whether these can be safely managed in a day patient service or whether the rate of weight loss (for example more than 1 kg a week) means they need inpatient care.
- Whether inpatient care is needed to actively monitor medical risk parameters such as blood tests, physical observations and ECG (for example bradycardia below 40 beats per minute or a prolonged QT interval) that have values or rates of change in the concern or alert ranges: refer to Box 1 in Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN), or Guidance 1 and 2 in junior MARSIPAN.
- The person's current physical health and whether this is significantly declining.
- Whether the parents or carers of children and young people can support them and keep them from significant harm as a day patient.

Children, young people and adults with an eating disorder who are admitted to day patient or inpatient care should be cared for in age-appropriate facilities (for example, paediatric wards or adolescent mental health services).

These should be near to their home, and have the capacity to provide appropriate educational activities during extended admissions

### **Discharge**

Develop a care plan for each person with an eating disorder who is admitted to inpatient care. The care plan should:

- Give clear objectives and outcomes for the admission.
- Be developed in collaboration with the person, their family members or carers (as appropriate), and the community-based eating disorder service.

- Set out how they will be discharged, how they will move back to community-based care, and what this care should be.

Whether or not the person is medically stable, within 1 month of admission review with them, their parents or carers (as appropriate) and the referring team, whether inpatient care should be continued or stepped down to a less intensive setting (NICE 2017)

## **Bipolar Disorder, Psychosis and Schizophrenia**

### **Bipolar Disorder, Psychosis and Schizophrenia: Secondary Prevention**

Not all children and young people who experience early symptoms will go on to develop bipolar disorder, psychosis or schizophrenia, but it is important to identify those at risk so that appropriate support can be provided.

The long-term outlook for young people with psychosis and schizophrenia is worse when onset is in childhood or adolescence. Early referral to specialist mental health services is very important, so that appropriate interventions can be provided to improve outcomes and long-term outlook (NICE 2016)

NICE indicates that treatment options for symptoms not sufficient for a diagnosis of psychosis or schizophrenia include:

When transient or attenuated psychotic symptoms or other mental state changes associated with distress, impairment or help-seeking behaviour are not sufficient for a diagnosis of psychosis or schizophrenia:

Consider individual cognitive behavioural therapy (CBT) with or without family intervention and offer treatments recommended in NICE guidance for children and young people with any of the anxiety disorders, depression, and emerging personality disorder or substance misuse. [2013]

### **Bipolar Disorder, Psychosis and Schizophrenia: Treatment**

Starting assessment for a first episode of psychosis within 2 weeks can improve outcomes by reducing the duration of untreated psychosis, as longer periods of untreated psychosis are linked to worse outcomes.

Specialist mental health services can improve symptoms and clinical outcomes such as admission and relapse rates (NICE 2015). For children and young people with first episode psychosis offer Oral antipsychotic medication in conjunction with psychological interventions; family intervention with individual CBT, delivered as set out in recommendations (NICE 2013).

Children and young people with a first episode of psychosis and their family members are offered family intervention.

Children and young people newly diagnosed with bipolar depression or a first episode of psychosis are offered a psychological intervention.

For children and young people with an acute exacerbation or recurrence of psychosis or schizophrenia offer oral antipsychotic medication [4] in conjunction with psychological interventions (family intervention with individual CBT) (NICE 2016).

### **Bipolar Disorder, Psychosis and Schizophrenia: Recovery and Monitoring**

Develop and use practice case registers to monitor the physical and mental health of children and young people with psychosis or schizophrenia in primary care [3]. [2013]

GPs and other primary healthcare professionals should monitor the physical health of children and young people with psychosis or schizophrenia at least once a year. They should bear in mind that people with schizophrenia are at higher risk of cardiovascular disease than the general population (NICE, 2013).

Identify children and young people with psychosis or schizophrenia who smoke or who have high blood pressure, raised lipid levels or increased waist measurement at the earliest opportunity and monitor for the emergence of cardiovascular disease and diabetes.

Children and young people with psychosis or schizophrenia who are being treated in an early intervention in psychosis service should have access to that service for up to 3 years (or until their 18th birthday, whichever is longer) whatever the age of onset of psychosis or schizophrenia (NICE, 2016).

### **Substance Misuse and Mental Health Treatment**

For people with an eating disorder who are misusing substances, or over the counter or prescribed medication, provide treatment for the eating disorder unless the substance misuse is interfering with this treatment.

If substance misuse or medication is interfering with treatment, consider a multidisciplinary approach with substance misuse services (NICE, 2017)

### **Role of Schools: Universal Primary Prevention**

There is significant interest and evidence about the role that schools play in supporting children and young people's resilience, building their emotional health, identifying mental health needs and supporting children's recovery. Education is a protective factor for children and young people's emotional and mental health but can also be risky if a child is bullied, excluded or faces unattainable expectations.

Some examples have already been referred to in the sections on Emotional Wellbeing in Primary Schools, Emotional Wellbeing in Secondary Schools and in relation to specific conditions.

There is evidence that promoting emotional and mental health in schools improves educational outcomes and educational attainment (PHE 2014)

Interventions which are evidenced as promoting good mental health include:

Whole school approaches which may also include:

- Curriculum based approaches which enable the development of social and emotional skills i.e. SEAL.
- PHSE and RSE which addresses underlying causes of or antecedents to poor mental health i.e. healthy/ unhealthy relationships.

### **The Role of Schools in Preventing Self-harm**

In seeking to understand whether school settings present an independent risk factor for self-harm and the mechanism which linked the school setting to self-harm, Evans 2016' s systematic review concluded that the following:

- Self-harm is invisible in school settings e.g. as a result of time constraints and this mean that schools resource to talking about it and intervening in it. There is also a fear that speaking about it may result in more self-harming behaviour.
- School culture may impact on self-harm, such that it is seen as bad behaviour, creating a problem for teachers. Self-harm and the emotional distress that underpins it may not respond quickly to improvement, in the way that school cultures demand. This constitutes a barrier to its detection.
- Self-harm strategies may result in the escalation of the issue within the school hierarchy and a tendency to refer on to specialist services. This reluctance to engage may result in self-harm remaining hidden.
- Anxiety and stress associated with performance may lead to self-harm as a means of coping or regaining control. Self-harm may be viewed by staff as a means of manipulation and avoidance of work.
- Bullying and conflictual peer relationships may lead to self-harm (Evans 2016)

### **Role of Schools: Secondary Prevention**

Research indicates that parents are more willing to talk to school staff about problems with their children and wider family than other professionals. This means that they are well placed to provide support and navigate parents and carers to other sources of support (PHE 2014)

School staff is in a position to identify early signs of emotional distress and could access learning to support their identification and facilitate the support i.e. through MHFA and MindEd.

Schools also have a key role to play in the early identification and interventions for children and young people with externalising behaviours like conduct disorder and ADHD. This may including delivering problem solving groups providing parent training onsite delivering the educational components of multi sector care plans for children with ADHD

### **Role of School Settings and other Professionals**

Public Health School Nurses have identified the promotion of resilience and emotional and mental health as a high impact area and ensuring that school staff, parents and carers and



children and young people is able to navigate their way to emotional and mental health services (PHE 2014).

Schools may employ and fund pastoral staff and school counsellors who are able to lead on whole school emotional health work, support individual children and young people and their parents and carers.

### **Further Education Colleges**

The age profile of young people in FE College's mean that these settings need to be included in any emotional health promoting practice and in building competencies in identifying need and supporting young people in treatment and through recovery.

### **Parenting**

Parenting is a key protective factor for the emotional wellbeing (including amongst girls), intentional self-harm (PHE 2017) and parenting education training is key to the prevention and treatment of Conduct Disorder and ADHD.

Parents and carers play an integral part in identifying episodes of ill health, enabling children and young people to access treatment and supporting recovery whilst in treatment and beyond.

## 11. Service Delivery and Utilization in Kent

This section provides an overview of the capacity of services to intervene to improve children and young people's mental health disorders in Kent. Services are categorised into Tiers of provision in line with the definitions provided below and the estimates based on the work of Kurtz 1996. It's important to understand that services may include a wider range of mental health professionals delivering a range of interventions. Appendix 5 provides a summary of the interventions suggested in the NICE guidance referred to in this needs assessment.

This section also provides data on the utilisation of acute services using SUS data. Acute care use is broken down to mental disorders and in each case, dependent on the presentation of the disorder, conclusions are drawn regarding the opportunity to prevent the use through improvements in management.

### **Tiers of intervention and the professionals who deliver at those tiers:**

Tier 1 CAMHS is provided by professionals whose main role and training is not in mental health. These include GPs, health visitors, school nurses, social services, voluntary agencies, teachers, residential social workers and juvenile justice workers.

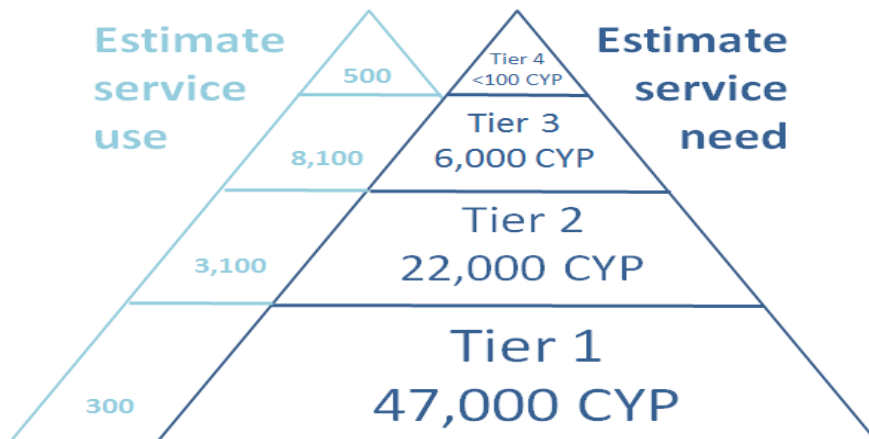
Tier 2 CAMHS is provided by specialist trained mental health professionals. They work primarily on their own but may provide specialist input to multiagency teams. Their role involves helping young people that have not responded to Tier 1 interventions and they usually provide consultation and training to Tier 1 professionals. Roles include clinical child psychologists, pediatricians (especially community), educational psychologists, child psychiatrists and community child psychiatric nurses/ nurse specialists

Tier 3 CAMHS is aimed at young people with more complex mental health problems than those seen at Tier 2. Many of the professionals working at Tier 2 will work in this area, however the service is provided by a multidisciplinary team. Roles include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists and art, music and drama therapists

Tier 4 services are aimed at children and young people with severe and/or complex problems. These specialized services may be offered in residential, day patient or out-patient settings. The service requires a combination or intensity of interventions that cannot be provided by Tier 3 CAMHS. These services include adolescent in-patient units, secure forensic adolescent units, eating disorder units, specialist teams for sexual abuse and specialist teams for neuro-psychiatric problems. (York et al, 2006, Kurtz, 1996)

### **Service Capacity in Kent**

**Figure 31: Estimated Service Need and Use at Each of the Tiers of intervention based on Kurtz 1996).**



**NHS England target for 2017/18: 8,763\***

\*not across all tiers

The numbers of children and young people who are estimated to have a need at each tier of the emotional wellbeing and mental health system are based on estimates produced by Kurtz et al (1998). Estimated service use figures are taken from performance data, Secondary Uses Service (SUS) and provider targets across Kent and are to be used as estimates only. KCC Early Help see an annual number of 2xxx families each year and many receive interventions for emotional and behavioural needs.

There is a lack of Tier 2 capacity in Kent. Delivery will increase with the increase with new procurement including embedded mental health workers in Early Help and School Public Health Services increased focus on Universal.

## Children in Care

**Table 7:**

**Table** Number of referrals of Kent children in care to the CAMHS for looked after children (Sussex Partnership NHS Foundation Trust) by age and gender (Apr 2014 to Mar 2015)

Age (years)	Number of referrals (%)
0-3	5 (1)
4-10	145 (29.9)
11-15	214 (44.1)
16-18	120 (24.7)
18+	1 (0.2)
<b>Gender</b>	
Male	258 (53.2)
Female	227 (46.8)
Not recorded	15 (8)
<p>The most common emotional/mental health issues managed by the service:</p> <ul style="list-style-type: none"> <li>- Attachment disorders</li> <li>- Trauma from early childhood</li> <li>- Self harm</li> <li>- Depression</li> <li>- Separation anxiety</li> <li>- Post traumatic stress disorder</li> <li>- Drug and alcohol misuse</li> <li>- Placement breakdown</li> <li>- School absconding</li> </ul>	

Ninety per cent of referrals to CAMHS were initiated by social workers. The average waiting time is five weeks. 173 (65%) of appointments attended are face to face.

The annual SDQ provides a systematic means of assessing symptoms, although with limitations. This should be supplemented through integrated working between schools, CIC nurses, and specialist CAMHS, SCS and foster carers.

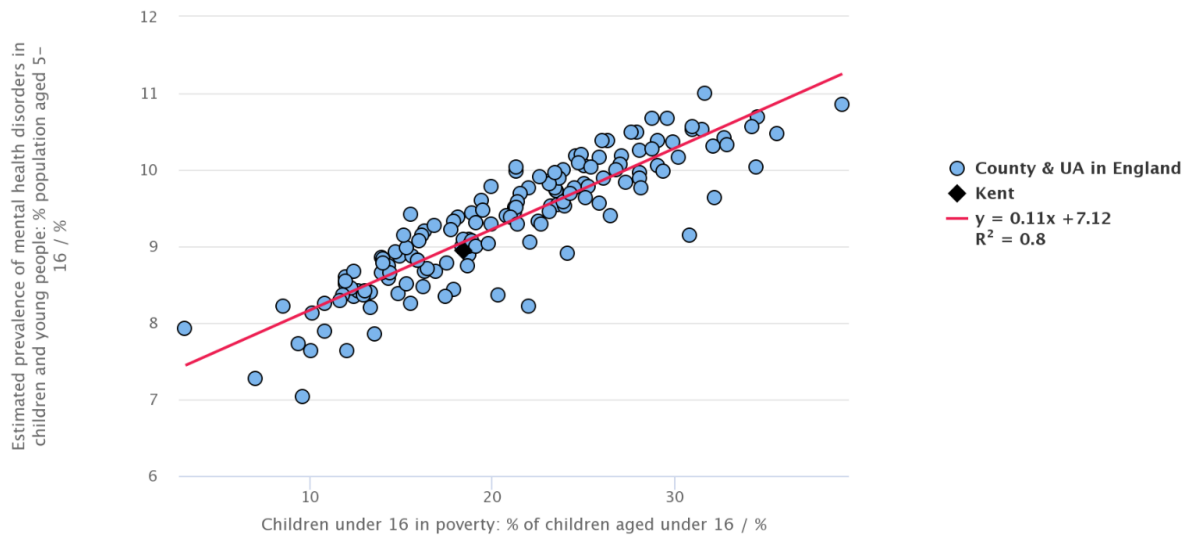
Although SDQ scores for children in care in Kent are currently in line with the England benchmark, there is evidence that a pathway is not currently in place for those children and young people whose score indicates a clinical need and who may benefit from services.

There is an absence of systematic identification of emotional and mental health needs amongst Children in Need, who are at greater risk of adversity.

### **Current Service Delivery and Health Inequalities**

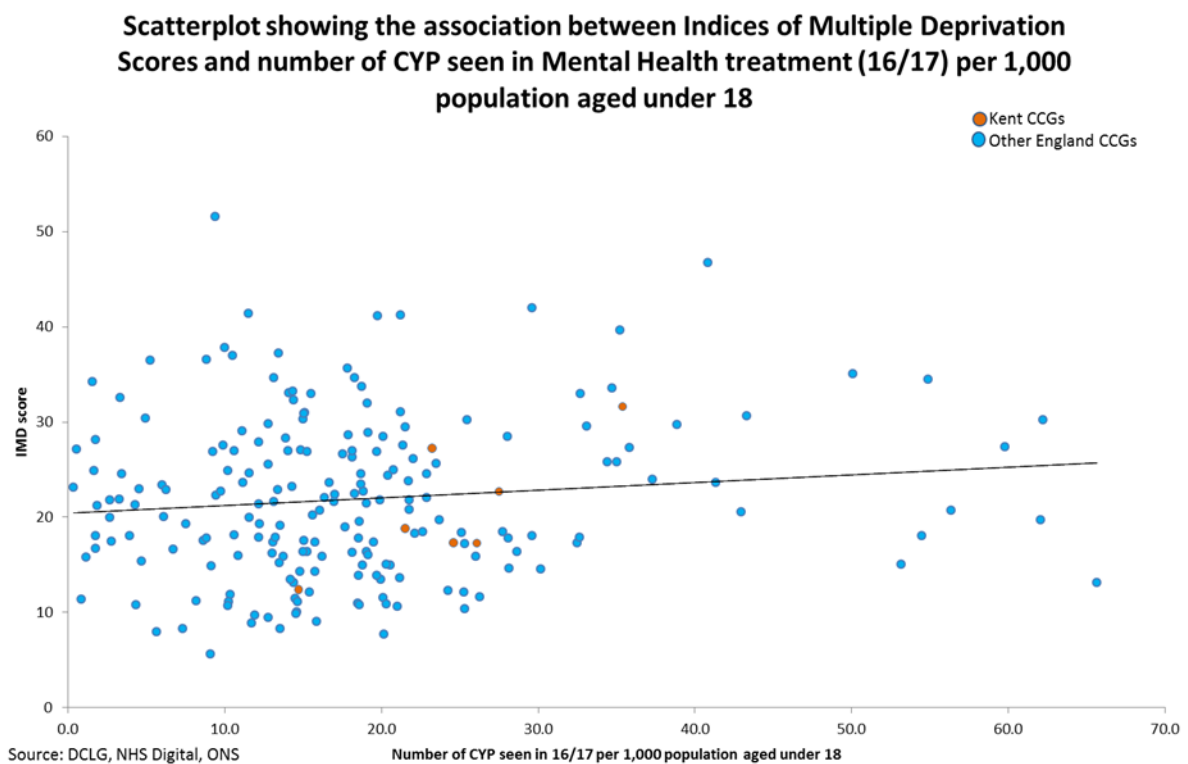
There is an association between poverty and deprivation and mental health disorders in children and young people such that children and young people from poorer communities are three times as likely to develop mental health problems than their peers (Green 2015). It would therefore likely that children and young people from the most deprived communities should be in receipt of and benefit from treatment.

**Figure 32: Scatterplot of Estimated Prevalence of Mental Health Disorder 5-16 against the Rate of Under 16's in Poverty for each County and Unitary Authority in UK**



The figure shows that there is a strong correlation ( $r=0.8$ ) between prevalence of mental health disorders and Under 16's in poverty at County and Unitary Authority level in Kent.

**Figure 33: Scatterplot of the association between indices of Multiple Deprivation Scores and number of CYP seen in Mental Health treatment (16/17) per 1000 population**



There is no correlation between IMD score and the number of CYP accessing treatment ( $r=0.12$ ).

The figure suggests that children and young people who are more deprived do not take up mental health treatment. There is work to do to increase uptake of services from children and young people who are more deprived.

### **Youth Justice Mental Health Workers**

National best practice indicates that there is a specific role for specialist mental health services:

*'Health provision does not have to be based full time in YOTs but appears to work best when there is a regular and systematic presence of health and mental health workers in these settings. Regular attendance allows YOT health practitioners access to consultation and advice and facilitates confident management of cases'* (Centre for Mental Health, 2010).

A review of the role of specialist mental health workers in Kent's Youth Offending Units has identified the need to standardize the role of CAMHS YOS workers to include the proactive identification, relationship building, assessment and referrals, building understanding of the population and their mental health needs in both mental health services and youth offending services, delivering training, working with families and contributing to pre-sentence reports and referral orders. This work needs to be undertaken within the context of a clear specification and shared management structure.

### **Children with child protection plans, children in need, children in care and their access to specialist treatment services**

Specialist mental health services for children in care had been provided for within a separate contract and service in Kent. This has now been subsumed within the contract for specialist services in operating in Kent from September 2017.

There is a clear mechanism for the systematic identification of need amongst children in care through the use of SDQs in annual and review health assessments. In Kent there has been a concern that a change in personnel has meant that the identification of children who meet a level which would indicate concern (scoring over 17) are not having additional STQ assessment by carers and are not being referred into services.

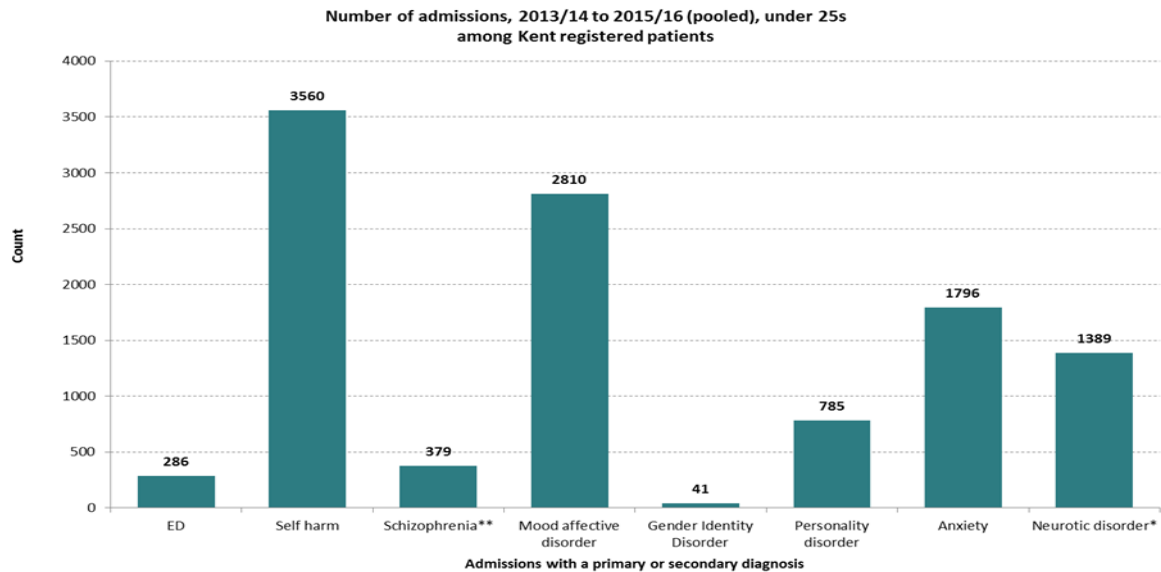
### **Acute Care Utilisation in Kent**

All hospital activity is provided by registered and resident population. This was defined as activity for individuals registered to a Kent general practice or activity for individuals residing in a Kent lower super output area (LSOA, geographical unit containing approximately 1500 household).

Hospital activity is analysed for either under 18s, 18 to 24-year olds or under 25s depending on the sufficient number of admissions to produce reliable trends. Data have also been pooled for three years in order to produce more reliable trends. All admissions were relating to the first consultant episode.

Hospital admissions data is available from the SUS from 2006/07 onwards, and reliably from 2009/10 onwards for A&E attendances. Changes to the figures over time need to be interpreted in the context of improvements in data quality and coverage (particularly in earlier years), improvements in coverage of independent sector activity (particularly from 2006-07) and changes in NHS practice. For example, apparent increases in activity may be due to improved recording of diagnosis or procedure information.

**Figure 34: Number of Admissions for Mental Health Conditions 2013/2014 pooled , under 25s amongst the Kent**



Source: SUS, prepared by ES, July 17  
 \*Neurotic, stress-related and somatoform disorders  
 \*\* Schizophrenia, schizotypal and delusional disorders  
 N.B. some individuals may be admitted for one of more of the above conditions, in the same hospital episode

For mental illness related conditions, self-harm accounted for 3560 admissions, while gender identity disorder accounted for just 41 admissions among under 25s between 2013/14 and 2015/16. Individuals can be diagnosed with multiple conditions during one admission, and so people may be double counted in the figure above. Likewise, anxiety admissions are partially identified using a subset of mood affective disorder ICD-10 codes.

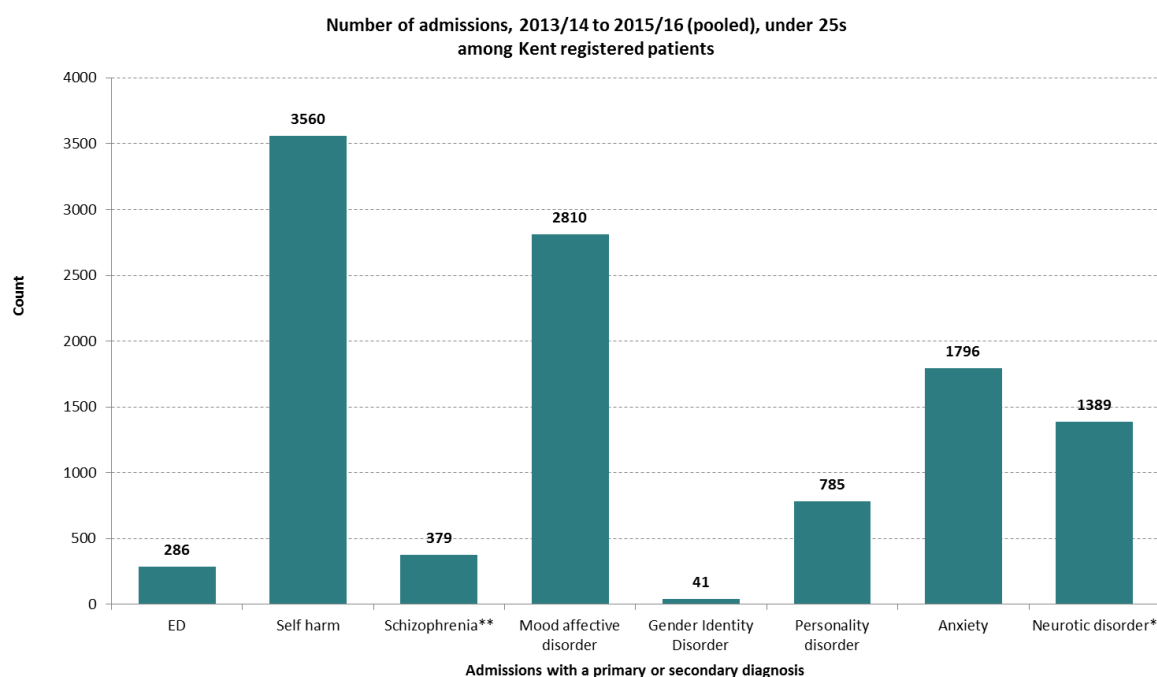
In total there were 219,258 admissions for Kent registered patients aged under 25 between 2013/14 and 2015/16.

### Acute Care Utilisation and System Assurance Metrics

Acute care presentation and attendance rates over time provides an indication of need across the health system and of the success or not of the treatment and management of conditions in the community over time.

Figure 35 below shows the number of admissions for those aged under 25 in Kent for 13/14-15/1 and illustrates the relative contribution of each disorder to overall admissions.

**Figure 35: Number of admissions for those aged under 25 in Kent**



Source: SUS, prepared by ES, July 17

\*Neurotic, stress-related and somatoform disorders

\*\* Schizophrenia, schizotypal and delusional disorders

N.B. some individuals may be admitted for one of more of the above conditions, in the same hospital episode

For mental illness related conditions, self-harm accounted for 3560 admissions, while gender identity disorder accounted for just 41 admissions among under 25s between 2013/14 and 2015/16. Individuals can be diagnosed with multiple conditions during one admission, and so people may be double counted in the figure above. Likewise, anxiety admissions are partially identified using a subset of mood affective disorder ICD-10 codes.

In total there were 219,258 admissions for Kent registered patients aged under 25 between 2013/14 and 2015/16.

**Appendix 4** provides presentation and admission data for the main mental health disorders and commentary which highlights the variation in admissions at CCG level.

## Findings Recommendations Eating Disorders

### Recommendations from the HNA Eating Disorders (2014)

- 1 Increase awareness amongst the population.** It is likely that some of those affected by ED are reluctant to acknowledge their problem; some may acknowledge it but are reluctant to seek treatment. To address this there needs to be efforts to increase awareness of ED, reduce associated stigma, and increase awareness of services available.
- 2 Early Identification and intervention.** The burden of illness secondary to ED is likely to be far greater than that is presently recognized by medical services. Although there is a lack of data to investigate the present care provided by primary health services, it is likely it is insufficient, considering the expected burden of disease.



- 3 Improve identification and early intervention in Primary Care.** It is recommended that there needs to be an improvement in identifying cases in the general population in the primary care setting to not just detect cases earlier during their illness, but importantly to offer treatment earlier. Guidelines from NICE and the Department of Health also highlights the importance of services at the primary care level in tackling the burden of disease attributed to ED (DoH, 1999). This will mean that measures will need to be put in place to support primary care to do this work. Importantly, if increased screening is introduced at the primary care level, there needs to be also increased capacity at the secondary care level, or possibly increased capacity at the primary care level to manage milder forms of the illness.

Increased case detection would result in increased caseload for the service.

Monitoring the service caseload and waiting times would provide early indication for the need to expand services. Commissioners will need to agree how meeting this potential increase in unmet need will be managed.

- 4 Model of Care:** These conditions are chronic and often associated with a relapsing and remitting course that may necessitates continuing support after discharge from specialist units. The aim is to provide a structured and consistent approach to help local health and social care partners shape the way they deliver integrated long term care locally. In achieving this much of the recommendations relate to services at the primary care level at detecting new clients, and following up those recovered to minimize relapses. In commissioning services, the aim is to match the level of care to the level of need. Focusing on the levels of care allows us to consider what improvements can be made at these levels, and goals that we hope to achieve in return. Following NICE (2004) guidance for service improvements will also be an important step in developing a service model ( Mookherjee 2014 [http://www.kpho.org.uk/\\_data/assets/pdf\\_file/0020/44633/Eating-Disorders-Needs-Assessment.pdf](http://www.kpho.org.uk/_data/assets/pdf_file/0020/44633/Eating-Disorders-Needs-Assessment.pdf) )

## **12. Stakeholder Views on Key Improvements to the Emotional and Mental Health System**

The comments below summarise interviews that were held with key stakeholders across the children and young people's mental health system of care. They are grouped into issues.

### **Stakeholder Views: The Mental and Emotional Health System**

- There is a focus is on Tier 3 CAMHS but mental health is everybody's business.
- Specialist Tier 3 services are stigmatised.
- There is recognition that specialist CAMHS are experiencing significant pressures reflected in waiting times across the system.
- Tier 2 providers are seeing increases in the level of need and risk amongst the children and young people they are working with. They are aware that they are receiving referrals for children and young people who are waiting for CAMHS assessments, are on waiting lists as well as those who do not meet the threshold.
- There is an inferred belief that the threshold for CAMHS varies according to capacity.
- There is a need to clarification of the threshold for each service.
- Mind and Body have proactively identified CYP with suicidal thoughts (and who have made attempts) but not disclosed which demonstrates the opportunities presented by using screening tools for early intervention.
- There is not enough capacity in the system of care.
- There is a need to clarification the pathway of care for children and young people.
- Year 6 and 8 transition is a big risk for onset of poor emotional health.
- Mind and Body identified early intervention needs in primary school.
- PSHE plays an important role but tools need to be standardized.
- There is a lack of outcomes data for CIC and generic CAMHS.

### **Commissioning, Collaboration and Partnership**

- There is a need to bring together providers in the voluntary and community sector (who are not currently commissioned by the CCG and KCC) with those providers who are, to build the capacity and capability to meet the needs of children and young people, maximising resources and coordinating action to develop a strategic approach.
- Commissioning and procurement has not been accessible to smaller providers and has not been successful at including schools any budgets they have it to contribute.
- There is a need to include the voice of smaller providers of emotional health services in Kent.
- There is a need to ensure that the voices of children and young people are heard and drive transformation.

## Schools

- The structure of pastoral and non-teaching staff varies across school communities. There is variation across school communities in the interest, commitment and resources they commit to the emotional health and resilience for children and young people.
- Schools budgets are being cut (per head) and this risks withdrawing funding for and investment in emotional health provision and pastoral and behavioural support staff i.e. school counselling which contributes to the wider system of emotional and mental health support. There is no means of monitoring these changes in Kent.
- School staff does not always have the confidence and competences (although this varies) in engaging children and young people around their emotional health in secondary school settings. This is a result of the culture in schools and the time constraints on school staff, logistics of having a confidential conversation, accountability for any disclosure a child may make, the structure of school teams which result in issues being escalated to pastoral staff rather than conversations being initiated by teaching staff.
- The culture in schools result in school staff underestimating the time it take for a children and young person's emotional and mental health to improve.
- The lack of confidence and skills at a school level means that schools are reacting to mental health needs and referring to targeted and additional services, who in turn do not feel able to make suggestions to school staff regarding lower level interventions. There is a lack of communication between specialist treatment services and schools which result in anxiety around the lack of assessment, engagement and treatment for young people.
- Schools want to be included in children and young people's exit / recovery plans.
- Schools have highly development systems of monitoring and any changes to them present a significant barrier.
- Schools are not systematically informed when children and young people are exposed to adversities and are very dependent on parents and carers and social workers informing them. An initial impact of the implementation by KHS of the identification of young people exposed to familial domestic abuse and communication to schools is identifying young people who the school are not aware of.
- Schools will use CVS providers of counselling and emotional support who they have existing relationships with and when they know they have capacity.
- Schools are reporting increasing levels of anxiety (including in response to terrorist incidents) and greater complexity of need amongst their populations.
- There is a question whether the universal resilience approaches are able to work effectively with externalising mental health conditions including ADHD.

- Special schools report that referrals to specialist treatment services are being turned down despite therapists reporting that the child does meet the clinical threshold for services. A more collaborative model of joint working with specialist staff in Special Schools and units within mainstream schools needs to be considered.

### **Engagement in Emotional and Mental Health Services**

- Positive engagement of children and young people in emotional and mental health services are critical to the success of the delivery of the treatment pathway. This is particularly important for those more vulnerable children and young people who may exhibit attachment issues/disorders and those with complex risk-taking behaviours.
- Attention needs to ensure that the NICE attachment guidelines are considered across the emotional and mental health system and proactive engagement is pursued.

### **Systematic Identification of Need**

- There are opportunities which are not being utilised to identify emotional and mental health needs at the point of entering care / initial health assessment (paediatricians are not trained to do it / absence of a validated tool), when children are CHIN and when children are adopted (NS- SDQ only undertaken for children in care for last 12 months).
- Mind and Body have successfully identified young people who have not otherwise disclosed their emotional health needs including self-harm and suicide attempts/ ideation.
- Opportunity to identify health needs through the CMF and Year 6, 10 self-report health assessments.
- Are there too many assessments in place?
- OLA needs may have been assessed in their initial and review health assessments but these are not being systematically shared with Kent services.
- Systematic identification of children and young people at risk of developing or showing early symptoms of CD/ODD.
- Lack of recognition of complexity and the impact on presenting mental health symptoms which is resulting in those children and young people with greatest risk and vulnerability not getting a service

### **Pathway Issues**

- Annual SDQs for CIC over the age of 5 who are in care for over 12 months is a key opportunity to identify children and young people who are above the clinical threshold, whose score could be validated by the school and who would benefit from a mental health intervention. This opportunity is not consistently being utilised for early identification.

- A central point of referral and collaboration across the system of mental health care is likely to result in children and young people being able to access care in a timely way
- The ADHD pathway includes (parenting skills and behavior management) education offer, specialist teaching and learning service / special school outreach / Education Psychology and Early Help Parenting offer (parent training) (to which CAMHS will contribute)
- The age that pediatricians will diagnose behavioral disorders varies across Kent.
- There is a lack of clarity of a pathway for young people who are questioning their gender identity.
- There have been cases where clinicians have recommended interventions which are not available in Kent – i.e. Tier 4

#### **ASD**

- There is a gap in ASD support for parents of primary aged children

#### **18-25 Transition**

- Transition is critical and risky for CYP who have been CIC and for whom, for health the statutory responsibility ends at 18, whereas for LA, it continues until young people are 21 or 25
- Transition is critical for CYP with ADHD

#### **Quality Issues**

- There is little understanding of the outcomes of mental health interventions to give assurance / no understanding of diversity of provision/ interventions for CIC
- A single outcomes framework across the mental health system but which includes brief interventions (for which SDQ may not be suitable) would enable benchmarking
- Family support workers (new role to support EHC planning) may benefit from training around emotional and mental health / MHFA
- Attention needs to ensuring that the NICE Attachment guidelines and standards are delivered across the system of mental health care

#### **Care Coordination**

- Opportunities to systemically share EHC/ CIC Health Plans and Emotional and Mental Health Treatment Plans are not being undertaken which may be resulting in a lack of care coordination, children and young people engaging in CAMHS

## | 13. Informatics

There is:

- Lack of comorbidity data
- No system of collecting and collating the CIC profile for children and young people. A database has been built but not implemented at the moment. It will take a year before it will produce data and track children
- Lack of systematic reporting across the system of ADHD ie.in school census and by social care
- Lack of linking of children and adult data to understand the outcomes for young people in transition particularly with ADHD, who are CIC,
- 
- EHC plans provide the opportunity to understand comorbidity and access to and success of CAMHS services
- The CHIN population, which are the most vulnerable, are not visible in the mental health system
- Learning Disability CAMHS is a separate modality within the generic CAMHS service and should identify within the new CAMHS performance monitoring.

## | Appendix 1

Provides additional detail on the methodology, definitions and measures and some of the key limitations of the health needs assessment.

- The health needs assessment includes evidence from policy, NICE guidelines, routine administrative health and social care data, and from published research identified through literature reviews. The evidence provided is not exhaustive and where possible focusses on systematic and evidence reviews.
- Stakeholder interviews have been undertaken where data has indicated a line of additional enquiry.
- Discussions may also identify more detailed key lines of additional detailed investigation.

## Appendix 2

Survey / Source of prevalence data	What it measures?	Frequency
Egger HL (2006) 'Mental health of children and young people in Great Britain,	Models prevalence based on a literature review of 4 studies of mental health conditions in 2-5 year olds	One off
What about YOU?	National survey of 15 year olds which asks about general health, diet, alcohol and drug use, experiences of bullying, feelings and satisfaction with life,	??
Green H et al (2004)	Modelled prevalence estimates for children aged 5 to 16 years based on the ICD-10 Classification of Mental and Behavioral Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life. Estimates are broken down to conditions.	One off
Singleton et al (2001)	A study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 inclusive living in private households.	One off
Kurtz, Z. (1996).	Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been provided by Kurtz (1996). A description of the services offered at each tier can be found in the notes section below.	One off
Emmerson (2004)	Emmerson et al (2004) calculated prevalence in children and young people with learning disabilities for different age groups as follows: 5 to 9 years	One off
Meltzer, H. et al (1999)	Meltzer H et al (1999) calculated modelled prevalence estimates for children aged 5 to 15 years based on the DAWBA which uses ICD-10 Classification and DSM-IV diagnostic research criteria.	One off
Adult Psychiatric Morbidity Survey (2007, 2014)	Prevalence rates for young people aged 16 and over are from the ONS survey of adult psychiatric morbidity survey (APMS) of 2014. This survey uses different assessment methods and categories to the surveys of under-16s so making direct comparisons with the data available for younger age groups is not advisable.	Every 7 years
Health Behaviour in School Aged Children Survey ( HBSC)	HBSC is a cross national research study of young people aged 11, 13 and 15 conducted with the WHO Regional Office for Europe.	4 years



## Appendix 3

### Any Mental Health Disorder

**Table 1 Current and Estimated number of children aged 2-5 with any Mental Health Disorder 2017-2021 in Kent and in each CCG**

CCG	Current	Projected				
	2016	2017	2018	2019	2020	2021
NHS Ashford CCG	1260	1317	1336	1354	1373	1392
NHS Canterbury And Coastal CCG	1631	1683	1695	1708	1720	1732
NHS Dartford, Gravesham And Swanley CCG	2785	2924	3003	3082	3160	3239
NHS South Kent Coast CCG	1774	1876	1908	1941	1973	2006
NHS Swale CCG	1160	1216	1245	1274	1303	1332
NHS Thanet CCG	1339	1431	1462	1493	1525	1556
NHS West Kent CCG	4703	4901	4984	5066	5149	5231
Kent	14651	15348	15633	15918	16203	16488

Source: Egger et al., 2006, PCIS (December 2016 and registered population projected forward based on 2006 to 2016 data)  
Prevalence based on literature review of four studies estimated to be 19.5%

**Table 2: Current and Estimated number of children aged 2-5 with any Mental Health Disorder 2017-2021 in Kent and in each District**

District	Current	Projected				
	2015	2017	2018	2019	2020	2021
Ashford	1271	1274	1265	1264	1286	1301
Canterbury	1255	1223	1211	1234	1240	1243
Dartford	1179	1177	1173	1177	1189	1207
Dover	984	957	941	932	939	944
Gravesham	1147	1158	1142	1149	1151	1169
Maidstone	1640	1602	1602	1604	1625	1647
Sevenoaks	1203	1197	1190	1199	1215	1228
Shepway	948	918	910	910	910	915
Swale	1469	1448	1437	1435	1445	1460
Thanet	1349	1325	1307	1307	1320	1334
Tonbridge and Malling	1244	1221	1222	1226	1240	1260
Tunbridge Wells	1123	1087	1073	1078	1088	1093
Kent	14811	14589	14474	14515	14648	14802

Source: Egger et al., 2006, ONS (mid year 2015 estimates and projected population from 2014)  
Prevalence based on literature review of four studies estimated to be 19.5%

## Conduct Disorders

**Table 3 Estimated number of children aged 5-16 with Conduct Disorders 2017-2021 in Kent and in each CCG**

CCG	Conduct disorders (5 - 16)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	1044	1051	1058	1065	1072
NHS Canterbury And Coastal CCG	1443	1442	1442	1442	1442
NHS Dartford, Gravesham And Swanley CCG	2161	2185	2208	2232	2256
NHS South Kent Coast CCG	1549	1545	1541	1537	1533
NHS Swale CCG	984	989	994	999	1005
NHS Thanet CCG	1222	1224	1227	1229	1231
NHS West Kent CCG	3482	3511	3540	3569	3598
Kent	11882	11947	12012	12077	12142

Source: PHE, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 4 Estimated number of children aged 5-16 with Conduct Disorders 2017-2021 in Kent and in each District**

District	Conduct disorders (5 - 16)				
	2017	2018	2019	2020	2021
Ashford	1053	1066	1075	1086	1097
Canterbury	1074	1084	1098	1109	1122
Dartford	878	900	922	939	956
Dover	892	901	906	911	917
Gravesham	973	990	1011	1029	1047
Maidstone	1252	1273	1295	1315	1332
Sevenoaks	822	833	846	861	873
Shepway	818	822	829	836	842
Swale	1285	1308	1332	1356	1375
Thanet	1236	1257	1276	1296	1312
Tonbridge and Malling	996	1011	1023	1033	1042
Tunbridge Wells	854	858	865	871	875
Kent	12116	12285	12460	12620	12768

Source: PHE, ONS (resident population projected from 2014)

## Hyperkinetic Disorders

**Table 5 Estimated number of children aged 5-16 with Hyperkinetic Disorders 2017-2021 in Kent and in each CCG**

CCG	Hyperkinetic disorders (5 - 16)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	283	285	287	289	291
NHS Canterbury And Coastal CCG	392	392	392	392	392
NHS Dartford, Gravesham And Swanley CCG	601	608	615	621	628
NHS South Kent Coast CCG	416	415	414	412	411
NHS Swale CCG	271	272	273	275	276
NHS Thanet CCG	331	332	333	333	334
NHS West Kent CCG	966	974	982	990	998
Kent	3255	3273	3290	3308	3326

Source: PHE, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 6 Estimated number of children aged 5-16 with Hyperkinetic Disorders 2017-2021 in Kent and in each District**

District	Hyperkinetic disorders (5 - 16)				
	2017	2018	2019	2020	2021
Ashford	285	289	291	294	297
Canterbury	291	294	298	301	305
Dartford	245	251	257	261	266
Dover	237	239	241	242	244
Gravesham	267	271	277	282	287
Maidstone	347	352	359	364	369
Sevenoaks	231	234	238	242	245
Shepway	222	223	225	226	228
Swale	351	357	363	370	375
Thanet	333	338	344	349	353
Tonbridge and Malling	277	281	284	287	289
Tunbridge Wells	234	235	237	239	240
Kent	3319	3365	3413	3457	3497

Source: PHE, ONS (resident population projected from 2014)

## ADHD

**Table 7 Estimated number of young people aged 16-25 self-reporting 4 or more symptoms of ADHD 2017-2021 in Kent and in each CCG**

CCG	ADHD (4 or more, 16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	2049	2066	2083	2101	2118
NHS Canterbury And Coastal CCG	5759	5850	5941	6031	6122
NHS Dartford, Gravesham And Swanley CCG	3999	4016	4032	4049	4065
NHS South Kent Coast CCG	3010	3016	3021	3027	3032
NHS Swale CCG	1765	1771	1777	1782	1788
NHS Thanet CCG	2215	2218	2221	2223	2226
NHS West Kent CCG	6816	6854	6891	6929	6966
Kent	25614	25790	25966	26142	26317

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 8 Estimated number of young people aged 16-25 self-reporting 6 or more symptoms of ADHD 2017-2021 in Kent and in each CCG**

CCG	ADHD (all 6, 16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	267	269	271	274	276
NHS Canterbury And Coastal CCG	750	762	774	786	798
NHS Dartford, Gravesham And Swanley CCG	521	523	525	527	530
NHS South Kent Coast CCG	392	393	394	394	395
NHS Swale CCG	230	231	231	232	233
NHS Thanet CCG	289	289	289	290	290
NHS West Kent CCG	888	893	898	903	908
Kent	3337	3360	3383	3406	3429

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

## Emotional Disorder

**Table 9 Estimated number of children aged 5-16 with Emotional Disorders 2017-2021 in Kent and in each CCG**

CCG	Emotional disorders (5 - 16)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	678	683	687	692	696
NHS Canterbury And Coastal CCG	942	942	941	941	941
NHS Dartford, Gravesham And Swanley CCG	1357	1372	1387	1402	1417
NHS South Kent Coast CCG	986	984	981	979	976
NHS Swale CCG	616	619	622	625	629
NHS Thanet CCG	763	765	766	767	769
NHS West Kent CCG	2330	2349	2369	2388	2407
Kent	7681	7723	7765	7807	7849

Source: PHE, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 10 Estimated number of children aged 5-16 with Emotional Disorders 2017-2021 in Kent and in each District**

District	Emotional disorders (5 - 16)				
	2017	2018	2019	2020	2021
Ashford	689	697	703	710	718
Canterbury	703	710	719	726	735
Dartford	556	570	584	594	605
Dover	579	585	588	591	595
Gravesham	613	624	638	649	660
Maidstone	817	830	845	858	869
Sevenoaks	559	567	576	586	594
Shepway	524	526	531	535	539
Swale	816	830	845	861	872
Thanet	780	793	805	818	828
Tonbridge and Malling	665	675	683	690	695
Tunbridge Wells	591	593	598	602	605
Kent	7832	7941	8055	8158	8254

Source: PHE, ONS (resident population projected from 2014)

## Mental Health Disorders

**Table 11 Estimated number of children aged 5-16 with Mental Health Disorders 2017-2021 in Kent and in each CCG**

CCG	Mental Health disorders (5 - 16)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	1742	1754	1765	1777	1788
NHS Canterbury And Coastal CCG	2414	2413	2413	2412	2412
NHS Dartford, Gravesham And Swanley CCG	3561	3600	3639	3678	3717
NHS South Kent Coast CCG	2543	2537	2530	2524	2517
NHS Swale CCG	1604	1612	1621	1629	1637
NHS Thanet CCG	1982	1986	1989	1993	1996
NHS West Kent CCG	5940	5989	6038	6087	6136
Kent	19787	19895	20003	20111	20219

Source: PHE, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 12 Estimated number of children aged 5-16 with Mental Health Disorders 2017-2021 in Kent and in each District**

District	Mental Health disorders (5 - 16)				
	2017	2018	2019	2020	2021
Ashford	1760	1782	1797	1815	1833
Canterbury	1795	1813	1835	1854	1877
Dartford	1455	1491	1528	1555	1584
Dover	1472	1488	1496	1504	1515
Gravesham	1593	1621	1656	1685	1714
Maidstone	2102	2136	2175	2207	2236
Sevenoaks	1417	1437	1460	1485	1506
Shepway	1349	1355	1366	1378	1387
Swale	2107	2144	2183	2223	2253
Thanet	2009	2043	2075	2107	2133
Tonbridge and Malling	1694	1720	1740	1758	1773
Tunbridge Wells	1475	1482	1495	1504	1512
Kent	20177	20458	20749	21017	21262

Source: PHE, ONS (resident population projected from 2014)

## Bi-Polar Disorder

**Table 13 Estimated number of young people aged 16-24 with (self-reported symptoms of) Bi Polar 2017-2021 in Kent and in each CCG**

CCG	Bipolar (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	480	484	488	492	496
NHS Canterbury And Coastal CCG	1348	1369	1390	1412	1433
NHS Dartford, Gravesham And Swanley CCG	936	940	944	947	951
NHS South Kent Coast CCG	704	706	707	708	710
NHS Swale CCG	413	414	416	417	418
NHS Thanet CCG	518	519	520	520	521
NHS West Kent CCG	1595	1604	1613	1621	1630
Kent	5994	6036	6077	6118	6159

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 14 Estimated number of young people aged 16-24 with (self-reported symptoms of) Bi Polar 2017-2021 in Kent and in each District**

District	Bipolar (16-24)				
	2017	2018	2019	2020	2021
Ashford	426	421	419	418	416
Canterbury	1029	1027	1019	1010	1001
Dartford	350	345	342	341	341
Dover	373	364	356	350	345
Gravesham	388	383	376	372	373
Maidstone	552	543	535	534	534
Sevenoaks	344	335	325	322	324
Shepway	356	348	338	333	329
Swale	502	491	483	479	477
Thanet	504	494	485	482	479
Tonbridge and Malling	417	411	402	400	402
Tunbridge Wells	344	333	324	320	321
Kent	5586	5496	5405	5362	5344

Source: APMS, ONS (resident population projected from 2014)

### Generalised Anxiety (GAD)

**Table 15 Estimated number of young people aged 16-24 with (self-reported symptoms of) Generalized Anxiety Disorder (GAD) 2017-2021 in Kent and in each CCG**

CCG	GAD (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	882	889	897	904	912
NHS Canterbury And Coastal CCG	2479	2518	2557	2596	2635
NHS Dartford, Gravesham And Swanley CCG	1722	1729	1736	1743	1750
NHS South Kent Coast CCG	1296	1298	1300	1303	1305
NHS Swale CCG	760	762	765	767	770
NHS Thanet CCG	954	955	956	957	958
NHS West Kent CCG	2934	2950	2966	2982	2999
Kent	11026	11101	11177	11253	11328

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 16 Estimated number of young people aged 16-24 with (self-reported symptoms of) Generalized Anxiety Disorder (GAD) 2017-2021 in Kent and in each District**

District	GAD (16-24)				
	2017	2018	2019	2020	2021
Ashford	783	774	770	768	766
Canterbury	1893	1888	1875	1858	1842
Dartford	644	635	629	627	628
Dover	686	670	654	643	635
Gravesham	714	705	692	684	687
Maidstone	1015	1000	984	983	983
Sevenoaks	633	616	598	592	596
Shepway	654	640	622	613	604
Swale	923	904	889	882	878
Thanet	927	908	892	887	881
Tonbridge and Malling	768	756	740	737	739
Tunbridge Wells	633	613	596	589	591
Grand Total	10274	10109	9941	9862	9830

Source: APMS, ONS (resident population projected from 2014)

## Depression

**Table 17 Estimated number of young people aged 16-24 with (self-reported symptoms of) Depression 2017-2021 in Kent and in each CCG**

CCG	Depressive (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	322	325	327	330	333
NHS Canterbury And Coastal CCG	905	919	934	948	962
NHS Dartford, Gravesham And Swanley CCG	628	631	634	636	639
NHS South Kent Coast CCG	473	474	475	476	477
NHS Swale CCG	277	278	279	280	281
NHS Thanet CCG	348	349	349	349	350
NHS West Kent CCG	1071	1077	1083	1089	1095
Kent	4025	4053	4080	4108	4136

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)



**Table 18 Estimated number of young people aged 16-24 with (self-reported symptoms of) Depression 2017-2021 in Kent and in each District**

District	Depressive episodes (16-24)				
	2017	2018	2019	2020	2021
Ashford	286	283	281	280	280
Canterbury	691	689	684	678	672
Dartford	235	232	230	229	229
Dover	250	245	239	235	232
Gravesham	261	257	253	250	251
Maidstone	371	365	359	359	359
Sevenoaks	231	225	218	216	218
Shepway	239	234	227	224	221
Swale	337	330	325	322	321
Thanet	338	331	326	324	322
Tonbridge and Malling	280	276	270	269	270
Tunbridge Wells	231	224	218	215	216
Grand Total	3751	3691	3629	3601	3589

Source: APMS, ONS (resident population projected from 2014)

## Phobias

**Table 19 Estimated number of young people aged 16-24 with (self-reported symptoms of) Phobias 2017-2021 in Kent and in each CCG**

CCG	Phobias (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	462	466	470	474	477
NHS Canterbury And Coastal CCG	1299	1319	1339	1360	1380
NHS Dartford, Gravesham And Swanley CCG	902	905	909	913	917
NHS South Kent Coast CCG	679	680	681	682	684
NHS Swale CCG	398	399	401	402	403
NHS Thanet CCG	500	500	501	501	502
NHS West Kent CCG	1537	1545	1554	1562	1571
Kent	5775	5815	5855	5894	5934

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 20 Estimated number of young people aged 16-24 with (self-reported symptoms of) Phobias 2017-2021 in Kent and in each District**

District	Phobias (16-24)				
	2017	2018	2019	2020	2021
Ashford	410	405	403	402	401
Canterbury	992	989	982	973	965
Dartford	337	333	330	329	329
Dover	359	351	343	337	333
Gravesham	374	369	362	358	360
Maidstone	532	524	515	515	515
Sevenoaks	332	323	313	310	312
Shepway	343	335	326	321	317
Swale	483	473	466	462	460
Thanet	486	476	467	464	461
Tonbridge and Malling	402	396	388	386	387
Tunbridge Wells	332	321	312	308	309
Grand Total	5381	5295	5207	5166	5149

Source: APMS, ONS (resident population projected from 2014)

## OCD

**Table 21 Estimated number of young people aged 16-24 with (self-reported symptoms of) OCD 2017-2021 in Kent and in each CCG**

CCG	OCD (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	252	254	256	258	260
NHS Canterbury And Coastal CCG	708	719	731	742	753
NHS Dartford, Gravesham And Swanley CCG	492	494	496	498	500
NHS South Kent Coast CCG	370	371	372	372	373
NHS Swale CCG	217	218	218	219	220
NHS Thanet CCG	272	273	273	273	274
NHS West Kent CCG	838	843	848	852	857
Kent	3150	3172	3193	3215	3237

**Table 22 Estimated number of young people aged 16-24 with (self-reported symptoms of) OCD 2017-2021 in Kent and in each District**

District	OCD (16-24)				
	2017	2018	2019	2020	2021
Ashford	224	221	220	219	219
Canterbury	541	539	536	531	526
Dartford	184	181	180	179	179
Dover	196	192	187	184	182
Gravesham	204	201	198	195	196
Maidstone	290	286	281	281	281
Sevenoaks	181	176	171	169	170
Shepway	187	183	178	175	173
Swale	264	258	254	252	251
Thanet	265	259	255	253	252
Tonbridge and Malling	219	216	211	210	211
Tunbridge Wells	181	175	170	168	169
Grand Total	2935	2888	2840	2818	2808

Source: APMS, ONS (resident population projected from 2014)

## Panic

**Table 23 Estimated number of young people aged 16-24 with (self-reported symptoms of) Panic 2017-2021 in Kent and in each CCG**

CCG	Panic (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	168	169	171	172	174
NHS Canterbury And Coastal CCG	472	480	487	495	502
NHS Dartford, Gravesham And Swanley CCG	328	329	331	332	333
NHS South Kent Coast CCG	247	247	248	248	249
NHS Swale CCG	145	145	146	146	147
NHS Thanet CCG	182	182	182	182	182
NHS West Kent CCG	559	562	565	568	571
Kent	2100	2115	2129	2143	2158

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 24 Estimated number of young people aged 16-24 with (self-reported symptoms of) Panic 2017-2021 in Kent and in each District**

District	Panic disorder (16-24)				
	2017	2018	2019	2020	2021
Ashford	149	147	147	146	146
Canterbury	361	360	357	354	351
Dartford	123	121	120	119	120
Dover	131	128	125	123	121
Gravesham	136	134	132	130	131
Maidstone	193	190	187	187	187
Sevenoaks	121	117	114	113	114
Shepway	125	122	119	117	115
Swale	176	172	169	168	167
Thanet	177	173	170	169	168
Tonbridge and Malling	146	144	141	140	141
Tunbridge Wells	121	117	114	112	113
Grand Total	1957	1926	1893	1879	1872

Source: APMS, ONS (resident population projected from 2014)

**Table 25 Estimated number of young people aged 16-24 with (self-reported symptoms of) Panic 2017-2021 in Kent and in each District**

District	Panic disorder (16-24)				
	2017	2018	2019	2020	2021
Ashford	149	147	147	146	146
Canterbury	361	360	357	354	351
Dartford	123	121	120	119	120
Dover	131	128	125	123	121
Gravesham	136	134	132	130	131
Maidstone	193	190	187	187	187
Sevenoaks	121	117	114	113	114
Shepway	125	122	119	117	115
Swale	176	172	169	168	167
Thanet	177	173	170	169	168
Tonbridge and Malling	146	144	141	140	141
Tunbridge Wells	121	117	114	112	113
Grand Total	1957	1926	1893	1879	1872

Source: APMS, ONS (resident population projected from 2014)

## Common Mental Health Disorder

**Table 26 Estimated number of young people aged 16-24 with (self-reported symptoms of) Common Mental Health Disorder – NOS 2017-2021 in Kent and in each CCG**

CCG	CMD-NOS (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	1176	1186	1196	1206	1215
NHS Canterbury And Coastal CCG	3306	3358	3410	3462	3514
NHS Dartford, Gravesham And Swanley CCG	2295	2305	2314	2324	2333
NHS South Kent Coast CCG	1727	1731	1734	1737	1740
NHS Swale CCG	1013	1016	1020	1023	1026
NHS Thanet CCG	1272	1273	1275	1276	1277
NHS West Kent CCG	3912	3934	3955	3977	3998
Kent	14701	14802	14903	15003	15104

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 27 Estimated number of young people aged 16-24 with (self-reported symptoms of) Common Mental Health Disorder – NOS 2017-2021 in Kent and in each District**

District	CMD-NOS (16-24)				
	2017	2018	2019	2020	2021
Ashford	1044	1032	1027	1024	1021
Canterbury	2524	2518	2500	2477	2456
Dartford	859	846	839	836	837
Dover	915	894	873	858	847
Gravesham	952	940	923	912	916
Maidstone	1353	1333	1312	1310	1311
Sevenoaks	844	821	797	789	795
Shepway	872	854	830	818	806
Swale	1231	1205	1185	1175	1171
Thanet	1236	1211	1189	1182	1174
Tonbridge and Malling	1024	1008	987	982	985
Tunbridge Wells	845	818	795	785	788
Grand Total	13698	13479	13254	13150	13106

Source: APMS, ONS (resident population projected from 2014)

**Table 28 Estimated number of young people aged 16-24 with (self-reported symptoms of) Common Mental Health Disorder – NOS 2017-2021 in Kent and in each CCG**

CCG	Any CMD (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	2646	2668	2690	2713	2735
NHS Canterbury And Coastal CCG	7437	7554	7672	7789	7906
NHS Dartford, Gravesham And Swanley CCG	5165	5186	5207	5228	5249
NHS South Kent Coast CCG	3887	3894	3901	3909	3916
NHS Swale CCG	2279	2287	2294	2302	2309
NHS Thanet CCG	2861	2864	2868	2871	2874
NHS West Kent CCG	8802	8851	8899	8947	8996
Kent	33077	33304	33531	33758	33985

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 29 Estimated number of young people aged 16-24 with (self-reported symptoms of) Common Mental Health Disorder – Any CMD 2017-2021 in Kent and in each District**

District	Any CMD (16-24)				
	2017	2018	2019	2020	2021
Ashford	2348	2322	2310	2305	2298
Canterbury	5680	5665	5624	5574	5526
Dartford	1932	1904	1887	1882	1883
Dover	2058	2011	1963	1930	1906
Gravesham	2141	2115	2076	2052	2060
Maidstone	3045	2999	2951	2948	2949
Sevenoaks	1899	1847	1794	1776	1789
Shepway	1963	1921	1866	1840	1813
Swale	2769	2712	2667	2645	2634
Thanet	2781	2724	2675	2660	2642
Tonbridge and Malling	2304	2268	2220	2210	2217
Tunbridge Wells	1900	1839	1788	1767	1772
Grand Total	30821	30327	29822	29587	29489

Source: APMS, ONS (resident population projected from 2014)

### Anti-Social Personality Disorder (ASPD)

**Table 30 Estimated number of young people aged 16-24 with (self-reported symptoms of) ASPD 2017-2021 in Kent and in each CCG**

CCG	ASPD (18-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	518	523	528	533	537
NHS Canterbury And Coastal CCG	1666	1696	1726	1756	1786
NHS Dartford, Gravesham And Swanley CCG	1034	1040	1047	1053	1059
NHS South Kent Coast CCG	770	774	777	780	784
NHS Swale CCG	459	461	464	467	470
NHS Thanet CCG	573	575	578	580	583
NHS West Kent CCG	1685	1697	1709	1722	1734
Kent	6705	6767	6829	6891	6954

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 31 Estimated number of young people aged 16-24 with (self-reported symptoms of) ASPD 2017-2021 in Kent and in each District**

District	ASPD (18-24)				
	2017	2018	2019	2020	2021
Ashford	456	446	444	441	440
Canterbury	1304	1304	1288	1273	1257
Dartford	384	379	371	365	363
Dover	406	397	384	376	369
Gravesham	425	420	412	404	402
Maidstone	597	591	581	572	569
Sevenoaks	356	345	334	326	323
Shepway	390	385	374	366	358
Swale	547	537	530	520	511
Thanet	559	550	539	531	522
Tonbridge and Malling	431	424	409	402	401
Tunbridge Wells	344	332	319	308	307
Grand Total	6199	6110	5985	5884	5820

Source: APMS, ONS (resident population projected from 2014)

### Post-Traumatic Stress Disorder (PTSD)

**Table 32 Estimated number of young people aged 16-24 with (self-reported symptoms of) PTSD 2017-2021 in Kent and in each CCG**

CCG	PTSD				
	2017	2018	2019	2020	2021
NHS Ashford CCG	1123	1132	1141	1151	1160
NHS Canterbury And Coastal CCG	3155	3205	3254	3304	3354
NHS Dartford, Gravesham And Swanley CCG	2191	2200	2209	2218	2227
NHS South Kent Coast CCG	1649	1652	1655	1658	1661
NHS Swale CCG	967	970	973	976	980
NHS Thanet CCG	1214	1215	1217	1218	1219
NHS West Kent CCG	3734	3755	3775	3796	3816
Kent	14032	14128	14224	14321	14417

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 33 Estimated number of young people aged 16-24 with (self-reported symptoms of) PTSD 2017-2021 in Kent and in each District**

District	PTSD				
	2017	2018	2019	2020	2021
Ashford	996	985	980	978	975
Canterbury	2410	2403	2386	2364	2344
Dartford	820	808	801	798	799
Dover	873	853	833	819	809
Gravesham	908	897	881	870	874
Maidstone	1292	1272	1252	1251	1251
Sevenoaks	806	784	761	753	759
Shepway	833	815	792	780	769
Swale	1175	1150	1131	1122	1118
Thanet	1180	1156	1135	1128	1121
Tonbridge and Malling	977	962	942	937	940
Tunbridge Wells	806	780	758	749	752
Kent	13075	12865	12651	12551	12510

Source: APMS, ONS (resident population projected from 2014)

### Psychotic Disorder

**Table 34 Estimated number of young people aged 16-24 with (self-reported symptoms of) Psychotic Disorder 2017-2021 in Kent and in each CCG**

CCG	Psychotic disorder				
	2017	2018	2019	2020	2021
NHS Ashford CCG	50	51	51	52	52
NHS Canterbury And Coastal CCG	142	144	146	149	151
NHS Dartford, Gravesham And Swanley CCG	99	99	99	100	100
NHS South Kent Coast CCG	74	74	74	75	75
NHS Swale CCG	43	44	44	44	44
NHS Thanet CCG	55	55	55	55	55
NHS West Kent CCG	168	169	170	171	172
Kent	631	635	640	644	648

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)



**Table 35 Estimated number of young people aged 16-24 with (self-reported symptoms of) Psychotic Disorder 2017-2021 in Kent and in each district**

District	Psychotic disorder				
	2017	2018	2019	2020	2021
Ashford	45	44	44	44	44
Canterbury	108	108	107	106	105
Dartford	37	36	36	36	36
Dover	39	38	37	37	36
Gravesham	41	40	40	39	39
Maidstone	58	57	56	56	56
Sevenoaks	36	35	34	34	34
Shepway	37	37	36	35	35
Swale	53	52	51	50	50
Thanet	53	52	51	51	50
Tonbridge and Malling	44	43	42	42	42
Tunbridge Wells	36	35	34	34	34
Kent	588	578	569	564	562

Source: APMS, ONS (resident population projected from 2014)

### Self-harm

**Table 36 Estimated number of young people aged 16-24 with (self-reported symptoms of) Self-Harm 2017-2021 in Kent and in each CCG**

CCG	Self harm (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	1916	1932	1948	1964	1980
NHS Canterbury And Coastal CCG	5386	5470	5555	5640	5725
NHS Dartford, Gravesham And Swanley CCG	3740	3755	3771	3786	3801
NHS South Kent Coast CCG	2815	2820	2825	2830	2836
NHS Swale CCG	1650	1656	1661	1667	1672
NHS Thanet CCG	2072	2074	2077	2079	2081
NHS West Kent CCG	6374	6409	6444	6479	6514
Kent	23952	24116	24281	24445	24609

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 37 Estimated number of young people aged 16-24 with (self-reported symptoms of) Self-Harm 2017-2021 in Kent and in each District**

District	Suicide attempt (16-24)				
	2017	2018	2019	2020	2021
Ashford	279	276	275	274	273
Canterbury	675	674	669	663	657
Dartford	230	226	224	224	224
Dover	245	239	233	230	227
Gravesham	255	252	247	244	245
Maidstone	362	357	351	351	351
Sevenoaks	226	220	213	211	213
Shepway	233	228	222	219	216
Swale	329	322	317	314	313
Thanet	331	324	318	316	314
Tonbridge and Malling	274	270	264	263	264
Tunbridge Wells	226	219	213	210	211
Kent	3665	3606	3546	3518	3507

Source: APMS, ONS (resident population projected from 2014)

### Suicidal Thoughts

**Table 38 Estimated number of young people aged 16-24 with (self-reported symptoms of) Suicidal thoughts 2017-2021 in Kent and in each CCG**

CCG	Suicide attempt (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	315	317	320	323	325
NHS Canterbury And Coastal CCG	884	898	912	926	940
NHS Dartford, Gravesham And Swanley CCG	614	617	619	622	624
NHS South Kent Coast CCG	462	463	464	465	466
NHS Swale CCG	271	272	273	274	275
NHS Thanet CCG	340	341	341	341	342
NHS West Kent CCG	1047	1052	1058	1064	1070
Kent	3933	3960	3987	4014	4041

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 39 Estimated number of young people aged 16-24 with (self-reported symptoms of) Suicidal thoughts 2017-2021 in Kent and in each District**

District	Suicidal thoughts (16-24)				
	2017	2018	2019	2020	2021
Ashford	1041	1029	1024	1021	1018
Canterbury	2517	2510	2492	2470	2449
Dartford	856	844	836	834	835
Dover	912	891	870	855	845
Gravesham	949	937	920	909	913
Maidstone	1349	1329	1308	1306	1307
Sevenoaks	842	819	795	787	793
Shepway	870	851	827	815	803
Swale	1227	1202	1182	1172	1167
Thanet	1232	1207	1185	1179	1171
Tonbridge and Malling	1021	1005	984	979	982
Tunbridge Wells	842	815	792	783	785
Kent	13658	13439	13215	13111	13068

Source: APMS, ONS (resident population projected from 2014)

### Suicidal Attempts

**Table 40 Estimated number of young people aged 16-24 with (self-reported symptoms of) Suicidal attempts 2017-2021 in Kent and in each CCG**

CCG	Suicide attempt (16-24)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	315	317	320	323	325
NHS Canterbury And Coastal CCG	884	898	912	926	940
NHS Dartford, Gravesham And Swanley CCG	614	617	619	622	624
NHS South Kent Coast CCG	462	463	464	465	466
NHS Swale CCG	271	272	273	274	275
NHS Thanet CCG	340	341	341	341	342
NHS West Kent CCG	1047	1052	1058	1064	1070
Kent	3933	3960	3987	4014	4041

Source: APMS, PCIS (registered population projected forward based on 2006 to 2016 data)

**Table 41 Estimated number of young people aged 16-24 with (self-reported symptoms of ) Suicidal attempts 2017-2021 in Kent and in Kent and by District**

District	Suicide attempt (16-24)				
	2017	2018	2019	2020	2021
Ashford	279	276	275	274	273
Canterbury	675	674	669	663	657
Dartford	230	226	224	224	224
Dover	245	239	233	230	227
Gravesham	255	252	247	244	245
Maidstone	362	357	351	351	351
Sevenoaks	226	220	213	211	213
Shepway	233	228	222	219	216
Swale	329	322	317	314	313
Thanet	331	324	318	316	314
Tonbridge and Malling	274	270	264	263	264
Tunbridge Wells	226	219	213	210	211
Kent	3665	3606	3546	3518	3507

Source: APMS, ONS (resident population projected from 2014)

## Eating Disorder

**Table 42 Estimated number of young people aged 13-18 with an Eating Disorder 2017-2021 in Kent and by District**

District	Eating Disorders (13 - 18)				
	2017	2018	2019	2020	2021
Ashford	578	573	580	586	599
Canterbury	651	652	659	668	681
Dartford	437	442	451	461	480
Dover	466	459	464	474	485
Gravesham	470	472	483	493	506
Maidstone	695	696	703	716	740
Sevenoaks	500	500	505	515	530
Shepway	425	416	416	420	428
Swale	619	616	626	639	659
Thanet	592	587	589	605	624
Tonbridge and Malling	612	613	620	633	648
Tunbridge Wells	550	548	555	568	585
Kent	6594	6573	6650	6777	6966

Source: Swanson and colleagues, 2011, ONS (resident population projected from 2014)

**Table 43 Estimated number of young people aged 13-18 with an Eating Disorder 2017-2021 in Kent and by CCG**

CCG	Eating Disorders (13 - 18)				
	2017	2018	2019	2020	2021
NHS Ashford CCG	593	595	597	598	600
NHS Canterbury And Coastal CCG	995	995	996	996	997
NHS Dartford, Gravesham And Swanley CCG	1088	1083	1078	1073	1069
NHS South Kent Coast CCG	827	817	808	798	788
NHS Swale CCG	474	470	465	461	457
NHS Thanet CCG	599	592	586	579	573
NHS West Kent CCG	2121	2120	2119	2118	2117
Kent	6696	6672	6649	6625	6601

Source: Swanson and colleagues, 2011, PCIS (registered population projected forward based on 2006 to 2016 data)

## | Appendix 4

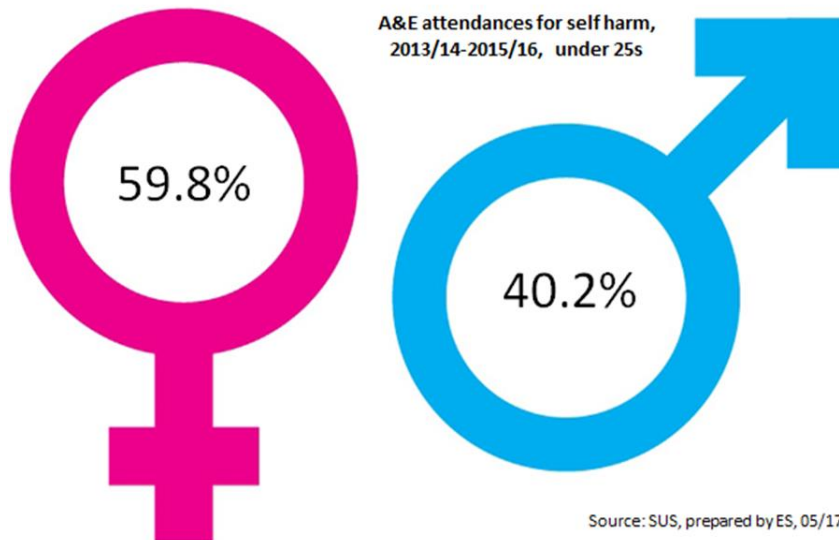
This section provides trend analysis from acute care settings for under 18s and for under 25. The section is broken down by mental health disorder. The data is provided for CCGs and by gender. Readmission data is provided for attendance data.

It is important to note that a single admission will result in a primary and a secondary diagnosis. Both primary and secondary diagnoses are included in this analysis.

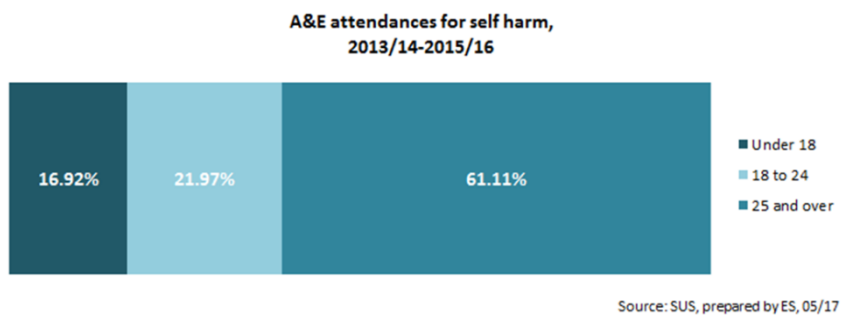
Further to that it is important to note that hospital admissions data is available from the Secondary Uses Service from 2006/07 onwards, and reliably from 2009/10 onwards for A&E attendances. Changes to the figures over time need to be interpreted in the context of improvements in data quality and coverage (particularly in earlier years), improvements in coverage of independent sector activity (particularly from 2006-07) and changes in NHS practice. For example, apparent increases in activity may be due to improved recording of diagnosis or procedure information

### Self-Harm

**Figure 1 Aggregated Attendances for Self-Harm Diagnosis for under 25's from 2006/07 to 2015/16 by Gender**



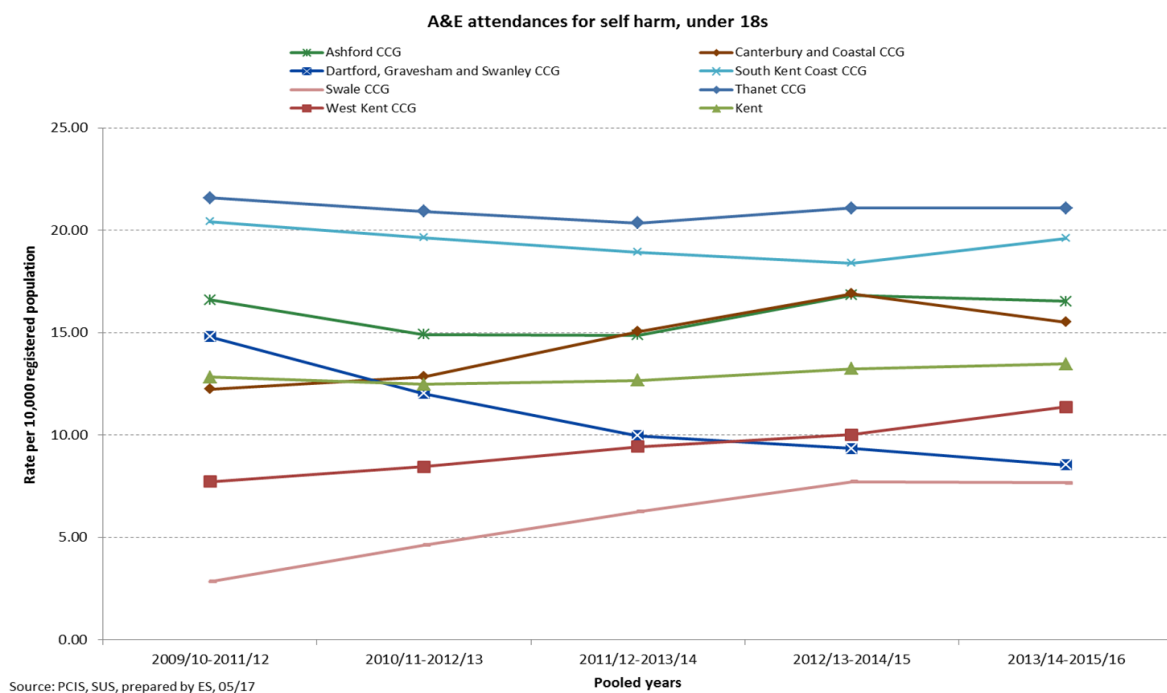
**Figure 2 Aggregated Attendances for Self-Harm by Age Band from 2006/07 to 2015/16**



Between 2013/14 and 2015/16, 59.8% of A&E attendances for self-harm were female, accounting for 1,560 attendances out of 2,608. For under 18s, the proportion of self-harm attendances for females was higher, accounting for 71.5% of attendances (797 out of 1,114).

Just over a third (38.9%, 1,306) of A&E self-harm attendances were for individuals aged under 25, with one in five (22.0%) for people aged 18 to 24 years.

**Figure 3 Attendances for Self-Harm for under 18's from 09/-10 -15/16 by CCG**

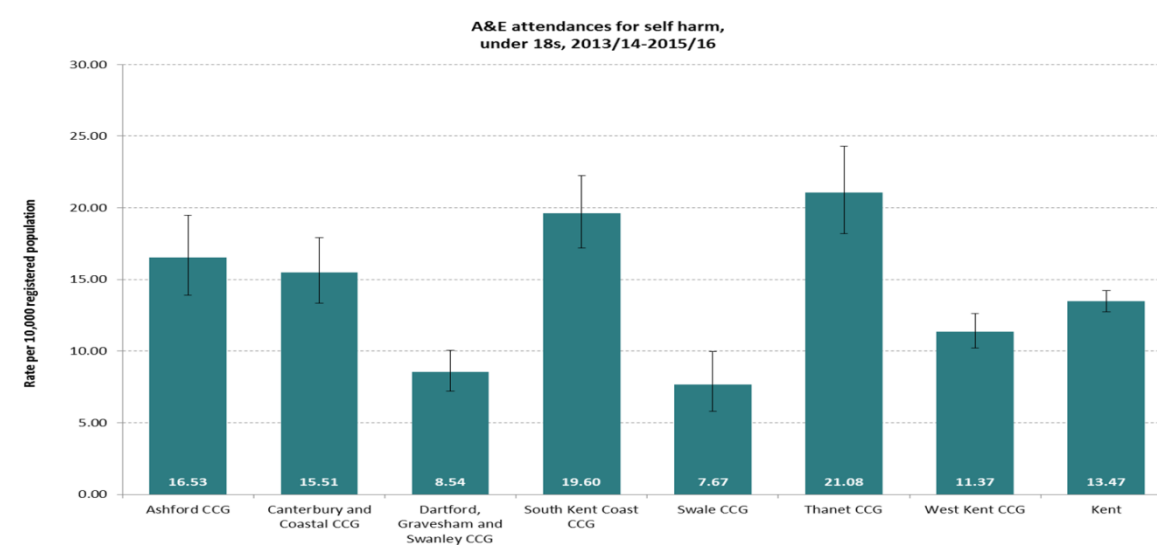


For under 18s, the A&E attendance rate for self-harm has remained fairly static, increasing from 12.8 to 13.5 attendances per 10,000 registered population between 2009/10-2011/12 and 2013/14-2015/16. Attendances in Thanet, South Kent Coast, Canterbury and Coastal and Ashford CCGs were consistently higher than Kent.

**Table 1 A&E Attendances for Self-Harm for under 18 by CCG, Count**

CCG	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	136	123	124	142	141
Canterbury and Coastal CCG	144	151	177	199	183
Dartford, Gravesham and Swanley CCG	234	194	164	157	146
South Kent Coast CCG	242	232	225	220	236
Swale CCG	20	33	45	56	56
Thanet CCG	189	184	180	188	189
West Kent CCG	230	255	288	310	355
Kent	1195	1172	1203	1272	1306

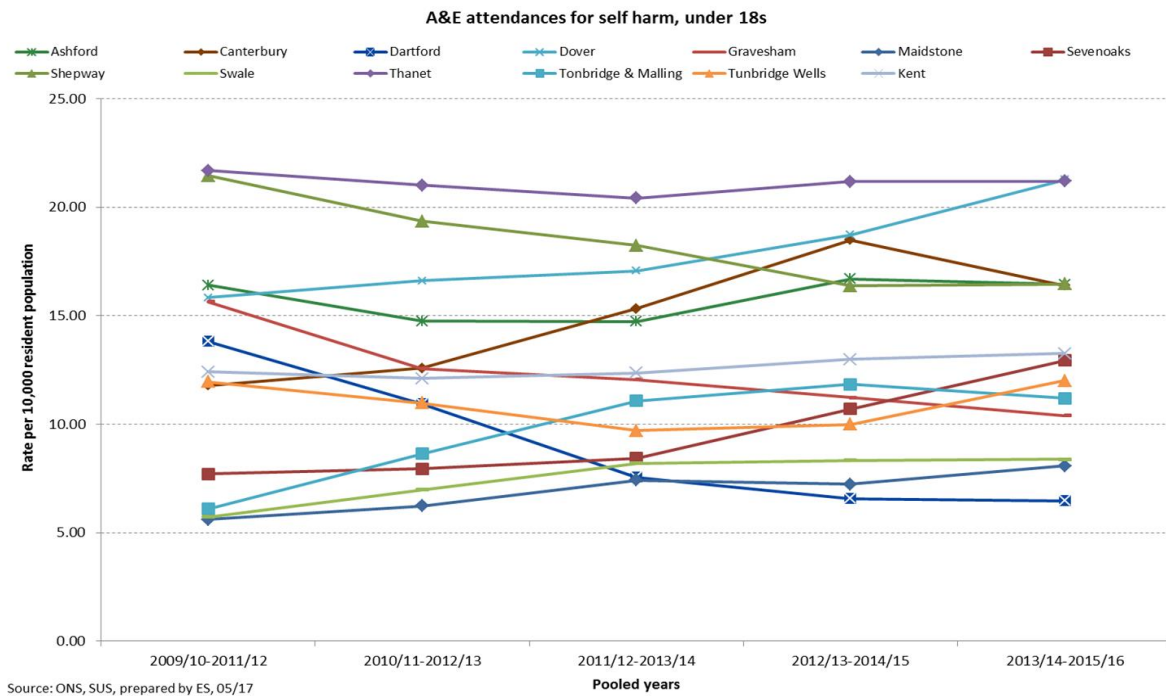
**Figure 4 Attendances for Self-Harm for under 18 13/14-15/16 for Kent and by CCG**



Across Kent, there were 13.5 A&E attendances for self-harm per 10,000 registered populations, ranging from 7.7 in Swale CCG to 21.1 in Thanet CCG. Both South Kent Coast (19.6) and Thanet CCGs have a significantly higher A&E attendance than Kent.

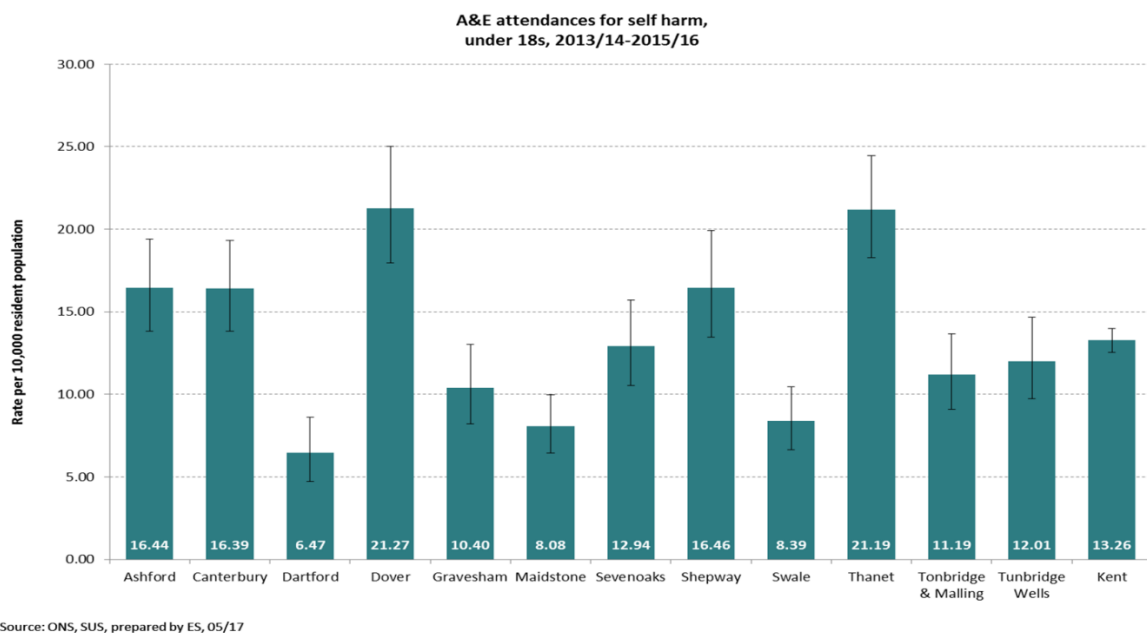


**Figure 5 Attendances for Self-Harm for under 18's from 13/14-15/16 by CCG**



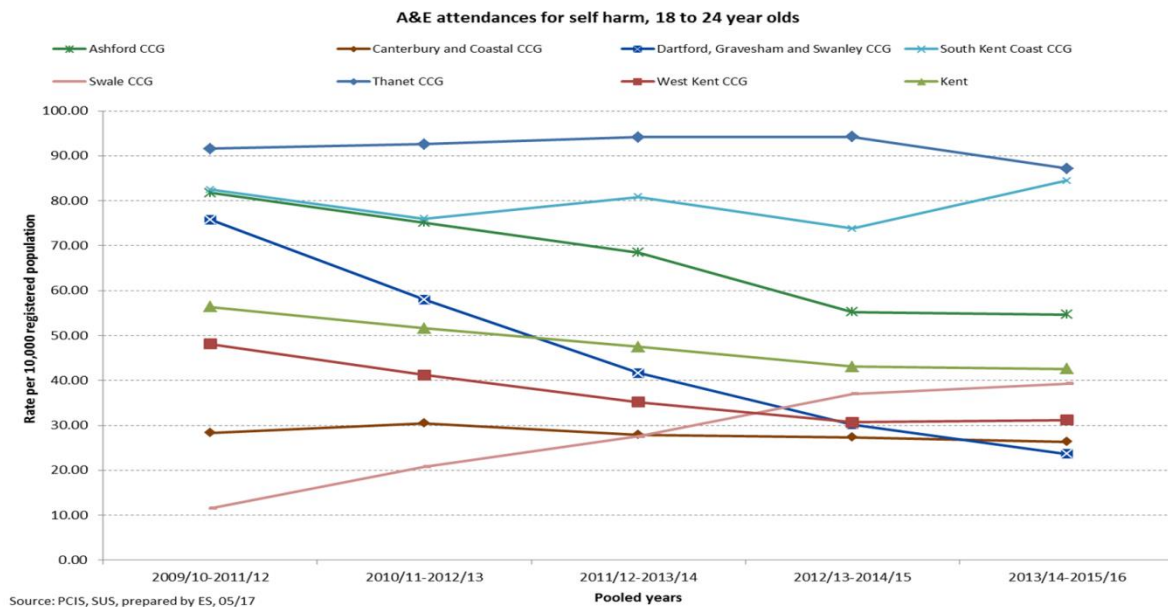
For under 18s, the A&E attendance rate for self-harm has remained fairly static, increasing from 12.4 to 13.7 attendances per 10,000 resident population between 2009/10-2011/12 and 2013/14-2015/16. Attendances in Thanet, Canterbury, Dover, Ashford and Shepway were consistently higher than Kent.

**Figure 6 Attendances for Self-Harm for under 18's from 13/14-15/16 for Kent and by District**



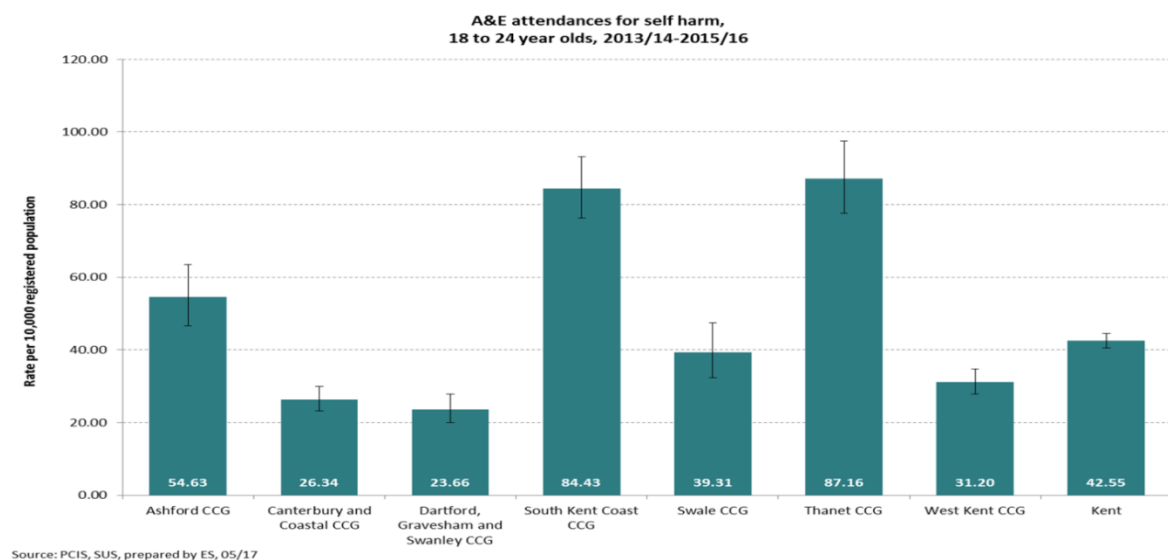
Across Kent, there were 13.3 A&E attendances for self-harm per 10,000 resident populations, ranging from 6.5 in Dartford to 21.3 in Dover. Dover and Thanet (21.2) have significantly higher A&E attendance rates than Kent.

**Figure 7 Attendances for Self-Harm for 18-24 years old from 09/-10 -15/16 by District**



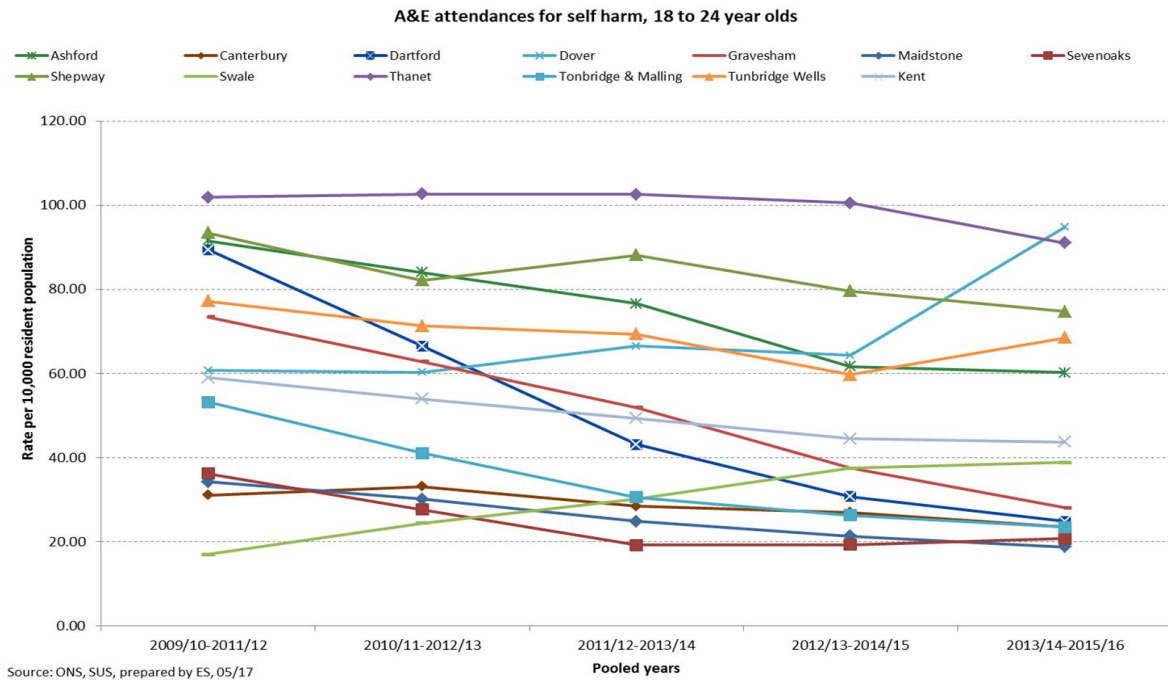
For 18 to 24 year olds, the self-harm A&E attendance rate has decreased from 56.4 per 10,000 registered populations in 2009/10-2011/12 to 42.3 in 2013/14-2015/16. Rates in South Kent Coast and Thanet CCGs have remained substantially higher than Kent. Ashford CCG has also had a markedly higher A&E self-harm attendance rate than Kent; however, this has been decreasing (although plateaued in the most recent time period).

**Figure 8 Attendances for Self-Harm by 18-24's from 13/14-15/16 for Kent and by CCG**



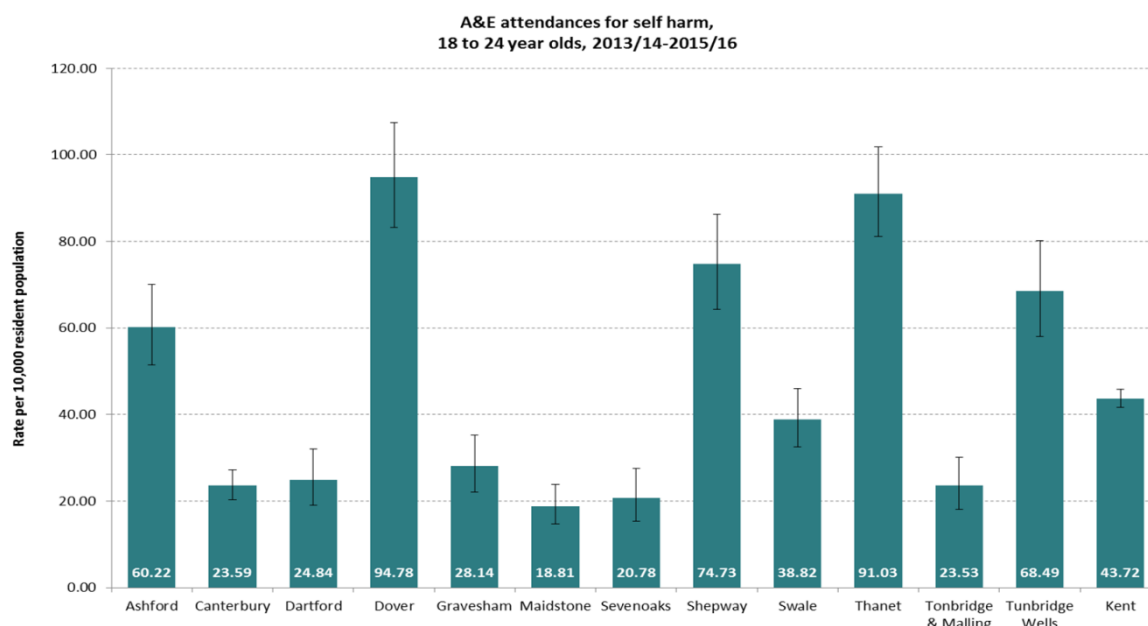
Across Kent, there were 42.3 A&E attendances for self-harm per 10,000 registered population, ranging from 23.7 in Dartford, Gravesham and Swanley CCG to 87.2 in Thanet CCG. South Kent Coast (19.6), Ashford (54.6) and Thanet CCGs have a significantly higher A&E attendance than Kent.

**Figure 9 Attendances for Self-Harm by 18-24's from 09/-10 -15/16 and by District**



For 18 to 24 year olds, the self-harm A&E attendance rate has decreased from 59.0 per 10,000 resident population in 2009/10-2011/12 to 43.7 in 2013/14-2015/16. Rates in Shepway, Thanet, Tunbridge Wells, Ashford and Dover have remained substantially higher than Kent. Dartford and Canterbury has also had a markedly higher A&E self-harm attendance rate than Kent; however, these have decreased to a rate lower than that of Kent.

**Figure 10 Attendances for Self-Harm by 18-24 Year olds from 13/14-15/16 for Kent and by District**



Source: ONS, SUS, prepared by ES, 05/17

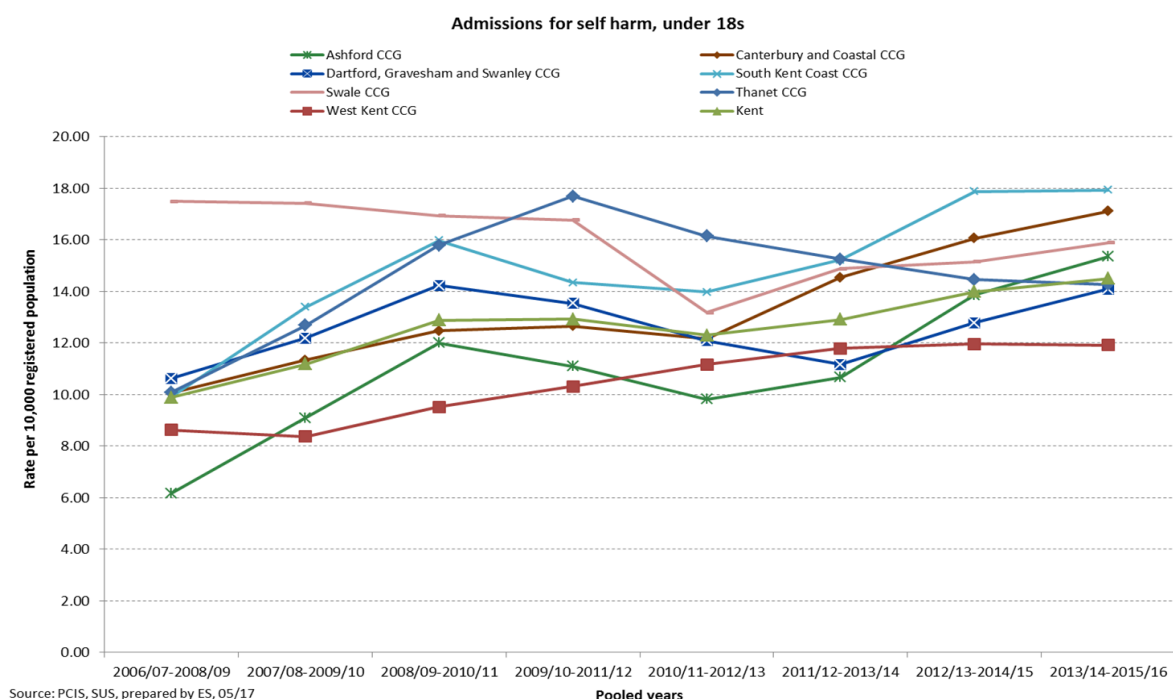
Across Kent, there were 43.7 A&E attendances for self-harm per 10,000 resident population, ranging from 18.8 in Maidstone to 94.8 in Dover. Ashford (60.2), Dover (94.78), Shepway (74.7), Thanet (91.0) and Tunbridge Wells (68.5) have significantly higher self-harm A&E attendance rates than Kent.

**Table 2 Percentage of Admissions for Self-Harm which were Elective Compared to Emergency 2013/14 to 2015/16 pooled, under 25s**

Provider	Elective	Emergency via A&E	All emergency
EKHUFT	0.2	98.5	99.8
MTW	1.0	97.9	99.0
DVT	0.4	99.6	99.6
Medway	0.0	93.6	100.0
Other	4.8	85.7	95.2
<b>Total</b>	<b>0.7</b>	<b>97.4</b>	<b>99.3</b>

The vast majority of admissions for self-harm were via A&E, accounting for 97.4% of admissions for under 25s between 2013/14 and 2015/16. Non-Kent Trusts had the highest proportion of elective admissions, accounting for 4.8% of admissions.

Figure 11 Admissions for Self-Harm for under 18 s from 06/-07 - 15/16 by District

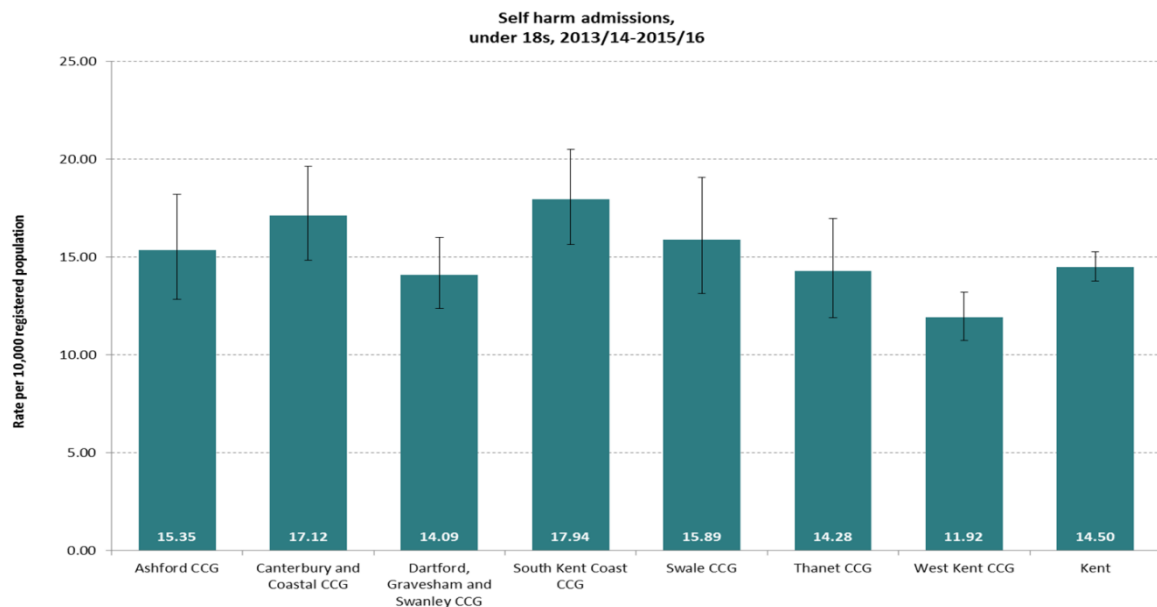


For under 18s, the hospital admission rate for self-harm has increased consistently, from 9.9 to 14.5 admissions per 10,000 registered population between 2009/10-2011/12 and 2013/14-2015/16. Admission rates in South Kent Coast, Canterbury and Coastal and Swale CCGs have all been higher than Kent in the past four time periods.

Table 3 Admissions for Self-Harm for under 18s from 2006/07-2015/16 for Kent and by CCG, Count

CCG	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	50	74	98	91	81	89	117	131
Canterbury and Coastal CCG	119	134	147	149	143	171	189	202
Dartford, Gravesham and Swanley CCG	165	190	223	214	195	184	215	241
South Kent Coast CCG	119	160	190	170	165	181	214	216
Swale CCG	120	120	118	118	94	107	110	116
Thanet CCG	85	109	138	155	142	135	129	128
West Kent CCG	253	247	282	307	337	360	370	372
Kent	911	1034	1196	1204	1157	1227	1344	1406

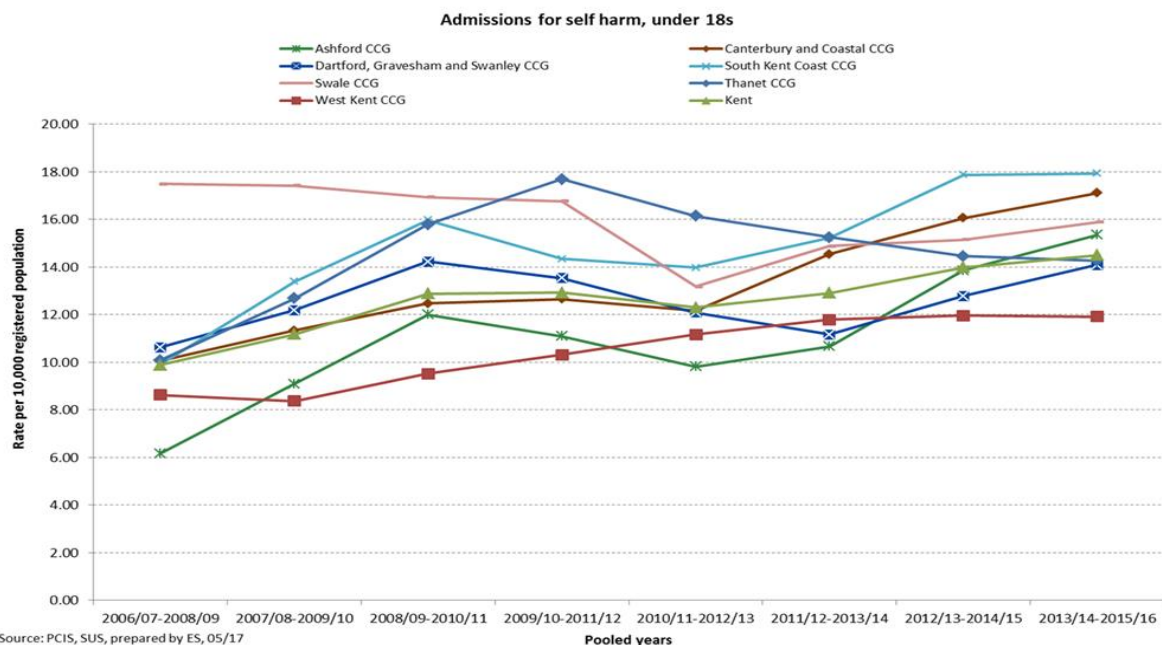
**Figure 12 Aggregated Admissions for Self-Harm for under 18s from 13/14-15/16 for Kent and by CCG**



Source: PCIS, SUS, prepared by ES, 05/17

Across Kent, there were 14.5 hospital admissions for self-harm per 10,000 registered population, ranging from 11.9 in West Kent CCG to 17.9 in South Kent Coast CCG. South Kent Coast had a significantly higher hospital admission rate for self-harm than Kent, while West Kent CCG had a significantly lower rate.

**Figure 13 Admissions for Self-Harm for under 18s from 06/07 -15/16 by CCG**

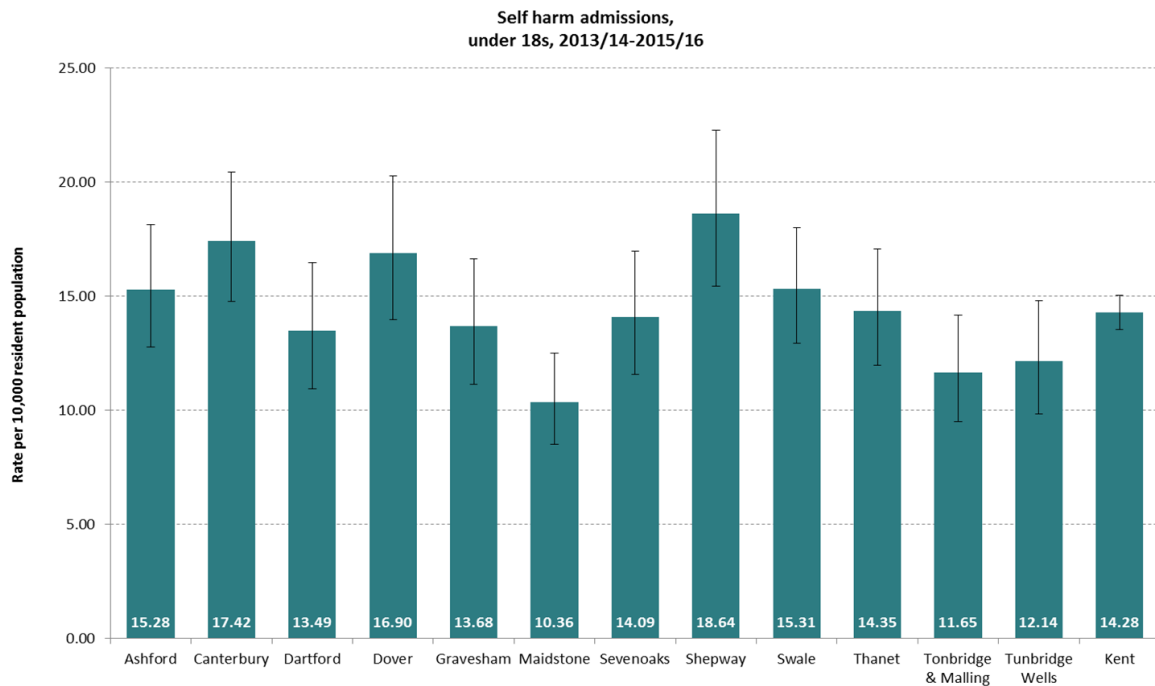


Source: PCIS, SUS, prepared by ES, 05/17

For under 18s, the hospital admission rate for self-harm has increased consistently, from 9.6 to 14.3 admissions per 10,000 resident population between 2009/10-2011/12 and 2013/14-2015/16. Admission rates in Shepway, Canterbury and Dover have all been higher than Kent

in the past four time periods; Thanet’s rate has also been consistently high but has decreased substantially since 2009/10-2011/12.

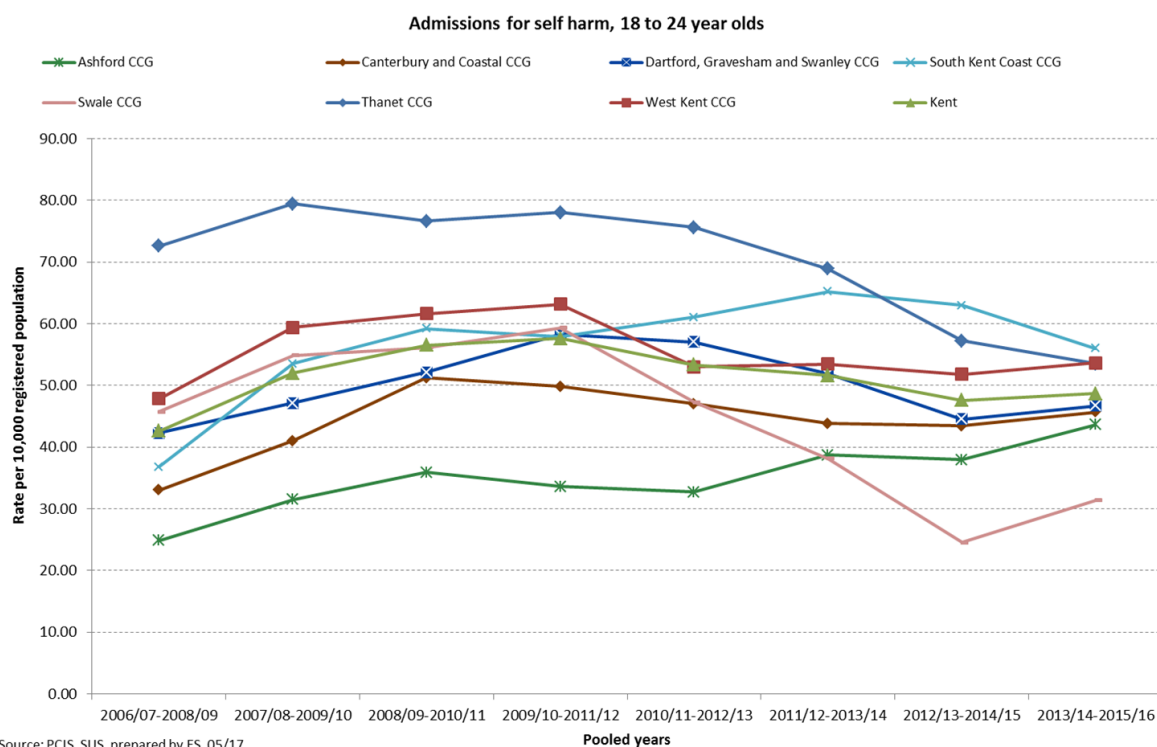
**Figure 14 Aggregated Admissions for Self-Harm for under 18s from 13/14-15/16 for Kent and by District**



Source: ONS, SUS, prepared by ES, 05/17

Across Kent, there were 14.3 hospital admissions for self-harm per 10,000 resident population aged under 18, ranging from 10.4 in Maidstone to 18.6 in Shepway. Shepway had a significantly higher hospital admission rate for self-harm than Kent, while Maidstone had a significantly lower rate.

**Figure 15 Admissions for Self-Harm for 18 – 24s from 06/07 -15/16 by CCG**



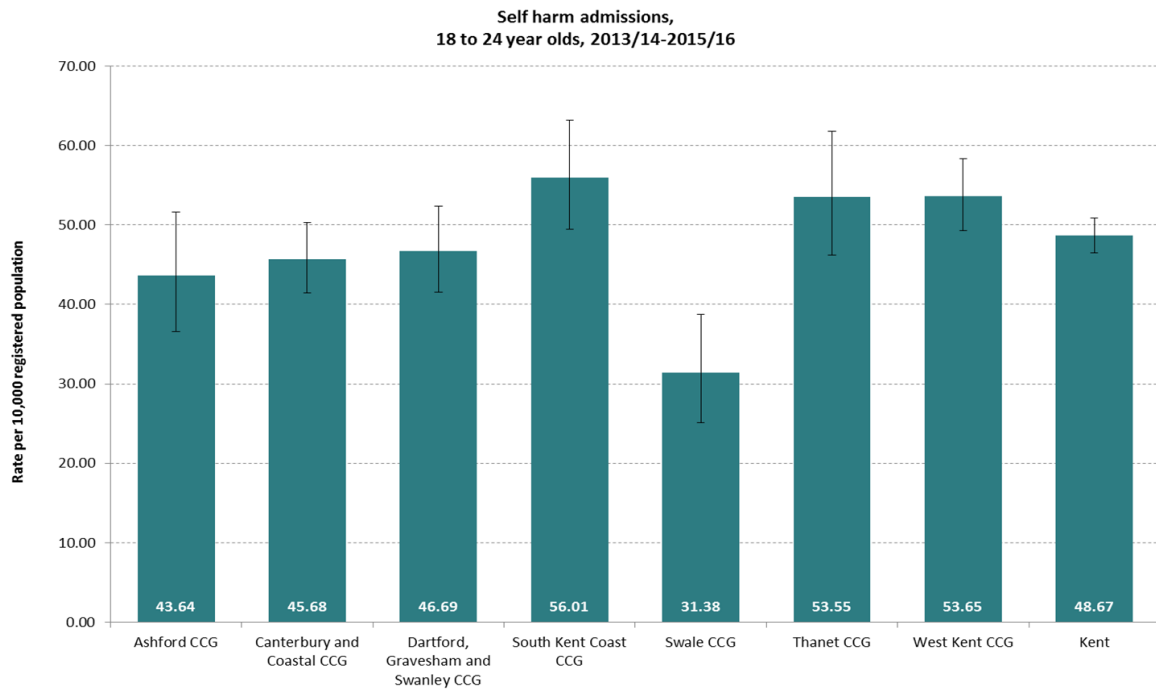
For 18 to 24 year olds, the hospital admission rate for self-harm has increased from 42.6 per 10,000 registered population in 2006/07-2008/09 to 57.6 in 2009/10-2011/12. Since then, the rate has decreased to 48.7 in 2013/14-2015/16. Admission rates in Thanet were markedly higher; however have decreased substantially. South Kent Coast and West Kent CCGs have all been higher than Kent in the past three time periods.

**Table 4 Admissions for Self-Harm for 18-24s by CCG, Count**

CCG	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	70	92	107	102	101	121	119	135
Canterbury and Coastal CCG	264	331	420	418	407	388	393	418
Dartford, Gravesham and Swanley CCG	247	281	316	359	358	328	282	294
South Kent Coast CCG	164	241	270	269	289	313	303	266
Swale CCG	117	144	152	165	134	108	69	87
Thanet CCG	231	265	267	278	272	246	203	188
West Kent CCG	457	580	614	638	543	549	534	552
Kent	1550	1934	2146	2229	2104	2053	1903	1940



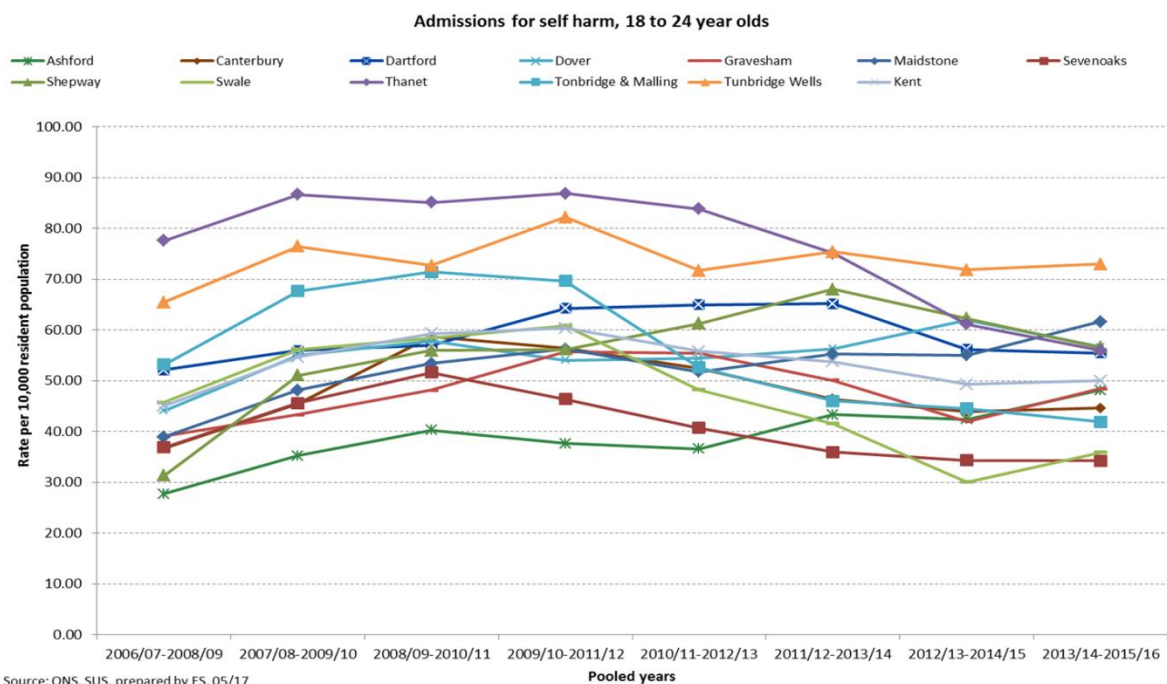
**Figure 16 Aggregated Admissions for Self-Harm for 18-24s from 13/14-15/16 for Kent and by CCG**



Source: PCIS, SUS, prepared by ES, 05/17

Across Kent, there were 48.7 hospital admissions for self-harm per 10,000 registered population aged 18 to 24 years, ranging from 31.4 in Swale CCG to 56.0 in South Kent Coast CCG. Swale CCG had a significantly lower hospital admission rate for self-harm than Kent.

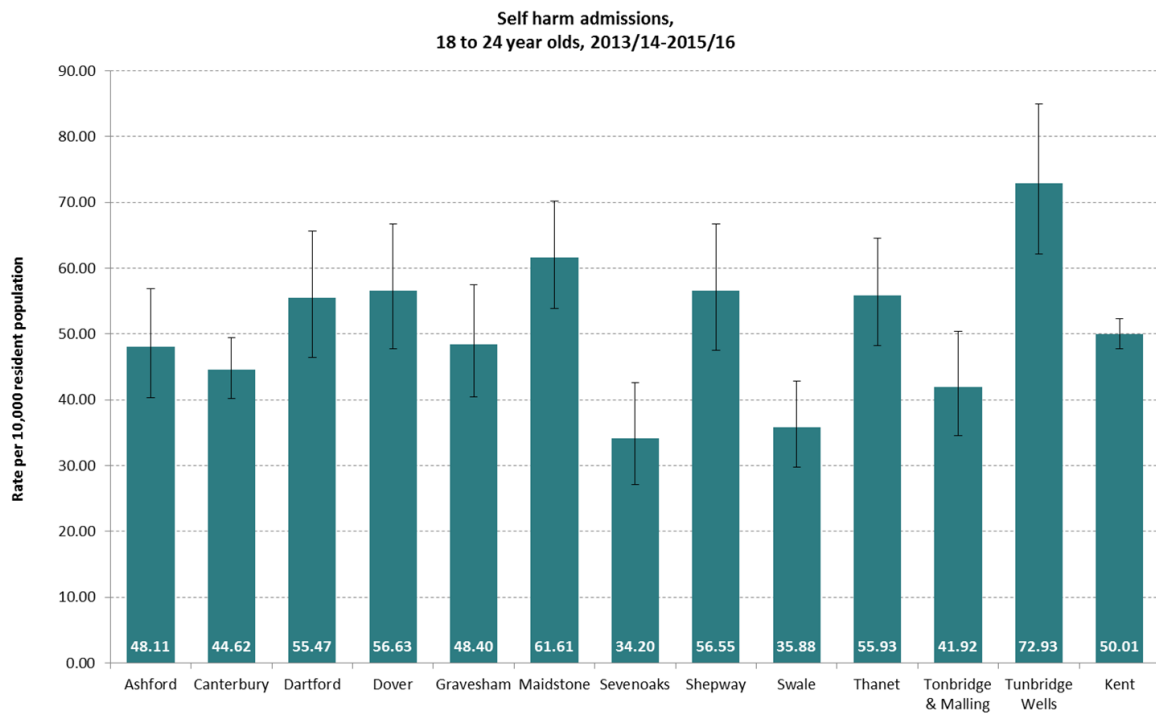
**Figure 17 Attendances for Self-Harm for 18 – 24 s from 06/07 -15/16 by District**



Source: ONS, SUS, prepared by ES, 05/17

For 18 to 24 year olds, the hospital admission rate for self-harm has increased from 45.0 per 10,000 resident population in 2006/07-2008/09 to 60.3 in 2009/10-2011/12. Since then, the rate has decreased to 50.0 in 2013/14-2015/16. Admission rates in Thanet were markedly higher; however have decreased substantially. Tunbridge Wells, Shepway, Maidstone and Dartford districts have all had higher rates than Kent in the past three time periods.

**Figure 18 Aggregated Admissions for Self-Harm for 18-24 s from 13/14-15/16 for Kent and by District**

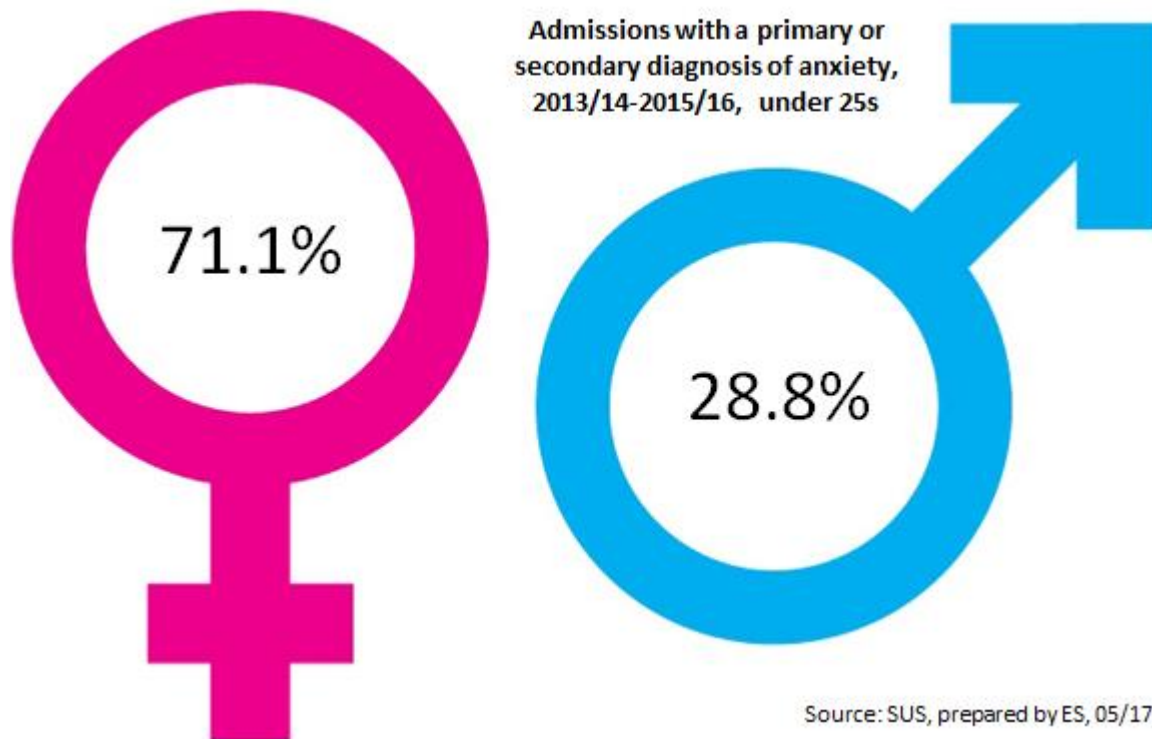


Source: ONS, SUS, prepared by ES, 05/17

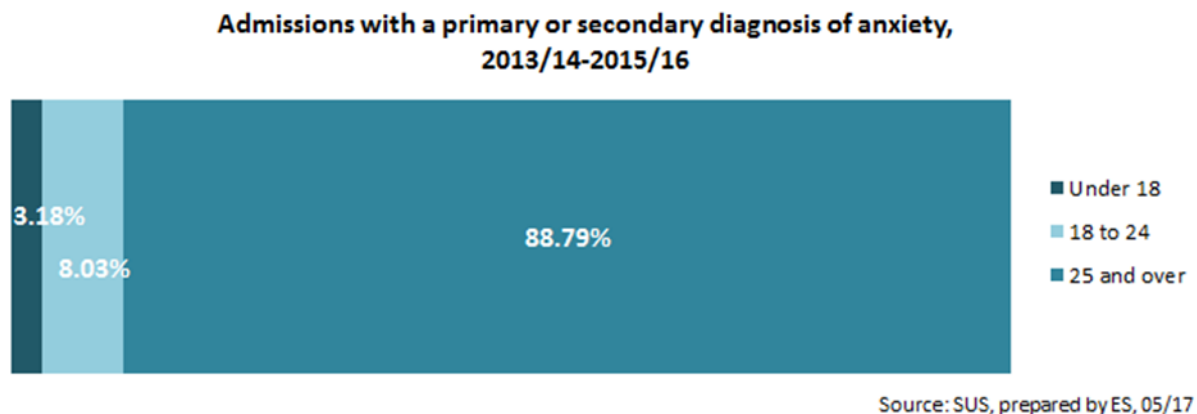
Across Kent, there were 50.0 hospital admissions for self-harm per 10,000 resident population aged 18 to 24 years, ranging from 34.2 in Sevenoaks to 72.9 in Tunbridge Wells. Maidstone (61.6) and Tunbridge Wells had significantly higher hospital admission rates for self-harm than Kent.

## Anxiety

**Figure 19 Admissions with a Primary or Secondary Diagnosis of Anxiety for under 25 s from 2013/14-15/16 pooled**



**Figure 20 Admissions with a Primary or Secondary Diagnosis of Anxiety by Age Band from 2013/14-15/16 pooled**



Between 2013/14 and 2015/16, 71.1% hospital admissions with a primary or secondary diagnosis of anxiety were female, accounting for 1,278 admissions out of 1,796 among under 25s with a valid gender code.

Just over a tenth of hospital admissions were for people aged under 25. Length of stay ranges from 0 to 317 days, with a median of one day.

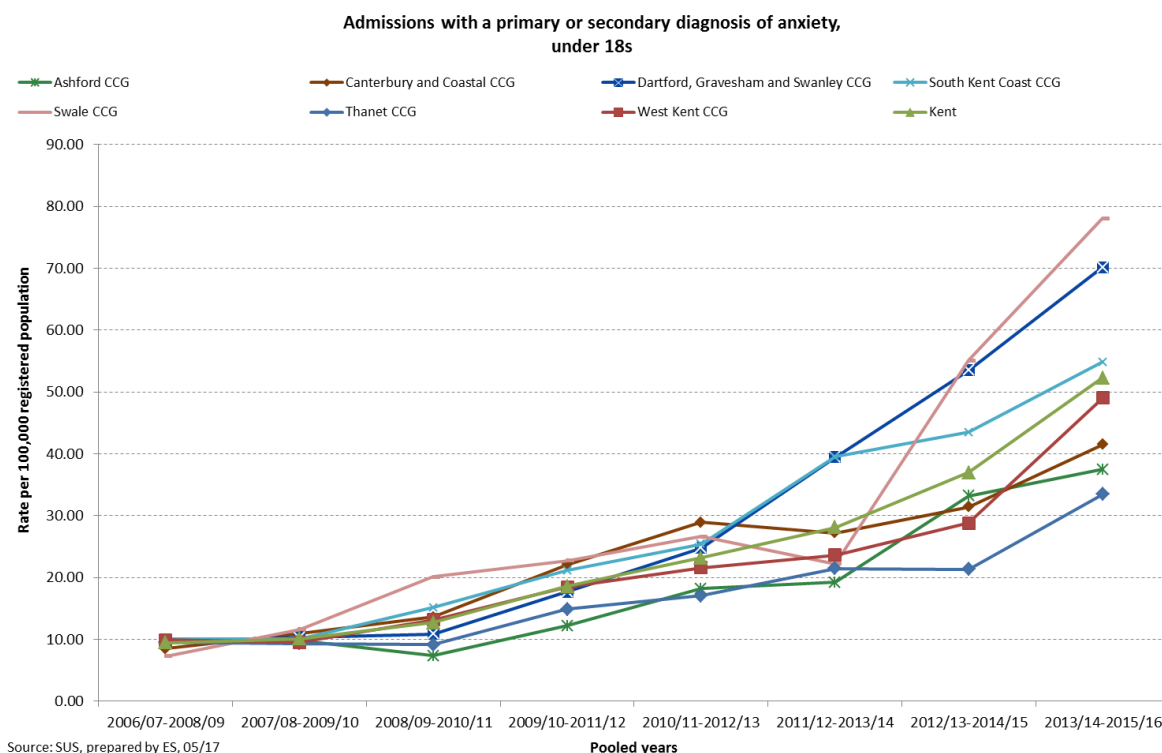
**Table 5 Percentage of Admissions with a Primary or Secondary Diagnosis of Anxiety which were Elective compared to Emergency for under 25s from 2013/14 to 15/16 pooled,**

Provider	Elective	Emergency via A&E	All emergency
EKHUFT	11.8	75.5	81.8
MTW	7.1	59.8	62.9
DVT	8.5	69.3	70.9
Medway	20.8	43.4	63.2
KMPT	31.3	0.0	68.8
Other	72.0	14.1	23.7
Total	24.5	54.5	62.1

**Source:** SUS

Just under two thirds of admissions with a primary or secondary diagnosis of an anxiety were an emergency, accounting for 62% of admissions for under 25s between 2013/14 and 2015/16. Non-Kent Trusts had the highest proportion of elective admissions, with 72%.

**Figure 21 Admissions with a Primary or Secondary Diagnosis of Anxiety for under 18 s from 2006/07 to 15/16 by CCG**



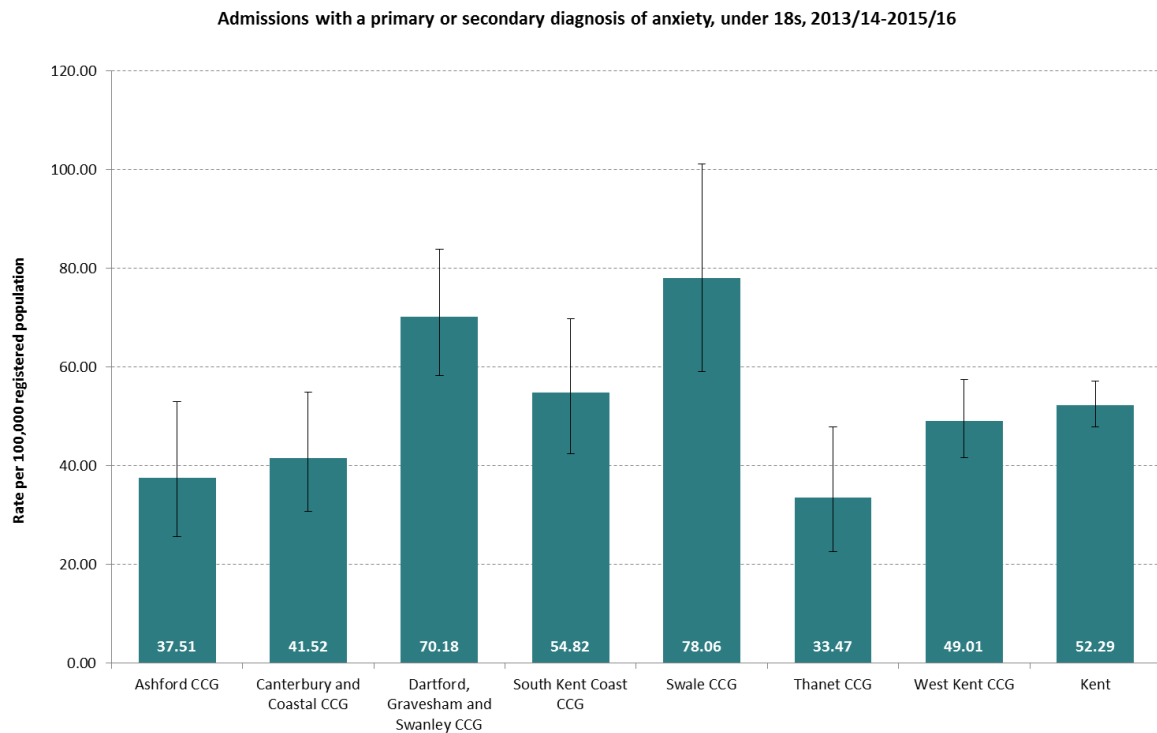
The admission rate with a primary or secondary anxiety diagnosis has increased from 9.4 per 100,000 resident population aged under 18 in 2006/07-2008/09 to 51.8 in 2013/14-2015/16. Swale, Dartford and Shepway have had higher rates than Kent in recent time periods, and continue to increase.

**Table 6 Admissions with a Primary or Secondary Diagnosis of Anxiety for under 18 s from 2006/07 to 15/16 by CCG Count**

CCG	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	8	8	6	10	15	16	28	32
Canterbury and Coastal CCG	10	13	16	26	34	32	37	49
Dartford, Gravesham and Swanley CCG	15	16	17	28	40	65	90	120
South Kent Coast CCG	12	12	18	25	30	47	52	66
Swale CCG	5	8	14	16	19	16	40	57
Thanet CCG	8	8	8	13	15	19	19	30
West Kent CCG	29	28	39	55	65	72	89	153
Kent	87	93	118	173	218	267	355	507

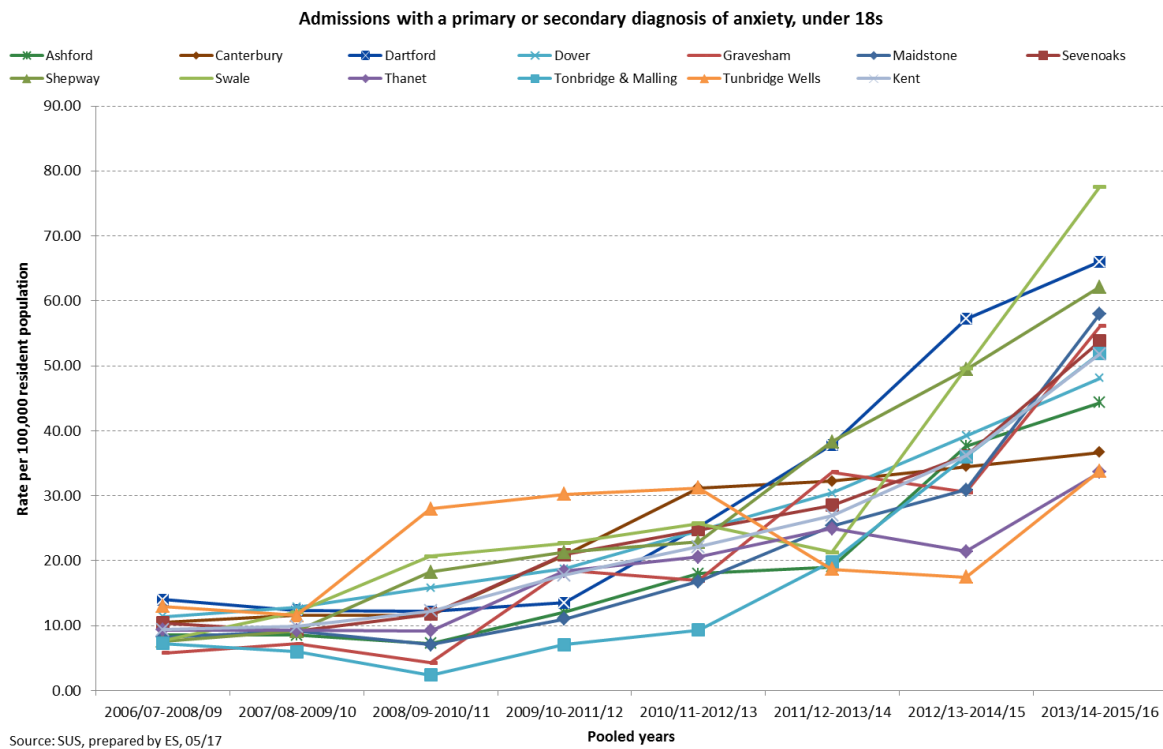
Source: SUS

**Figure 22 Admissions with a Primary or Secondary Diagnosis of Anxiety for under 18 s from 2013/14 to 15/16 pooled for Kent and by CCG**



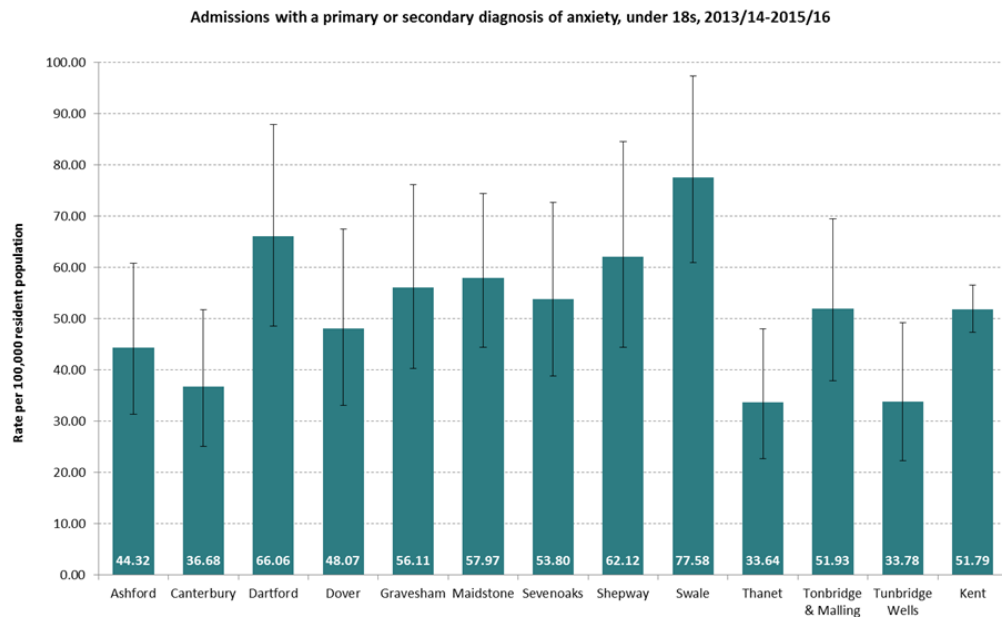
There were 52.3 hospital admissions per 100,000 registered under 18 year olds in 2013/14-2015/16 with a primary or secondary anxiety diagnosis across Kent. This ranged from 33.5 in Thanet CCG to 78.1 in Swale CCG. Alongside Swale CCG, Dartford, Gravesham and Swanley CCG (70.2) had a significantly higher admission rate than Kent.

**Figure 23 Admissions with a Primary or Secondary Diagnosis of Anxiety for under 18 s from 2006/07 to 15/16 pooled for Kent and by District**



The admission rate with a primary or secondary anxiety diagnosis has increased from 9.4 per 100,000 resident population aged under 18 in 2006/07-2008/09 to 51.8 in 2013/14-2015/16. Swale, Dartford and Shepway have had higher rates than Kent in recent time periods, and continue to increase.

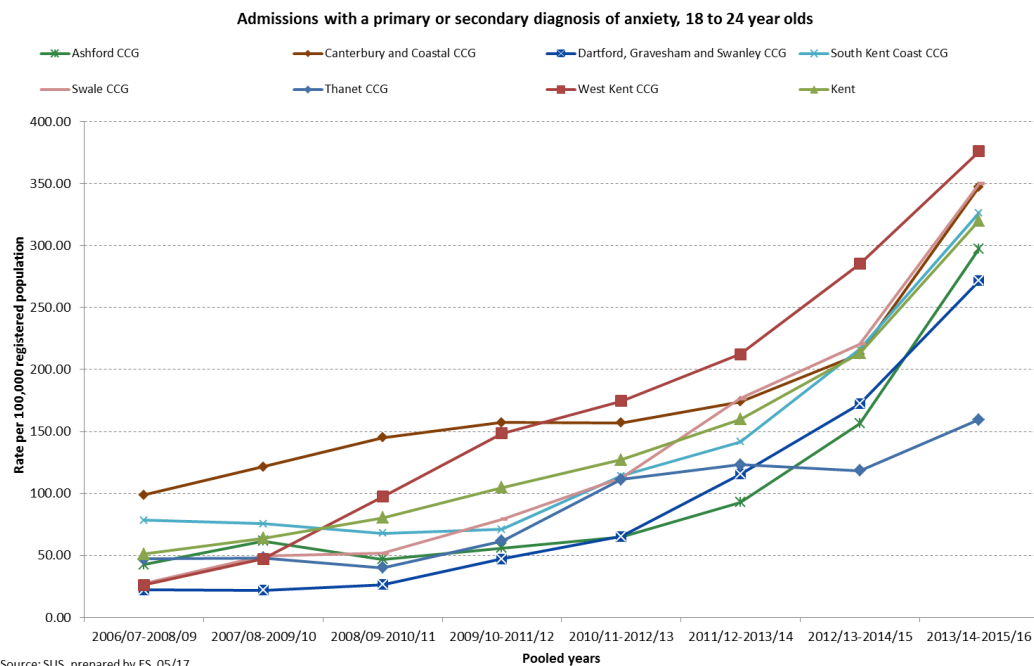
**Figure 24 Admissions with a Primary or Secondary Diagnosis of Anxiety for under 18s from 2013/14 to 15/16 pooled for Kent and by District**



Source: SUS, prepared by ES, 05/17

Across Kent there were 51.8 hospital admissions per 100,000 resident under 18 year olds in 2013/14-2015/16 with a primary or secondary anxiety diagnosis. This ranged from 33.6 in Thanet to 77.6 in Swale; significantly higher than Kent (95% confidence intervals).

**Figure 25 Admissions with a Primary or Secondary Diagnosis of Anxiety for 18-24s from 2006/07 to 15/16 pooled for by CCG**



Source: SUS, prepared by ES, 05/17

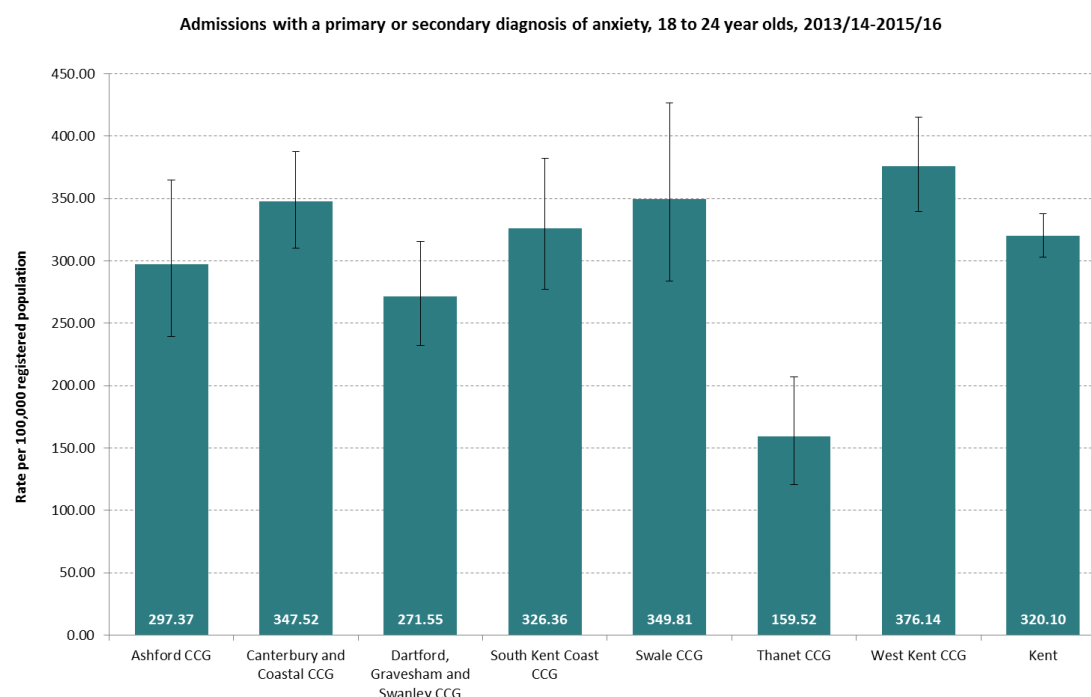


Across Kent, the admission rate with an anxiety diagnosis increased from 51.1 per 100,000 registered population aged 18 to 24 in 2006/07-2008/09 to 320.1 in 2013/14-2015/16. The rate in West Kent CCG has been notably higher than Kent and continues to rise.

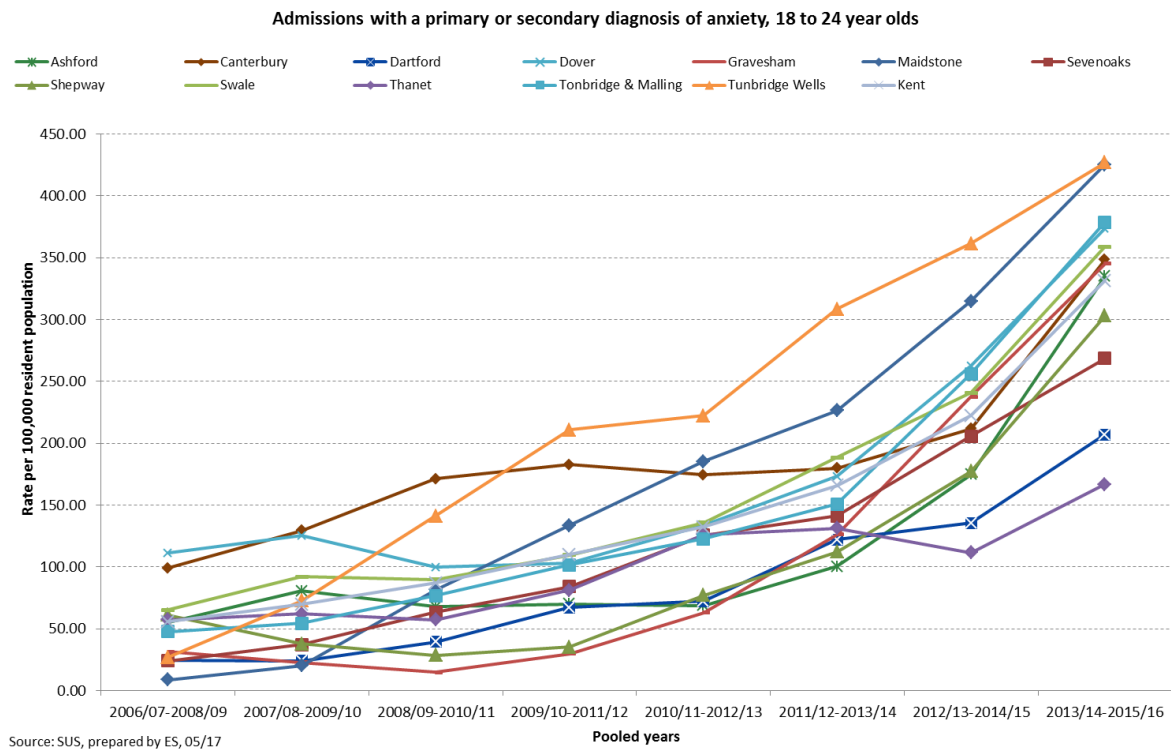
**Table 7 Admissions with a Primary or Secondary Diagnosis of Anxiety for 18 to 24s from 2006/07-15/16, Count**

CCG	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	12	18	14	17	20	29	49	92
Canterbury and Coastal CCG	79	98	119	132	136	154	192	318
Dartford, Gravesham and Swanley CCG	13	13	16	29	41	73	109	171
South Kent Coast CCG	35	34	31	33	54	68	104	155
Swale CCG	7	13	14	22	32	50	62	97
Thanet CCG	15	16	14	22	40	44	42	56
West Kent CCG	25	46	97	150	179	218	294	387
Kent	186	238	305	405	502	636	852	1276

**Figure 26 Admissions with a Primary or Secondary Diagnosis of Anxiety for 18 to 24s from 2013/14-15/16 pooled for Kent and by CCG**



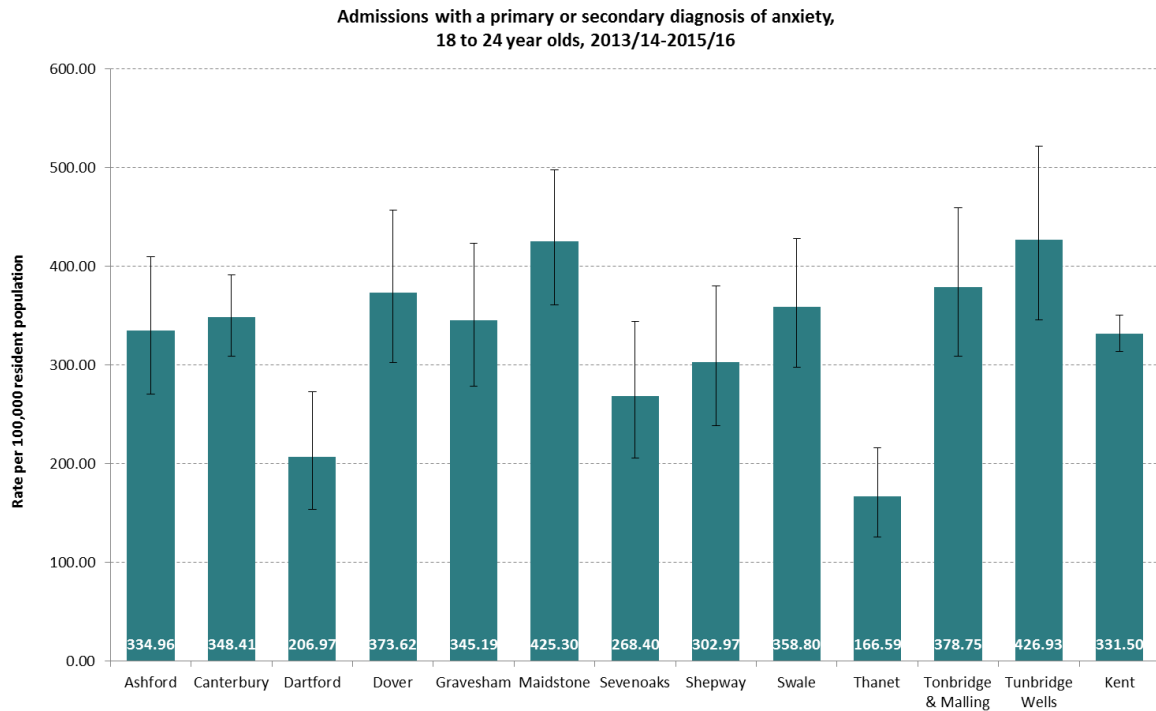
**Figure 27 Admissions with a Primary or Secondary Diagnosis of Anxiety for 18 to 24s from 2006/07-15/16 by District**



The admission rate with a primary or secondary anxiety diagnosis has increased from 55.7 per 100,000 resident population aged 18 to 24 years in 2006/07-2008/09 to 331.5 in 2013/14-2015/16. Maidstone and Tunbridge Wells have had higher rates than Kent in recent time periods, and continue to increase, and Maidstone (425.3) had a significantly higher rate than Kent in the most recent time period.

It is important to note that the Hospital admissions data is available from the Secondary Uses Service from 2006/07 onwards, and reliably from 2009/10 onwards for A&E attendances. Changes to the figures over time need to be interpreted in the context of improvements in data quality and coverage (particularly in earlier years), improvements in coverage of independent sector activity (particularly from 2006-07) and changes in NHS practice. For example, apparent increases in activity may be due to improved recording of diagnosis or procedure information

**Figure 28 Admissions with a Primary or Secondary Diagnosis of Anxiety for 18 to 24s from 2013/14-15/16 pooled for Kent and by District**

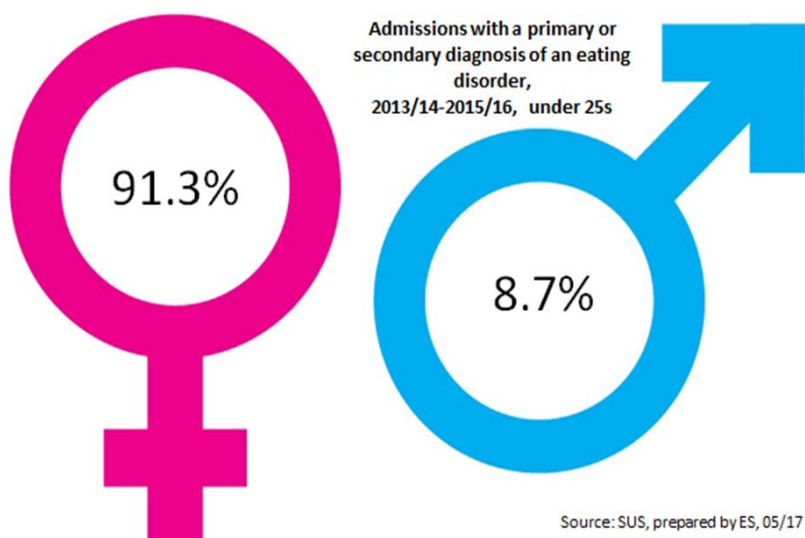


Source: SUS, prepared by ES, 05/17

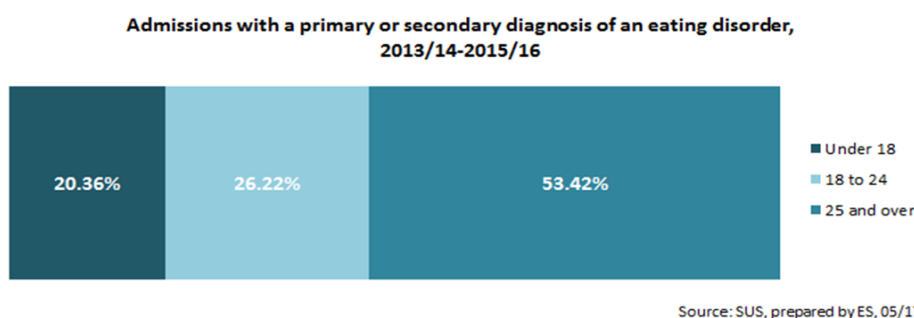
There were 331.5 hospital admissions per 100,000 resident 18 to 24 year olds in 2013/14-2015/16 with a primary or secondary anxiety diagnosis in Kent. This ranged from 166.7 in Thanet to 426.9 in Tunbridge Wells. Maidstone had a significantly higher than Kent (425.3; 95% confidence intervals).

## Eating Disorder

**Figure 29 Aggregated Admissions with a Primary or Secondary Diagnosis of a Eating Disorders for under 25's from 2006/07 to 2015/16 by Gender**



**Figure 30 Aggregated Admissions with a Primary or Secondary Diagnosis of a Eating Disorders by Age Band from 2006/07 to 2015/16**



Of the 286 admissions with a diagnosis of an eating disorder between 2013/14 and 2015/16, for individuals aged under 25, 261 (91.3%) were female.

People aged under 25 accounted for 46.6% of the 614 total admissions, with one in four admissions for an individual aged between 18 and 24 years.

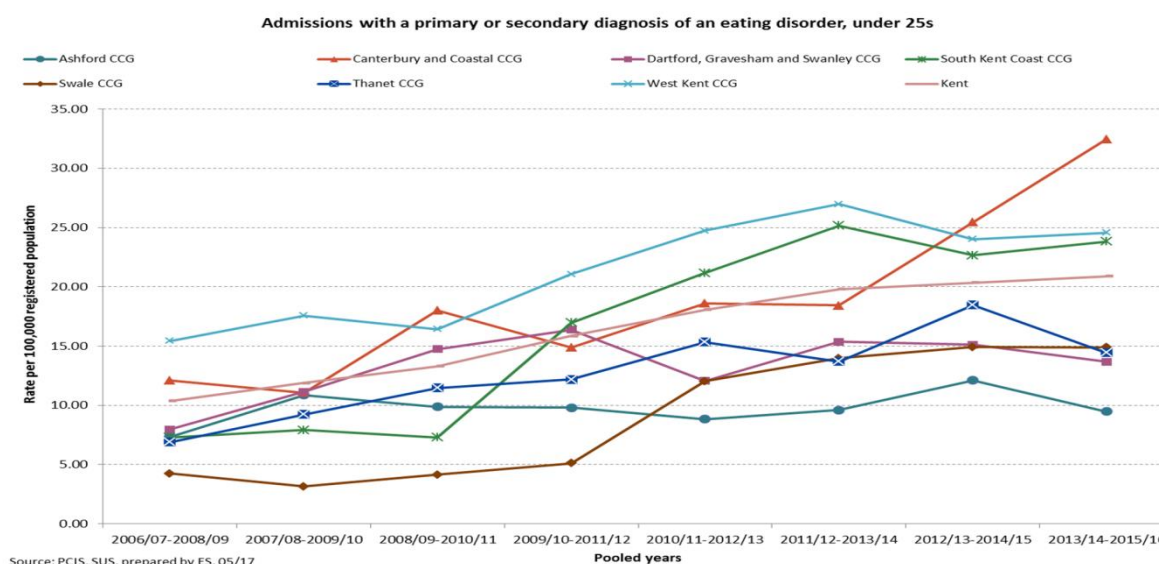
Length of stay ranges from 0 to 284 days, with a median of two days.

**Table 8 Percentage of Admissions for an Eating Disorder which were Elective compared to Emergency 2013/14 to 2015/16 pooled, under 25s**

Provider	Elective	Emergency via A&E	All emergency
EKHUFT	4.8	75.8	95.2
MTW	5.3	77.3	94.7
DVT	10.5	68.4	89.5
Medway	14.3	85.7	85.7
KMPT	86.4	0.0	13.6
Other	60.8	22.8	39.2
Total	33.6	49.7	66.4

For under 25s between 2013/14 and 2015/16 approximately two thirds of admissions for eating disorders were emergency admissions, with 50% of individuals admitted via A&E. Among non-Kent trusts, 61% were elective, and 86% were elective for KMPT.

**Figure 31 Percentage of Admissions for an Eating Disorder which were Elective compared to Emergency 2013/14 to 2015/16 pooled, under 25s**



Across Kent, the admission rate with a primary or secondary diagnosis of an eating disorder increased from 10.4 per 100,000 registered population in 2006/07-2008/09 to 19.8 in 2011/12-2013/14. Since then, it has remained relatively stable, increasing marginally to 20.9 in 2013/14-2015/16. Greater fluctuation is observed among the CCGs, due to smaller numbers of admissions; however, West Kent, South Kent Coast and Canterbury and Coastal CCGs have generally had higher admission rates than Kent over the past five-time periods.

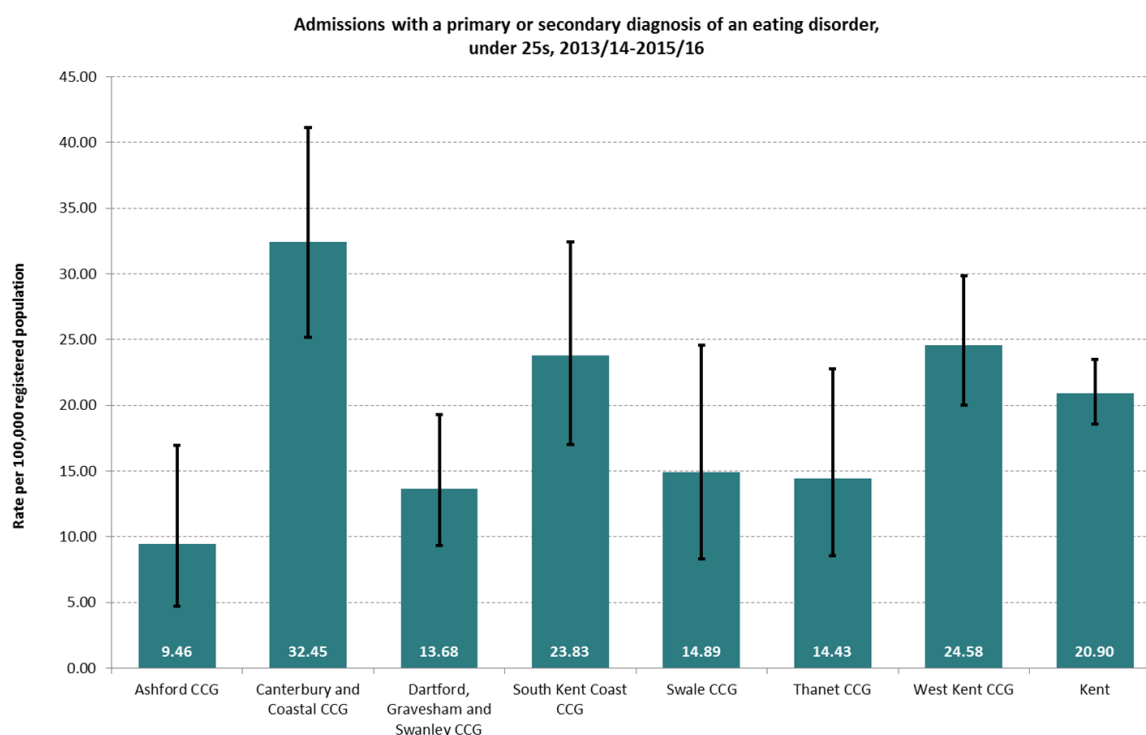
**Table 9 Under 25 Admissions with a Primary or Secondary Diagnosis of an Eating Disorder, Count**

CCG	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	8	12	*	11	10	11	14	11
Canterbury and Coastal CCG	24	22	36	30	38	38	53	68
Dartford, Gravesham and Swanley CCG	17	24	32	36	27	35	35	32
South Kent Coast CCG	12	13	12	28	35	42	38	40
Swale CCG	*	*	*	5	12	14	15	15
Thanet CCG	*	*	14	15	19	17	23	18
West Kent CCG	60	69	65	84	100	110	99	102
Kent	133	154	174	209	241	267	277	286

Source: SUS

\*Numbers under 5, or that may allow for identification are suppressed

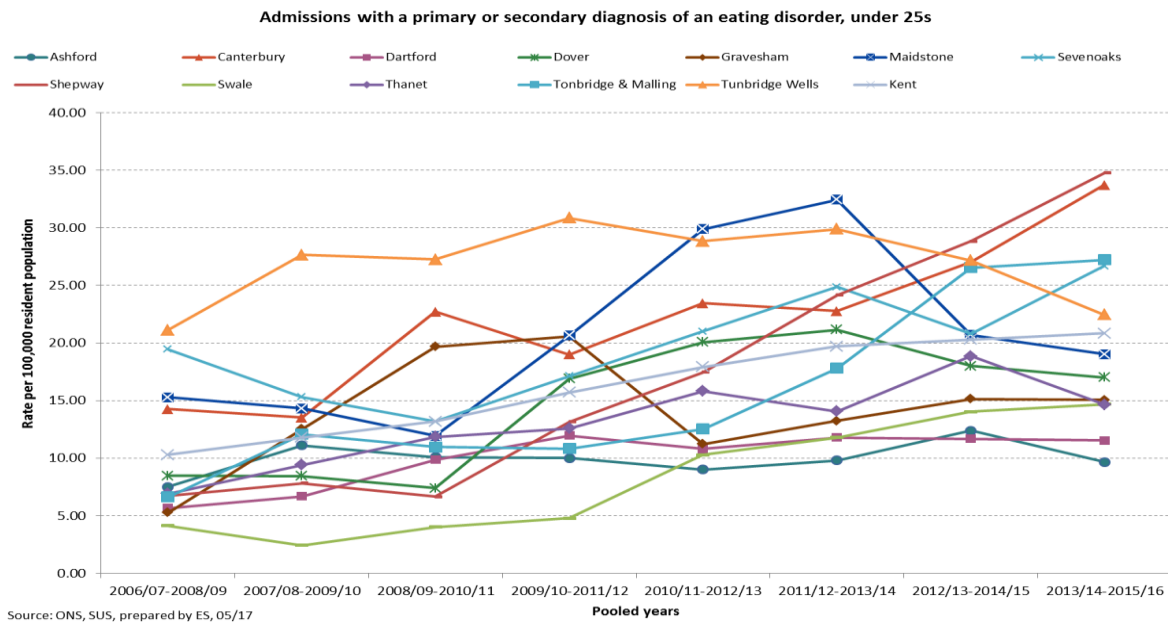
**Figure 32 Admissions for Primary or Secondary Eating Disorder 13/-14 -15/16 for Kent and by CCG :**



Source: PCIS, SUS, prepared by ES, 05/17

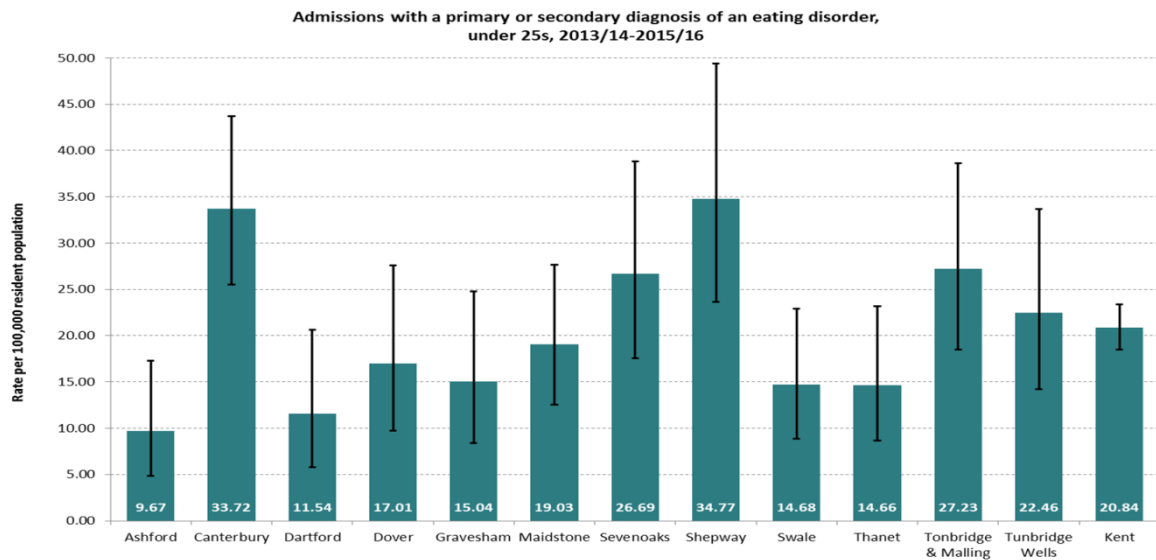
Based on pooled rates for hospital admissions with a primary or secondary diagnosis of an eating disorder, Ashford CCG (9.5) has a significantly lower rate than Kent (20.9), whilst Canterbury and Coastal CCG (32.5) has a significantly higher rate (95% confidence intervals).

Figure 33 Admissions for Primary or Secondary Eating Disorder 06/-07 -15/16 by CCG



Across Kent, the admission rate with a primary or secondary diagnosis of an eating disorder increased from 10.3 per 100,000 resident population in 2006/07-2008/09 to 19.7 in 2011/12-2013/14. Since then, it has remained relatively stable, increasing marginally to 20.8 in 2013/14-2015/16. Greater fluctuation is observed among the districts, due to smaller numbers of admissions. Shepway and Canterbury have rates which are higher than Kent and have been increasing steadily over the past three time periods. Tunbridge Wells and Maidstone had substantially higher rates in 2011/12-2013/14; however they have since decreased. The rate in Shepway has been increasing at a significantly faster rate than Kent (95% confidence intervals).

**Figure 34 Admissions for Primary or Secondary Eating Disorder 13/-14 -15/16 for Kent and by District**

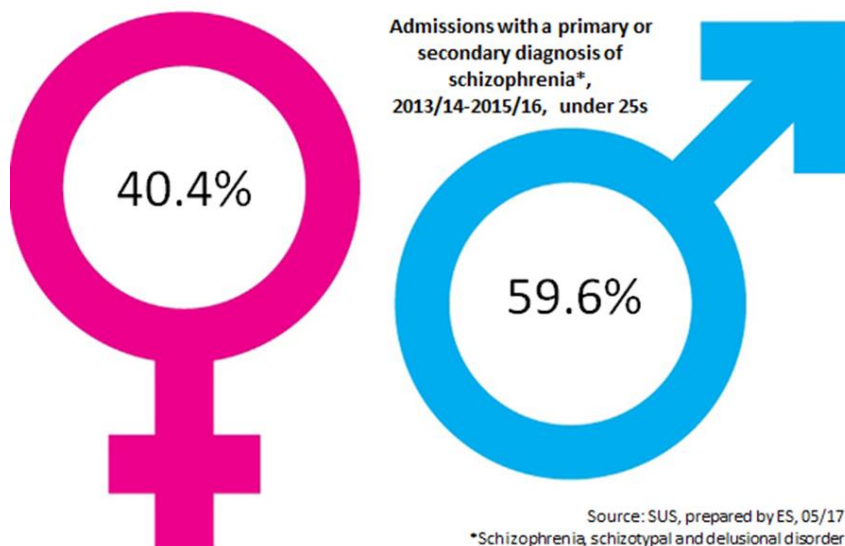


Source: ONS, SUS, prepared by ES, 05/17

The pooled rates for hospital admissions with a primary or secondary diagnosis of an eating disorder, vary substantially across districts, from 9.7 per 100,000 in Ashford to 34.8 in Shepway. Ashford, Canterbury and Shepway have significantly different rates to Kent (20.8, 95% confidence intervals).

## Schizophrenia

**Figure 35 Admissions with a Primary or Secondary Diagnosis of Schizophrenia for under 25s from 2013/14-15/16 by Gender**



**Figure 36 Admissions with a Primary or Secondary Diagnosis of Schizophrenia by age band from 2013/14-15/16**



**Admissions with a primary or secondary diagnosis of schizophrenia\*,  
2013/14-2015/16**



Source: SUS, prepared by ES, 05/17  
\*Schizophrenia, schizotypal and delusional disorder

Between 2013/14 and 2015/16, 40.4% hospital admissions with a primary or secondary diagnosis of schizophrenia were female, accounting for 153 admissions out of 379. For under 18s, the proportion of hospital admissions with a primary or secondary diagnosis of schizophrenia for females was higher, accounting for 68.1% of admissions (49 out of 72).

Less than 8% of hospital admissions were for people aged under 25.

Length of stay ranges from 0 to 510 days, with a median of one day.

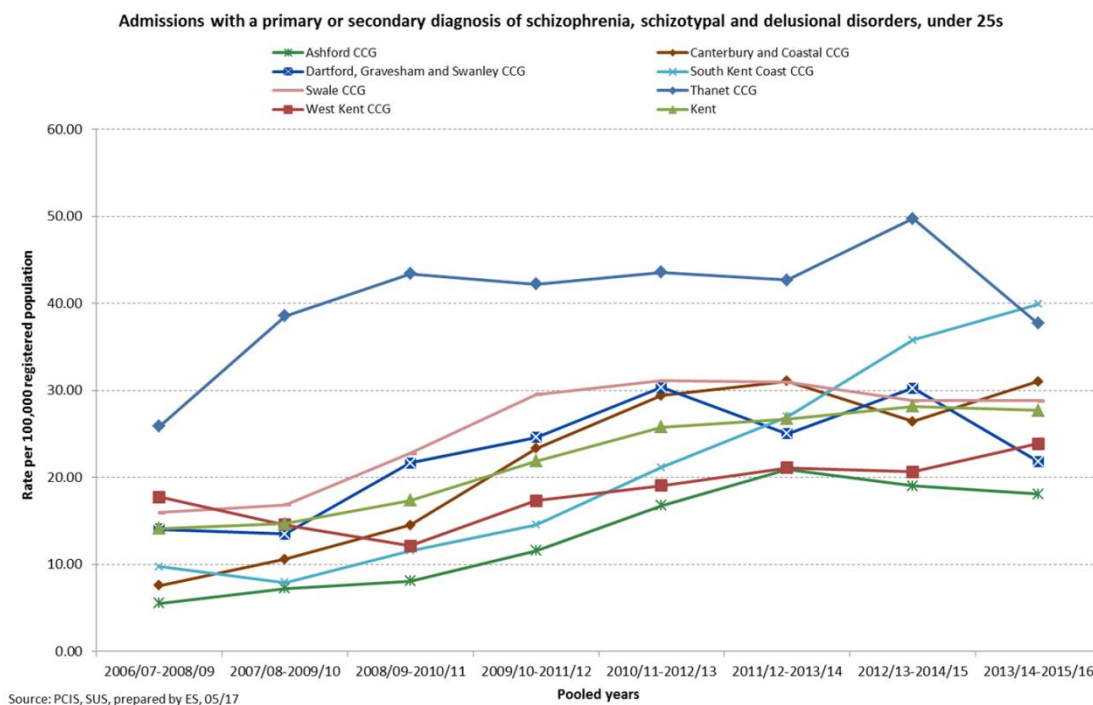
**Table 10 Percentage of Admissions for Schizophrenia\* which were Elective compared to Emergency 2013/14 to 2015/16 pooled for under 25s**

Provider	Elective	Emergency via A&E	All emergency
EKHUFT	4.8	90.3	93.5
MTW	1.6	88.9	92.1
DVT	0.0	89.7	89.7
Medway	8.3	75.0	83.3
KMPT	51.0	0.0	43.0
Other	33.3	33.3	64.7
Total	20.1	58.0	75.5

\*Schizophrenia, schizotypal and delusional disorders

Three quarters of admissions with a primary or secondary diagnosis of schizophrenia were emergencies, accounting for 76% of admissions for under 25s between 2013/14 and 2015/16. KMPT had the highest proportion of elective admissions, accounting for 51% of admissions

**Figure 37 Admissions with a Primary or Secondary Diagnosis of Schizophrenia Schizotypal and Delusional Disorders for under 25s from 2006/7-2013/16 by CCG**



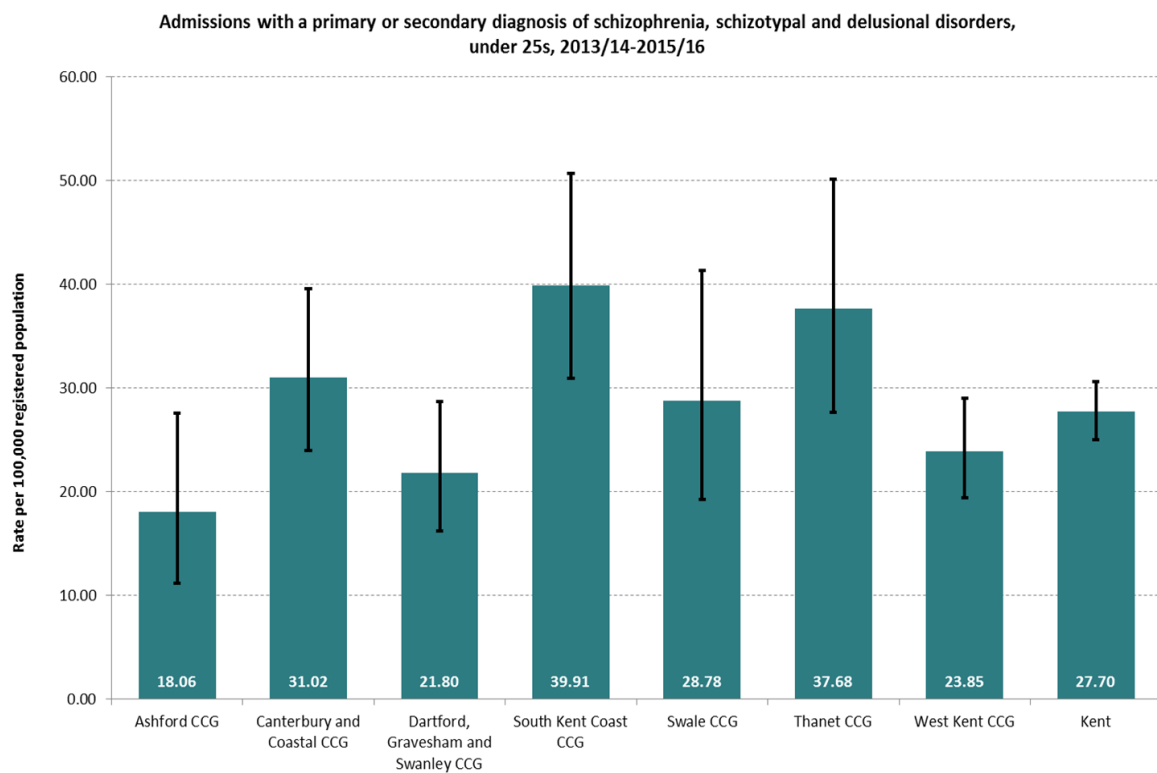
For under 25s, the hospital admission rate with a primary or secondary diagnosis of schizophrenia has increased consistently, from 14.1 to 27.7 admissions per 100,000 registered population between 2006/07-2008/09 and 2013/14-2015/16. The admission rate in Thanet CCG has been consistently higher than Kent, and the rate in South Kent Coast has increased at a significantly faster rate than observed across Kent (95% confidence intervals).

**Table 11 Admissions with a Primary or Secondary Diagnosis of a Schizophrenia, Schizotypal and Delusional disorder Count, under 25s**

CCG	2006/07- 2008/09	2007/08- 2009/10	2008/09- 2010/11	2009/10- 2011/12	2010/11- 2012/13	2011/12- 2013/14	2012/13- 2014/15	2013/14- 2015/16
Ashford CCG	6	8	9	13	19	24	22	21
Canterbury and Coastal CCG	15	21	29	47	60	64	55	65
Dartford, Gravesham and Swanley CCG	30	29	47	54	68	57	70	51
South Kent Coast CCG	16	13	19	24	35	45	60	67
Swale CCG	15	16	22	29	31	31	29	29
Thanet CCG	30	46	53	52	54	53	62	47
West Kent CCG	69	57	48	69	77	86	85	99
Kent	181	190	227	288	344	360	383	379

Source: SUS

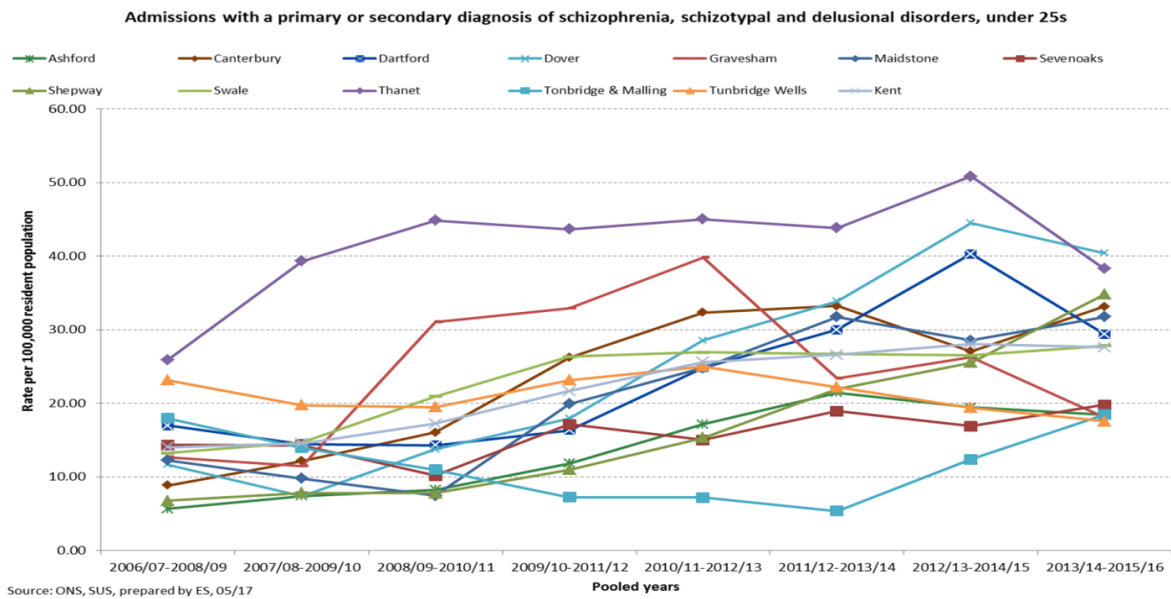
**Figure 38 Admissions with a Primary or Secondary Diagnosis of a Schizophrenia, Schizotypal and Delusional Disorder for under 25 years old from 13/14-15/16 pooled for Kent and by CCG**



Source: PCIS, SUS, prepared by ES, 05/17

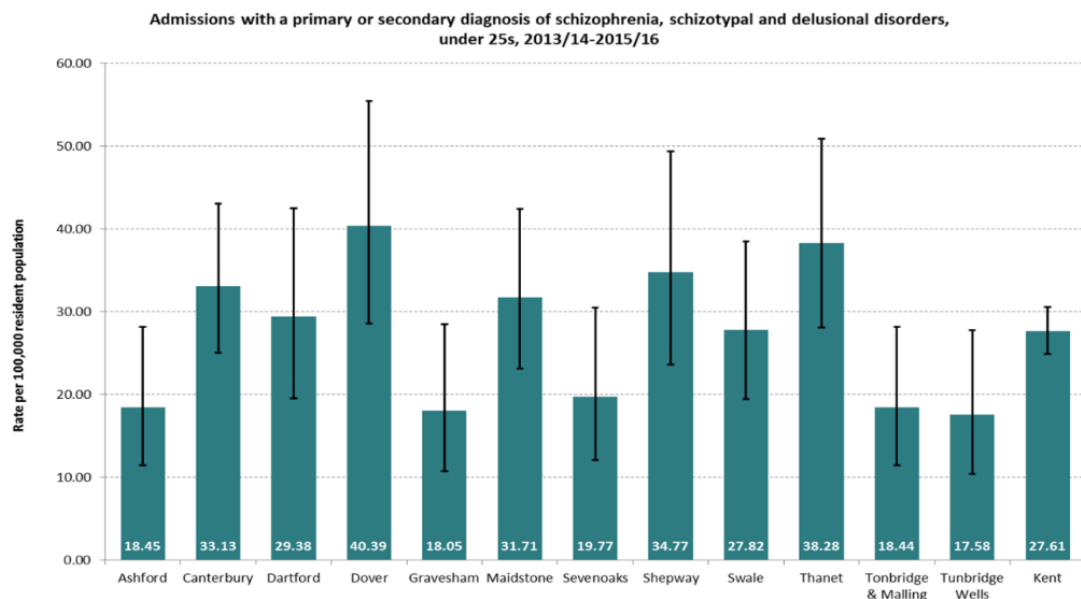
Across Kent, there were 27.7 hospital admissions with a primary or secondary diagnosis of schizophrenia per 100,000 registered population, ranging from 18.1 in Ashford CCG to 39.9 in South Kent Coast CCG. South Kent Coast had a significantly higher hospital admission rate than Kent.

**Figure 39 Admissions with a Primary or Secondary Diagnosis of Schizophrenia Schizotypal and Delusional Disorders for under 25s from 2006/07-15/16 by District**



For under 25s, the hospital admission rate with a primary or secondary diagnosis of schizophrenia has increased consistently, from 14.0 to 27.6 admissions per 100,000 registered population between 2006/07-2008/09 and 2013/14-2015/16. The admission rate in Thanet has been routinely higher than Kent, and the rates in Dover and Shepway have increased consistently to rates above that of Kent.

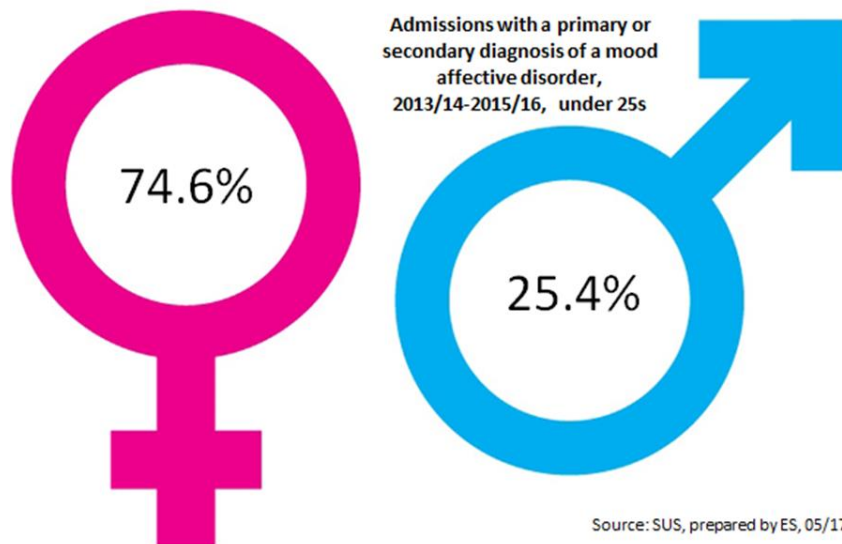
**Figure 40 Admissions with a Primary or Secondary Diagnosis of a Schizophrenia, Schizotypal and Delusional Disorder for under 25 s from 2013/14-15/16 pooled for Kent and by CCG**



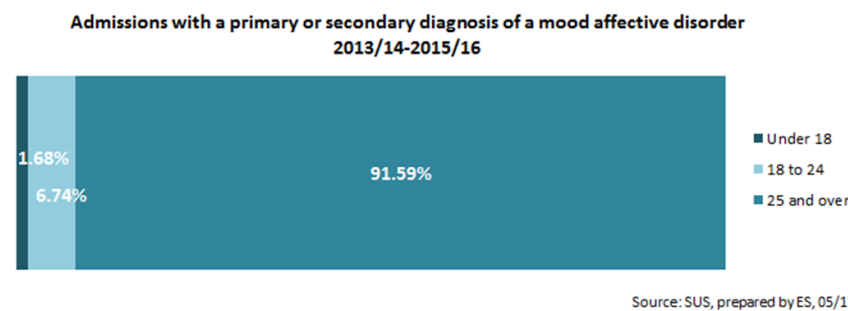
Across Kent, there were 27.6 hospital admissions with a primary or secondary diagnosis of schizophrenia per 100,000 resident population, ranging from 18.1 in Gravesham to 40.4 in Dover. None of the districts have a rate that is significantly different to that of Kent.

### Mood Affective Disorder

**Figure 41 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for under 25s from 2013/14-15/16 pooled by Gender**



**Figure 42 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder by age band from 2013/14-15/16 pooled**



Between 2013/14 and 2015/16, 74.6% hospital admissions with a primary or secondary diagnosis of a mood affective disorder were female, accounting for 2,097 admissions out of 2,810 among under 25s.

Just over 8% of hospital admissions were for people aged under 25.

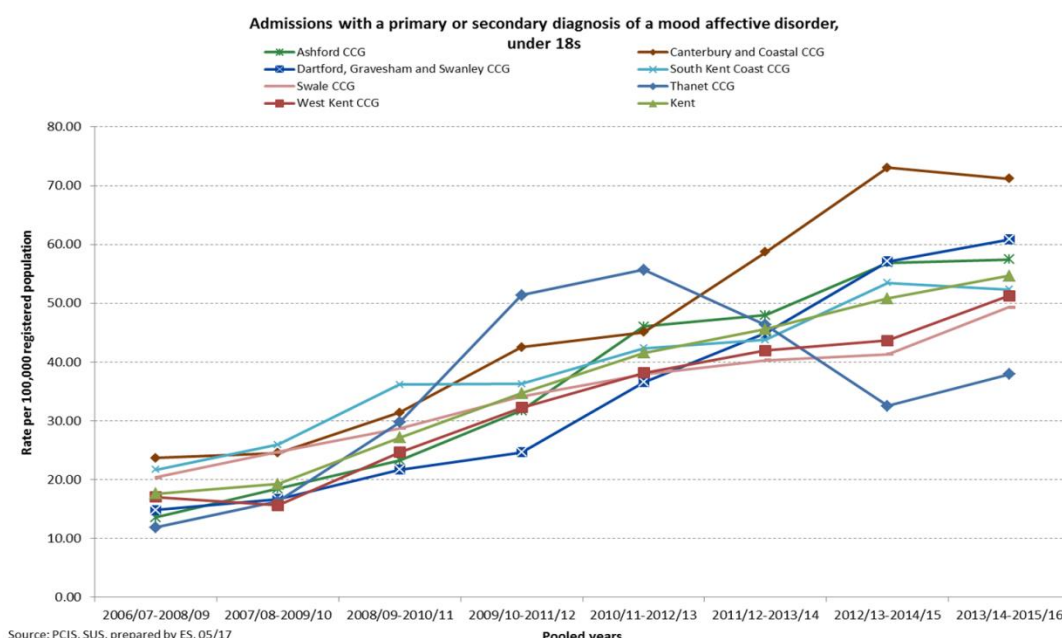
Length of stay ranges from 0 to 273 days, with a median of 1 day.

**Table 12 Percentage of Admissions with a Primary or Secondary Diagnosis of a Mood Affective Disorder which were Elective compared to Emergency 2013/14 to 2015/16 pooled, under 25s**

Provider	Elective	Emergency via A&E	All emergency
EKHUFT	6.4	84.8	89.0
MTW	7.2	76.7	79.5
DVT	6.0	62.7	64.1
Medway	10.2	58.8	74.9
KMPT	41.7	0.0	53.9
Other	48.4	31.4	46.3
Total	14.4	67.1	75.0

Three quarters of admissions with a primary or secondary diagnosis of mood affective disorders were an emergency, accounting for 75% of admissions for under 25s between 2013/14 and 2015/16. Non-Kent Trusts had the highest proportion of elective admissions, accounting for 48% of admissions, followed by KMPT (42%).

**Figure 43 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for under 18s from 2006/07-15/16 by District**



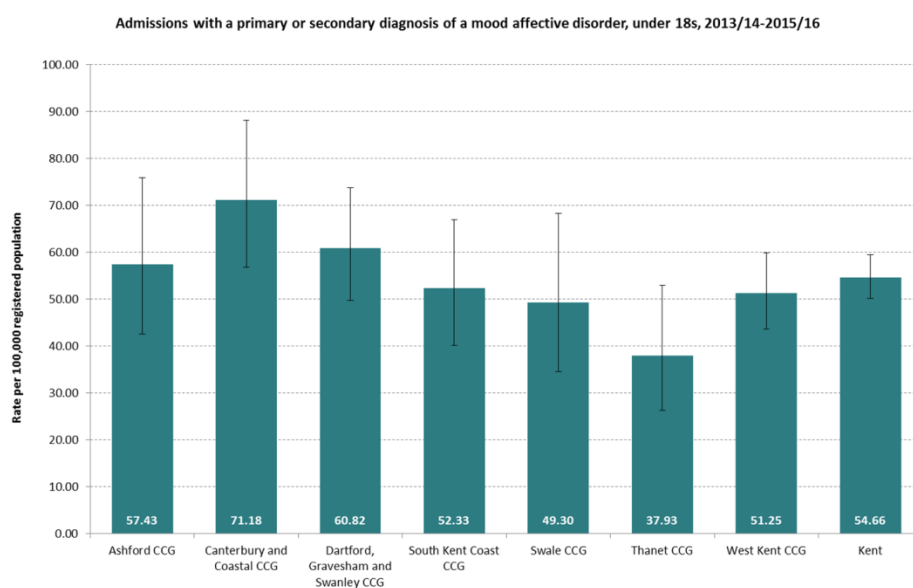
For under 18s, the hospital admission rate with a primary or secondary diagnosis of mood affective disorder has increased consistently, from 17.6 to 54.7 admissions per 100,000 registered population between 2006/07-2008/09 and 2013/14-2015/16. Ashford, Dartford, Gravesham and Swanley and Canterbury and Coastal CCGs have had consistently higher

rates for the past three-time periods. The rate in Thanet CCG has fluctuated and despite having the highest rate of all Kent CCGs in 2009/10-2011/12 had the lowest rates within the last two-time periods.

**Table 13 Admissions with a Primary or Secondary Diagnosis of a Mood Affective Disorder Count for Under 18s from 2006/7-15/16 for Kent and By CCG**

CCG	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	11	15	19	26	38	40	48	49
Canterbury and Coastal CCG	28	29	37	50	53	69	86	84
Dartford, Gravesham and Swanley CCG	23	26	34	39	59	74	96	104
South Kent Coast CCG	26	31	43	43	50	52	64	63
Swale CCG	14	17	20	24	27	29	30	36
Thanet CCG	10	14	26	45	49	41	29	34
West Kent CCG	50	46	73	96	115	128	135	160
Kent	162	178	252	323	391	433	488	530

**Figure 44 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for Under 18s from 2013/14-15/16 pooled for Kent and by CCG**

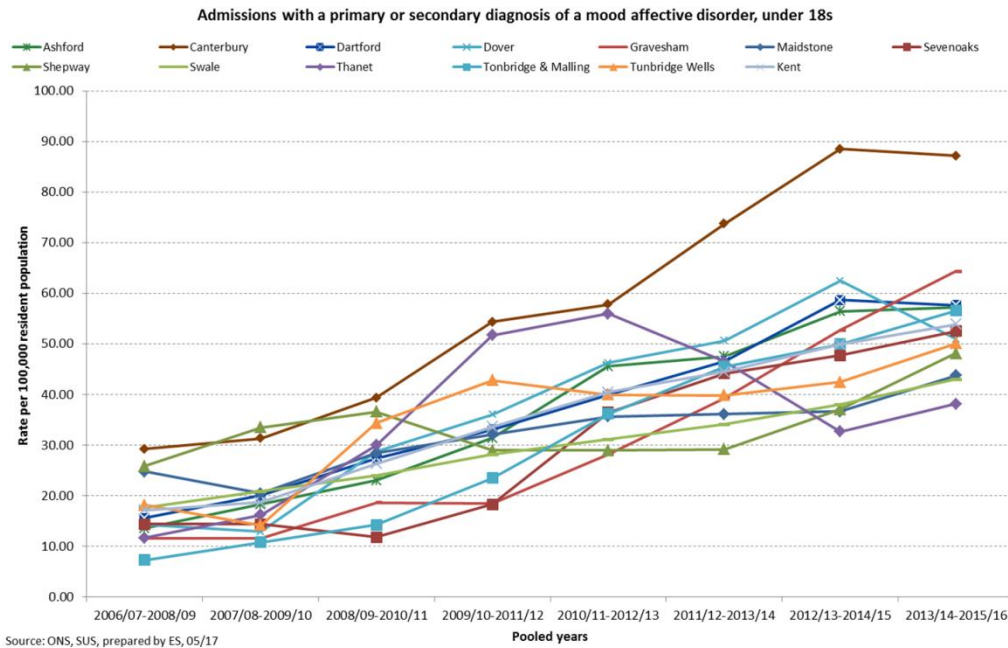


Source: PCIS, SUS, prepared by ES, 05/17

Across Kent, there were 54.7 hospital admissions with a primary or secondary diagnosis of mood affective disorder per 100,000 registered population aged under 18, ranging from 37.9 in Thanet CCG to 71.2 in Canterbury and Coastal CCG. None of the CCGs had a significantly different hospital admission rate than Kent.

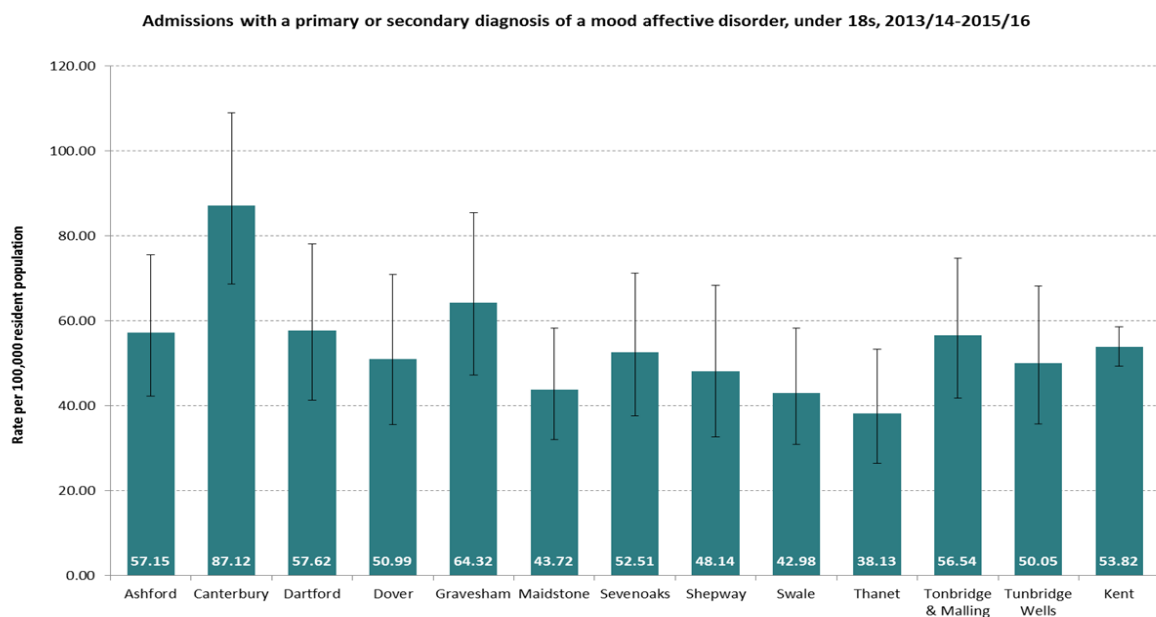


**Figure 45 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for under 18s from 2006/07-15/16 by District**



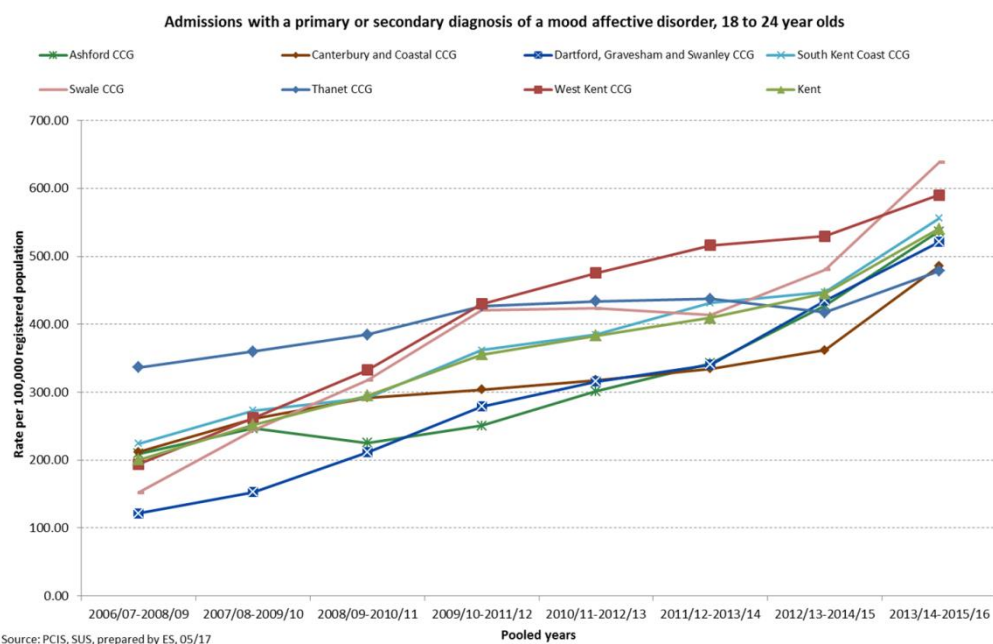
For under 18s, the hospital admission rate with a primary or secondary diagnosis of mood affective disorder has increased consistently, from 17.1 to 53.8 admissions per 100,000 resident population between 2006/07-2008/09 and 2013/14-2015/16. Canterbury has had a consistently higher rate than Kent, and has increased at a significantly faster rate than Kent, along with Tonbridge and Malling.

**Figure 46 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for under 25s from 2013/14-15/16 pooled by District**



Across Kent, there were 53.8 hospital admissions with a primary or secondary diagnosis of mood affective disorder per 100,000 resident population aged under 18, ranging from 38.1 in Thanet to 87.1 in Canterbury. Canterbury had a significantly higher hospital admission rate than Kent.

**Figure 47 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for 18- 24s from 2006/07-15/16 by CCG**

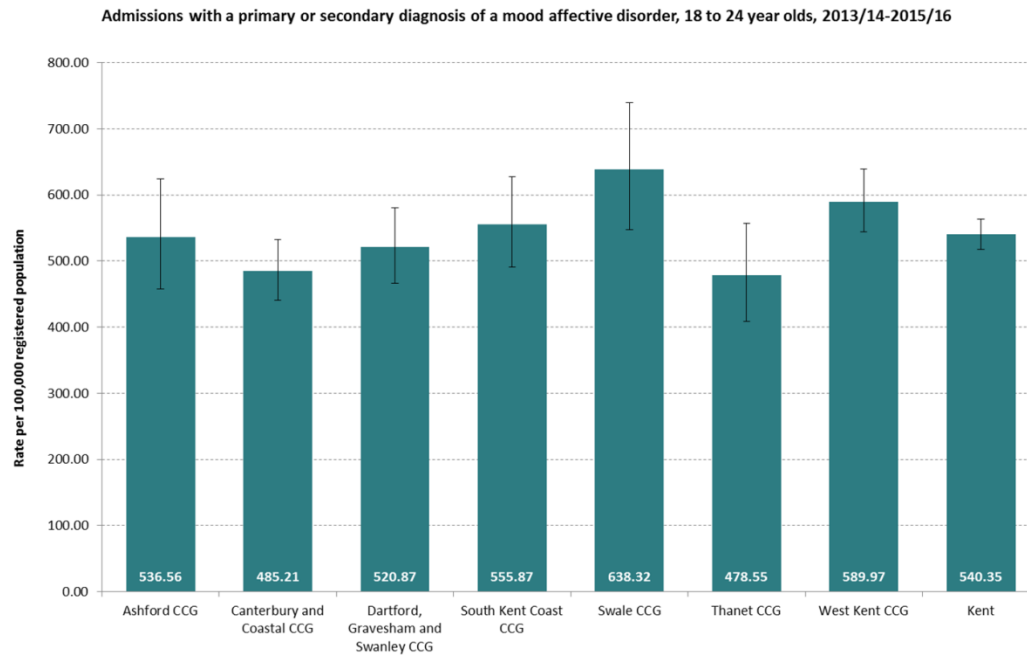


For people aged 18 to 24 years, the hospital admission rate with a primary or secondary diagnosis of mood affective disorder has increased consistently, from 200.6 to 540.4 admissions per 100,000 registered population between 2006/07-2008/09 and 2013/14-2015/16. South Kent Coast, Swale and West Kent CCGs have had consistently higher rates than Kent, and have continually increased.

**Table 14 Admissions with a Primary or Secondary Diagnosis of a Mood Affective Disorder for 18 to 24s , Count**

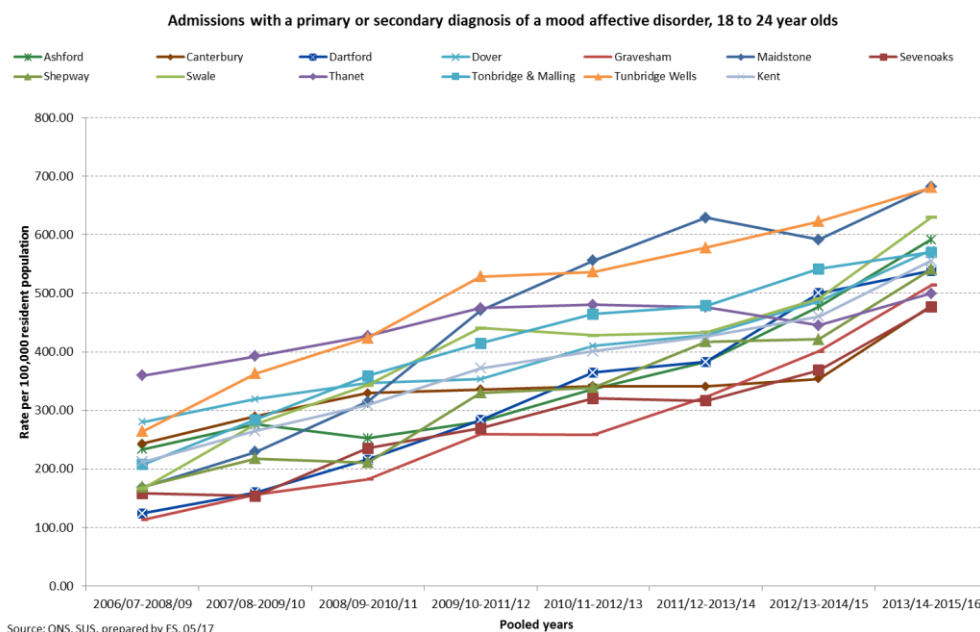
CCG	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	59	72	67	76	93	107	134	166
Canterbury and Coastal CCG	169	210	239	255	275	296	327	444
Dartford, Gravesham and Swanley CCG	71	91	128	172	198	215	275	328
South Kent Coast CCG	100	123	133	168	182	207	215	264
Swale CCG	39	64	86	117	120	117	135	177
Thanet CCG	107	120	134	152	156	156	148	168
West Kent CCG	185	256	331	434	487	530	546	607
Kent	730	936	1118	1374	1511	1628	1780	2154

**Figure 48 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for 18-24s from 2013/14-15/16 pooled for Kent and by CCG**



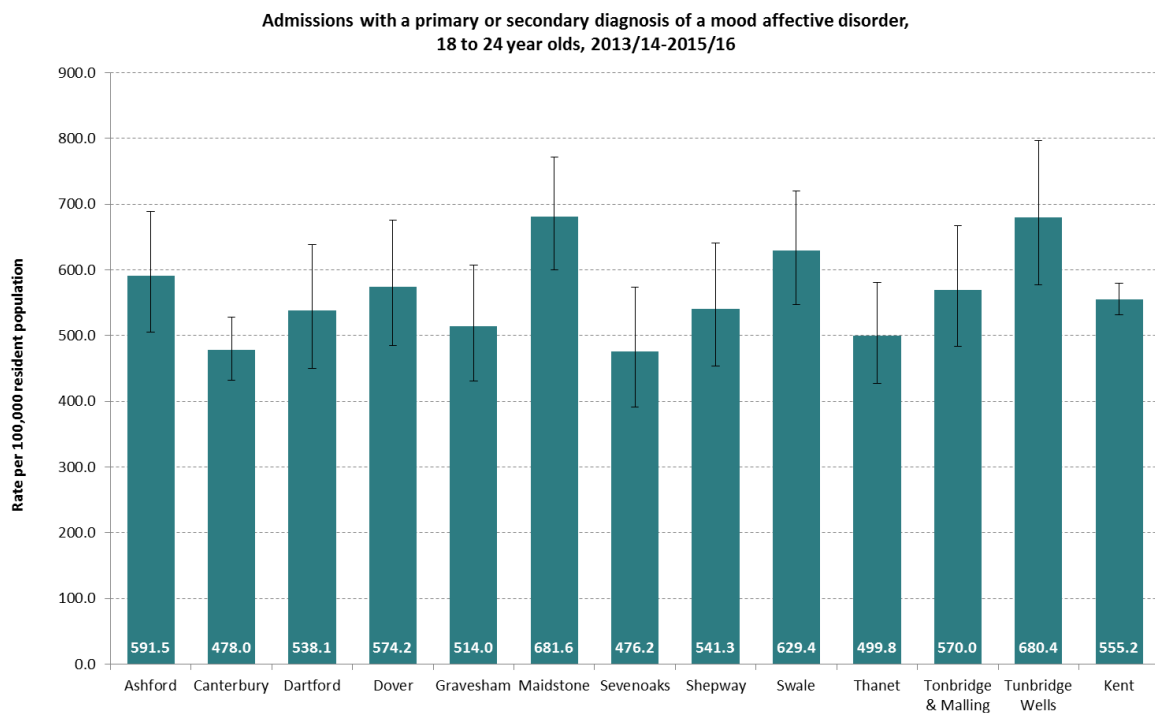
Across Kent, there were 540.4 hospital admissions with a primary or secondary diagnosis of mood affective disorder per 100,000 registered population aged 18 to 24 years, ranging from 478.6 in Thanet CCG to 638.3 in Swale CCG. None of the CCGs had a significantly different hospital admission rate than Kent.

**Figure 49 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for 18-24s from 2006/7-15/16 by District**



For people aged 18 to 24 years, the hospital admission rate with a primary or secondary diagnosis of mood affective disorder has increased consistently, from 211.8 to 555.3 admissions per 100,000 resident population between 2006/07-2008/09 and 2013/14-2015/16. Tunbridge Wells and Maidstone districts have had a consistently higher rate than Kent, and continue to increase.

**Figure 50 Admissions with a Primary or Secondary Diagnosis of Mood Affective Disorder for 18-24s from 2006/7-15/16 pooled for Kent and by District**

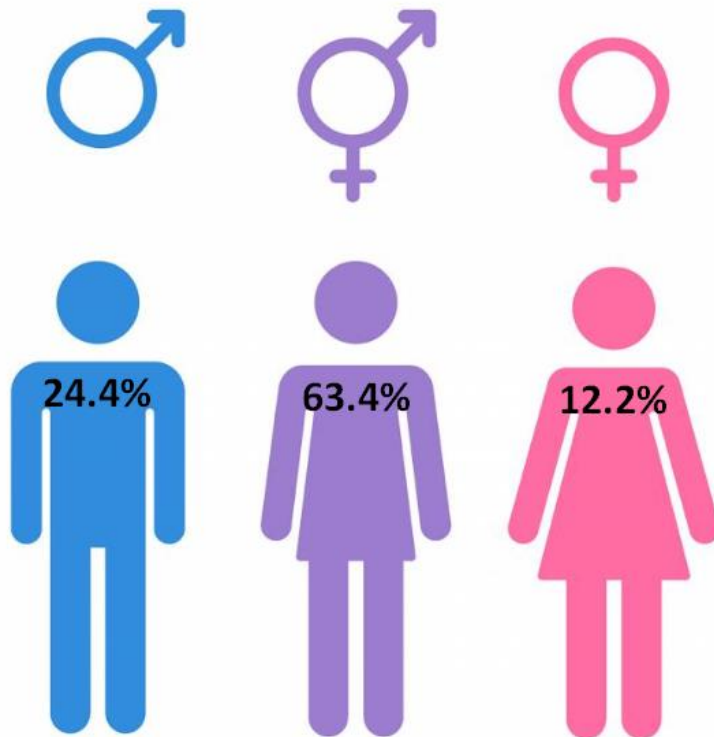


Source: ONS, SUS, prepared by ES, 05/17

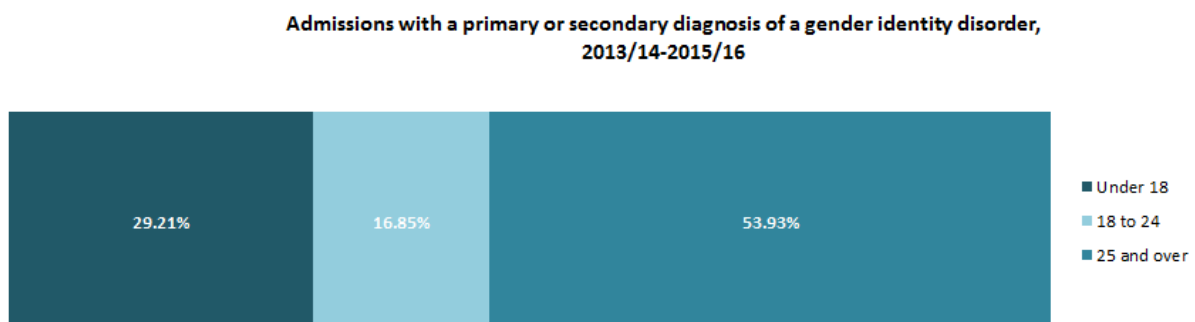
Across Kent, there were 555.3 hospital admissions with a primary or secondary diagnosis of mood affective disorder per 100,000 resident population aged between 18 and 24 years, ranging from 476.2 in Sevenoaks to 681.6 in Maidstone. Maidstone had a significantly higher hospital admission rate than Kent, while Canterbury's rate was significantly lower.

## Gender Identify Disorder

**Figure 51 Admissions with a Primary or Secondary Diagnosis of a Gender Identity Disorder for under 25s from 2013/14-2015/16 pooled by gender**



**Figure 52 Admissions with a Primary or Secondary Diagnosis of a Gender Identity Disorder by age band from 2013/14-2015/16 pooled**



Source: SUS, prepared by ES (06/17)

Between 2013/14 and 2015/16, there were 41 admissions for people aged under 25, with a primary or secondary diagnosis of a gender identity disorder across Kent. Of these, five (12.2%) were for women, 10 for males (24.4%), and nearly two-thirds were classified as a 'not specified' gender.

Of the 89 admissions for people of all ages, 26 (29.2%) were for under 18s, 15 (16.9%) for 18 to 24 year olds and 48 (53.9%) for people aged 25 and over. Due to such small numbers, it is not possible to conduct analysis at a geoFigureical level lower than Kent.

## Personality Disorder

Figure 53 Admissions with a Primary or Secondary Diagnosis of a Personality Disorder for under 25s from 2013/14-2015/16 pooled by gender

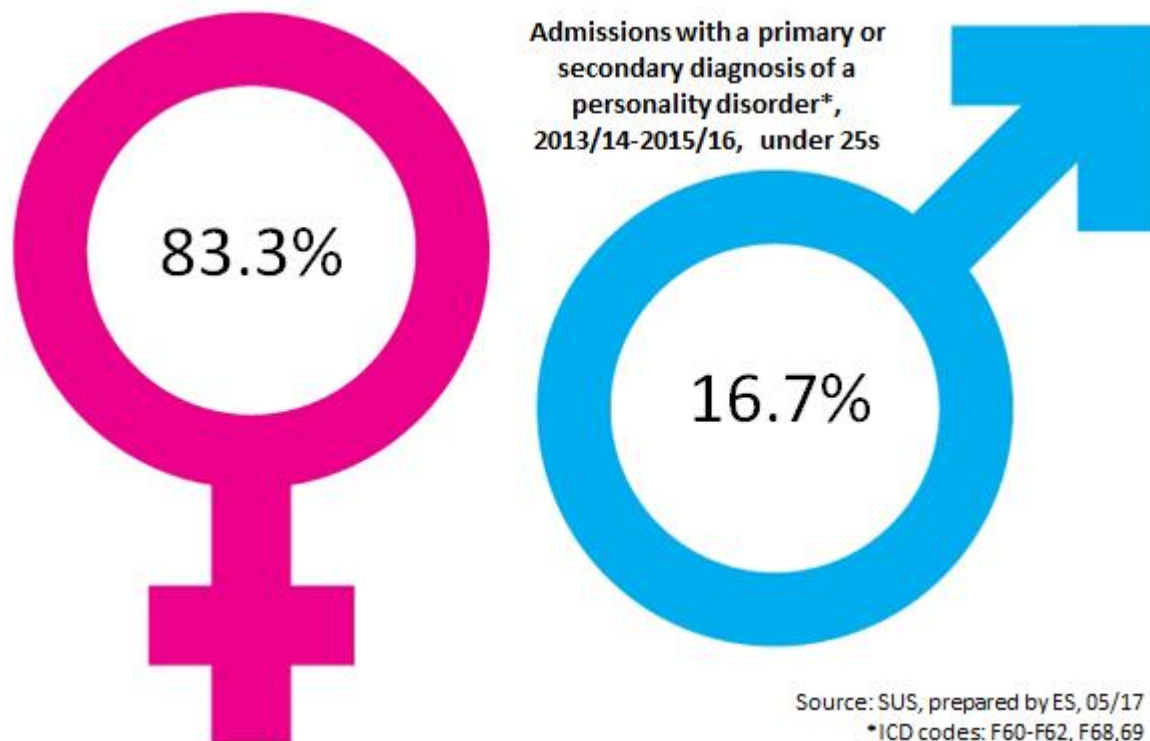
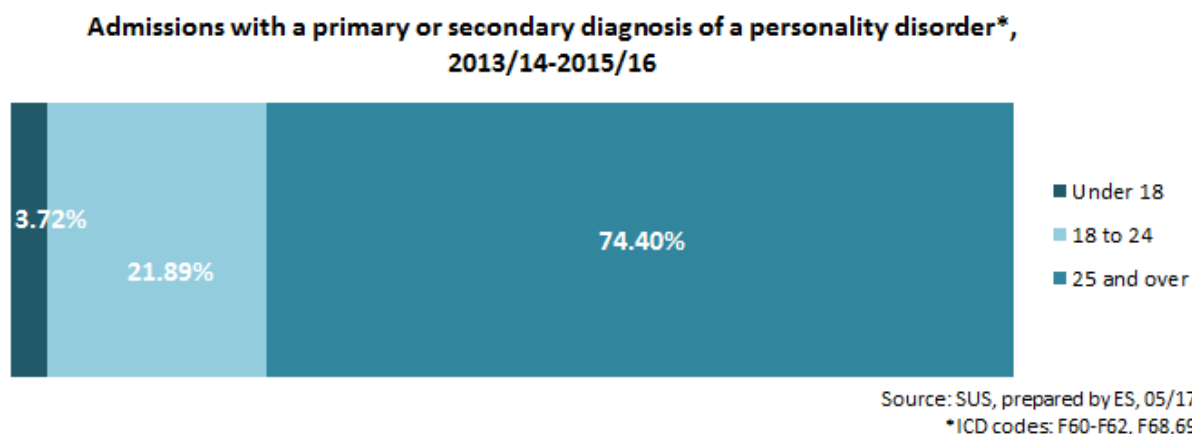


Figure 54 Admissions with a Primary or Secondary Diagnosis of a Personality Disorder by age band from 2013/14-2015/16 pooled



Between 2013/14 and 2015/16, 83.3% hospital admissions with a primary or secondary diagnosis of a personality disorder were female, accounting for 654 admissions out of 785 among under 25s with a valid gender code.

Just under a quarter of hospital admissions were for people aged under 25, with one in five aged 18 to 24. Length of stay ranges from 0 to 1,068 days, with a median of two days.

**Table 15 Percentage of Admissions with a Primary or Secondary Diagnosis of a Personality Disorder which were Elective compared to Emergency for under 25s from 2013/14 to 2015/16 pooled**

Provider	Elective	Emergency via A&E	All emergency
EKHUFT	4.6	90.8	92.9
MTW	3.0	84.4	85.2
DVT	1.5	84.6	86.2
Medway	3.6	50.0	82.1
KMPT	36.9	0.0	59.4
Other	31.7	26.7	65.3
Total	16.4	54.4	77.8

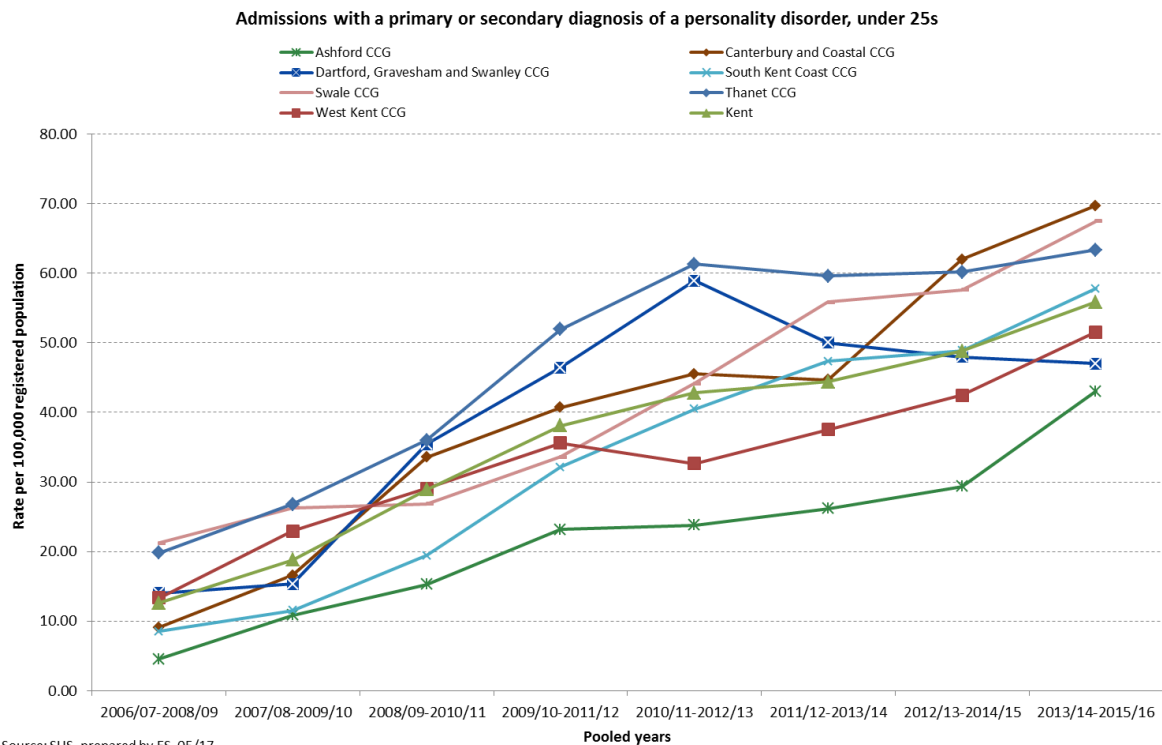
Source: SUS

Three quarters of admissions with a primary or secondary diagnosis of a personality disorders were an emergency, accounting for 78% of admissions for under 25s between 2013/14 and 2015/16. In KMPT and the Non-Kent Trusts approximately a third of admissions are elective.

**Table 16 Admissions with a Primary or Secondary Diagnosis of a Personality Disorder Count for under 25s from 2006/7-15/16**

CCG	2006/07- 2008/09	2007/08- 2009/10	2008/09- 2010/11	2009/10- 2011/12	2010/11- 2012/13	2011/12- 2013/14	2012/13- 2014/15	2013/14- 2015/16
Ashford CCG	5	12	17	26	27	30	34	50
Canterbury and Coastal CCG	18	33	67	82	93	92	129	146
Dartford, Gravesham and Swanley CCG	30	33	77	102	132	114	111	110
South Kent Coast CCG	14	19	32	53	67	79	82	97
Swale CCG	20	25	26	33	44	56	58	68
Thanet CCG	23	32	44	64	76	74	75	79
West Kent CCG	52	90	115	142	132	153	175	214
Kent	162	244	378	502	571	598	664	764

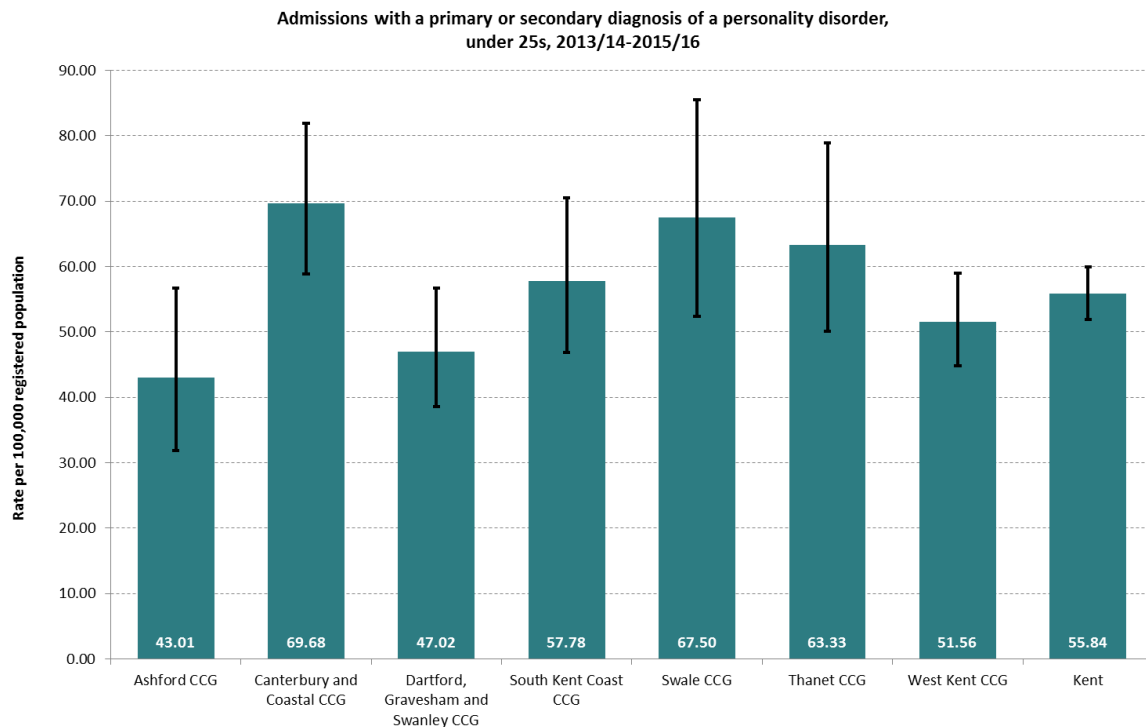
**Figure 55 Admissions with a Primary or Secondary Diagnosis of a Personality Disorder Count for under 25s from 2006/7-15/16 by CCG**



Across Kent, the hospital admission rate for admissions with a primary or secondary diagnosis of a personality disorder has increased steadily from 12.6 per 100,000 registered population aged under 25 in 2006/07-2008/09 to 48.8 in 2013/14-2015/16. Swale, Canterbury and Coastal and Thanet CCGs have had admission rates which have been increasing are higher than Kent in most recent time periods. While the admission rate in Dartford, Gravesham and Swanley CCG has been high, peaking at 58.9 in 2010/11-2012/13, the rate has since decreased, and was lower than Kent in 2013/14-2015/16.



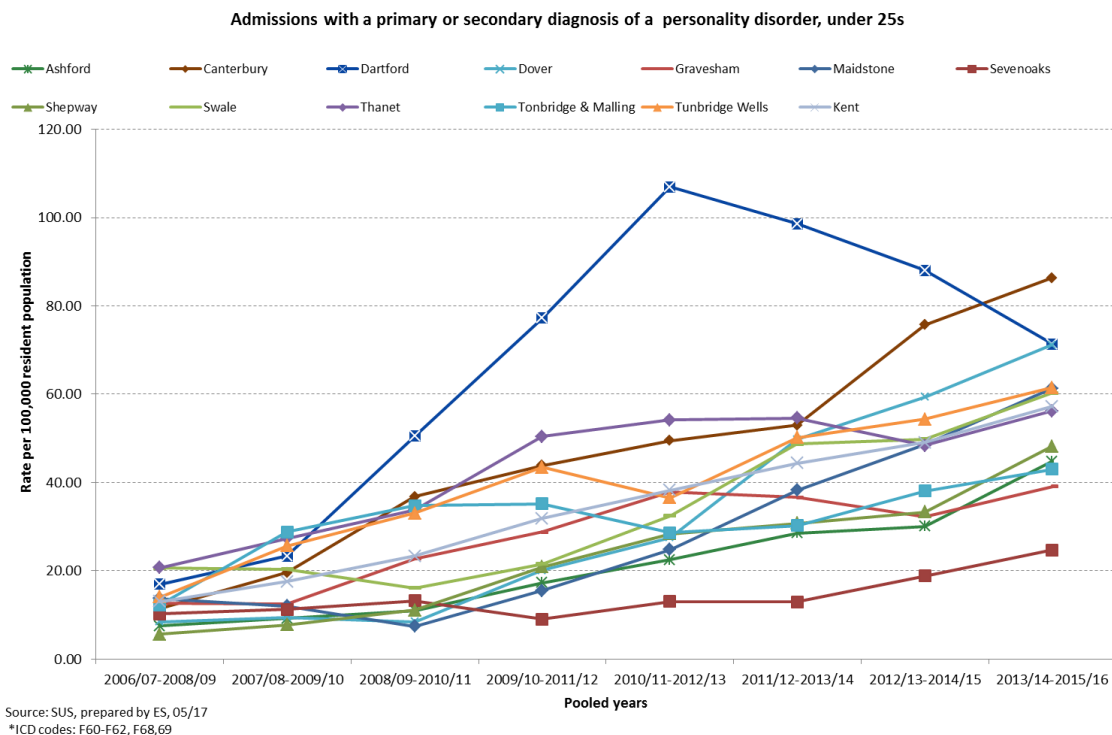
**Figure 56 Admissions with a Primary or Secondary Diagnosis of a Personality Disorder  
Count for under 25s from 2006/7-15/16 pooled for Kent and by CCG**



Source: SUS, prepared by ES, 05/17  
\*ICD codes: F60-F62, F68,69

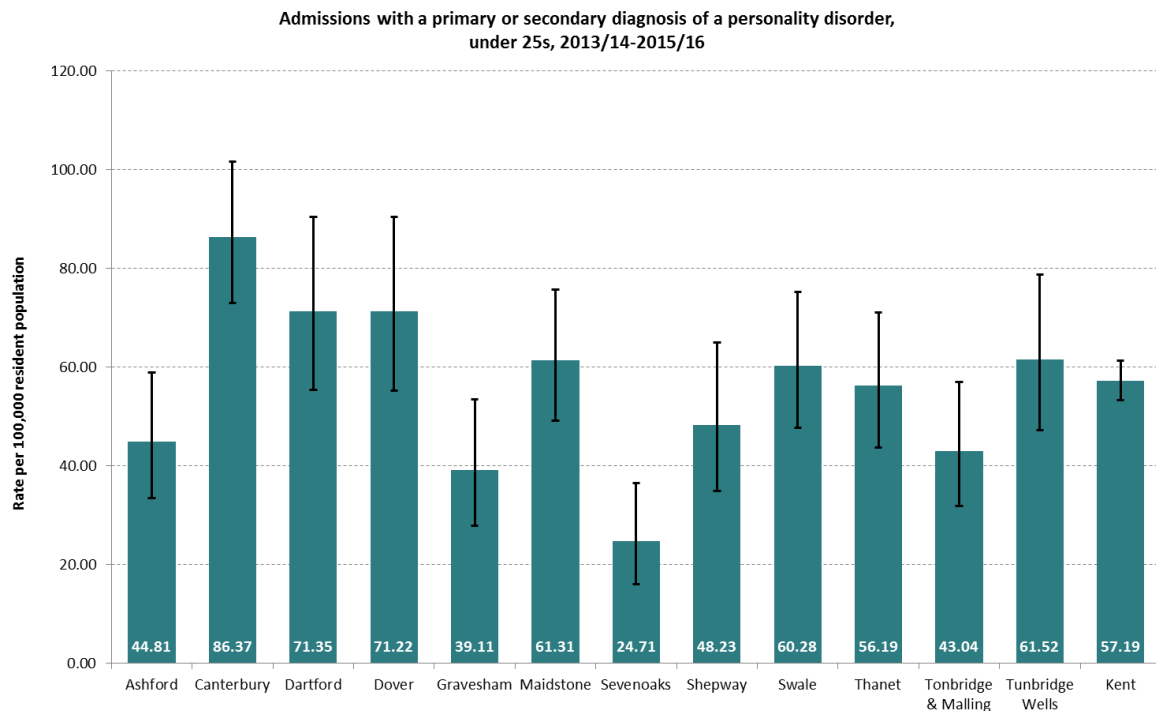
In 2013/14-2015/16, the rate of admissions with a primary or secondary diagnosis of a personality disorder was 55.8 per 100,000 registered population aged under 25. This ranged from 43.0 in Ashford CCG to 69.7 in Canterbury and Coastal CCG. None of the CCGs had a rate that was significantly different to that of Kent.

**Figure 57 Admissions with a Primary or Secondary Diagnosis of a Personality Disorder Count for under 25s from 2006/7-15/16 by District**



Across Kent, the hospital admission rate for admissions with a primary or secondary diagnosis of a personality disorder has increased steadily from 13.1 per 100,000 resident population aged under 25 in 2006/07-2008/09 to 57.2 in 2013/14-2015/16. Canterbury, Swale, Tunbridge Wells, Dover and Maidstone have had admission rates which have been increasing and were higher than Kent in most recent time periods. While the admission rate in Dartford has been high, peaking at 107.0 in 2010/11-2012/13, the rate has since decreased; however, is still above Kent.

**Figure 58 Admissions with a Primary or Secondary Diagnosis of a Personality Disorder  
Count for under 25s from 2013/14-15/16 pooled for Kent and by District**



Source: SUS, prepared by ES, 05/17  
\*ICD codes: F60-F62, F68,69

Based on pooled data for 2013/14-2015/16, Kent had an admission rate with a primary or secondary diagnosis of a personality disorder of 57.2 per 100,000 resident population. Within Kent, this varied from 24.7 in Sevenoaks to 86.4 in Canterbury, which was significantly higher than Kent. Sevenoaks had a significantly lower admission rate than Kent (95% confidence intervals).

## Neurotic Disorder

Figure 59 Admissions with a Primary or Secondary Diagnosis of a Neurotic Disorder for under 25s from 2013/14-15/16 pooled by Gender

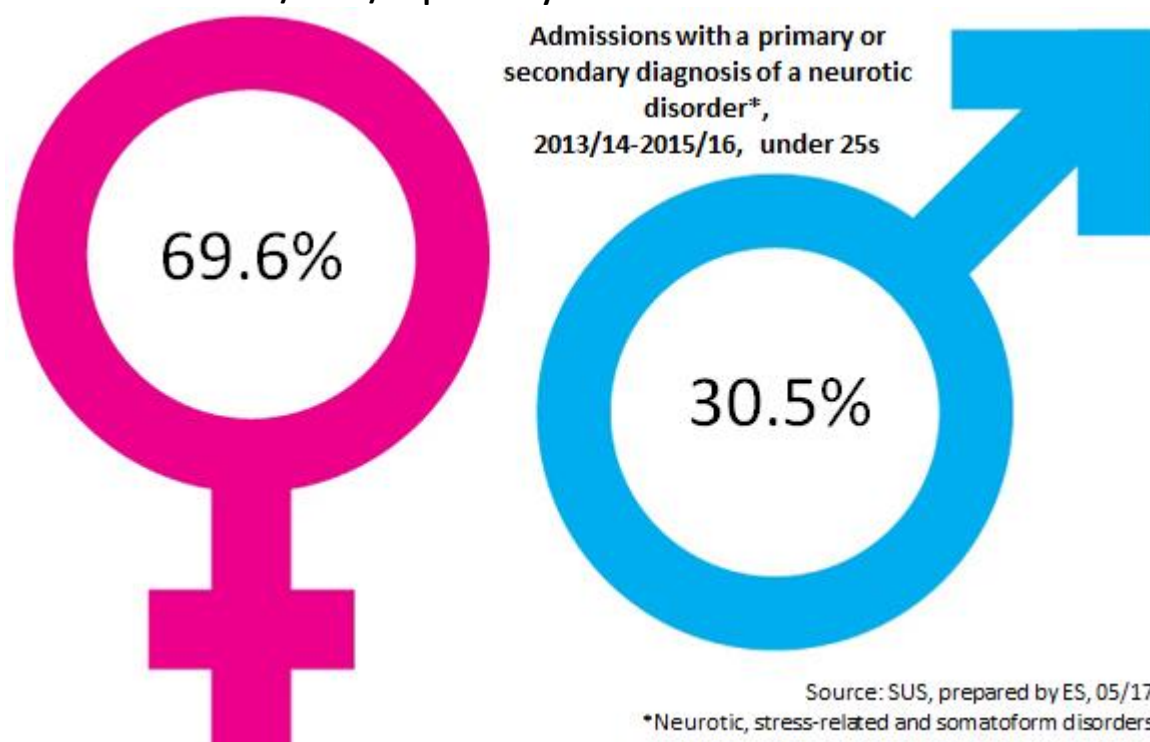
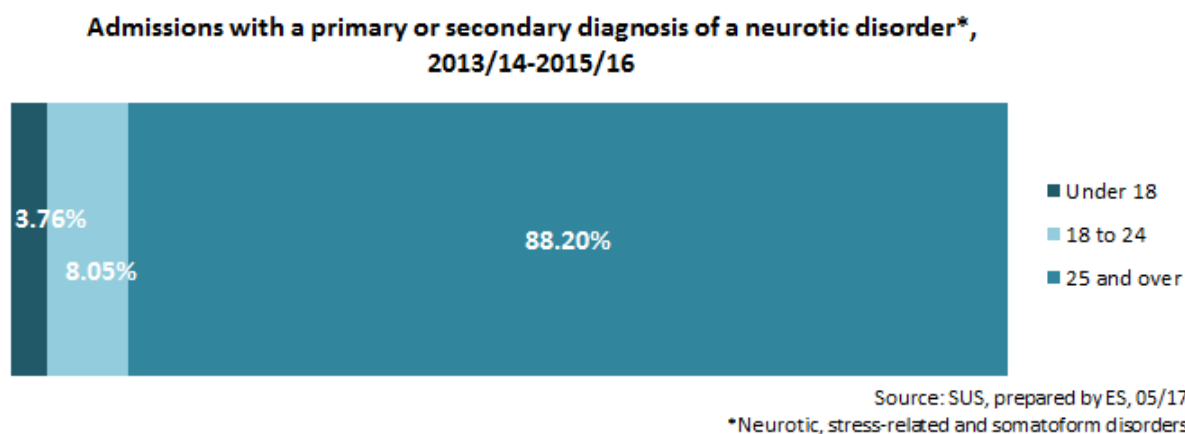


Figure 60 Admissions with a Primary or Secondary Diagnosis of a Neurotic Disorder by age band from 2013/14-15/16 pooled



Between 2013/14 and 2015/16, 69.6% hospital admissions with a primary or secondary diagnosis of a neurotic disorder were female, accounting for 966 admissions out of 1,389 among under 25s with a valid gender code.

Just over a tenth of hospital admissions were for people aged under 25. The length of stay varied from 0 days to 317 days, with a median of 1 day.

Table 17 Percentage of Admissions with a Primary or Secondary Diagnosis of a Neurotic Disorder\* for under 25s which were Elective compared to Emergency 2013/14 to 2015/16 pooled

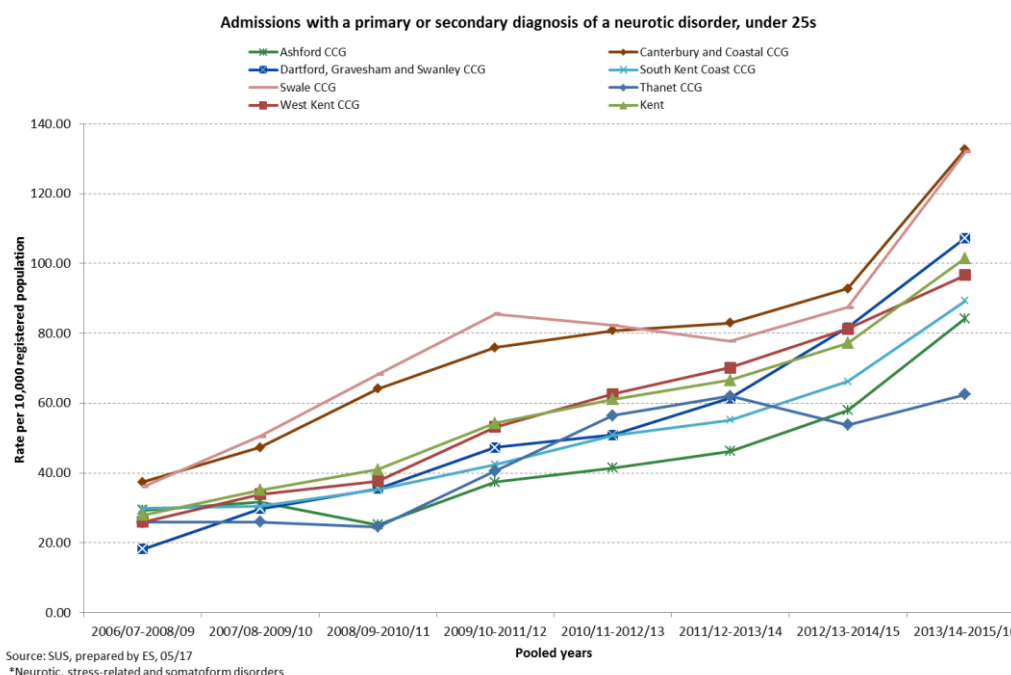
Provider	Elective	Emergency via A&E	All emergency
EKHUFT	7.1	83.3	88.6
MTW	10.1	55.1	56.2
DVT	4.7	67.2	70.3
KMPT	37.7	0.0	62.3
Other	72.4	9.9	23.0
Total	28.8	49.0	59.2

**Source:** SUS

\*Neurotic, stress-related and somatoform disorders

Just under half of admissions with a primary or secondary diagnosis of a neurotic disorder were an emergency admission via A&E, accounting for 49% of admissions for under 25s between 2013/14 and 2015/16. Non-Kent Trusts had the highest proportion of elective admissions, with 72%.

**Figure 61 Admissions with a Primary or Secondary Diagnosis of a Neurotic Disorder\* for under 25s from 2006/07 - 15/16 by CCG**



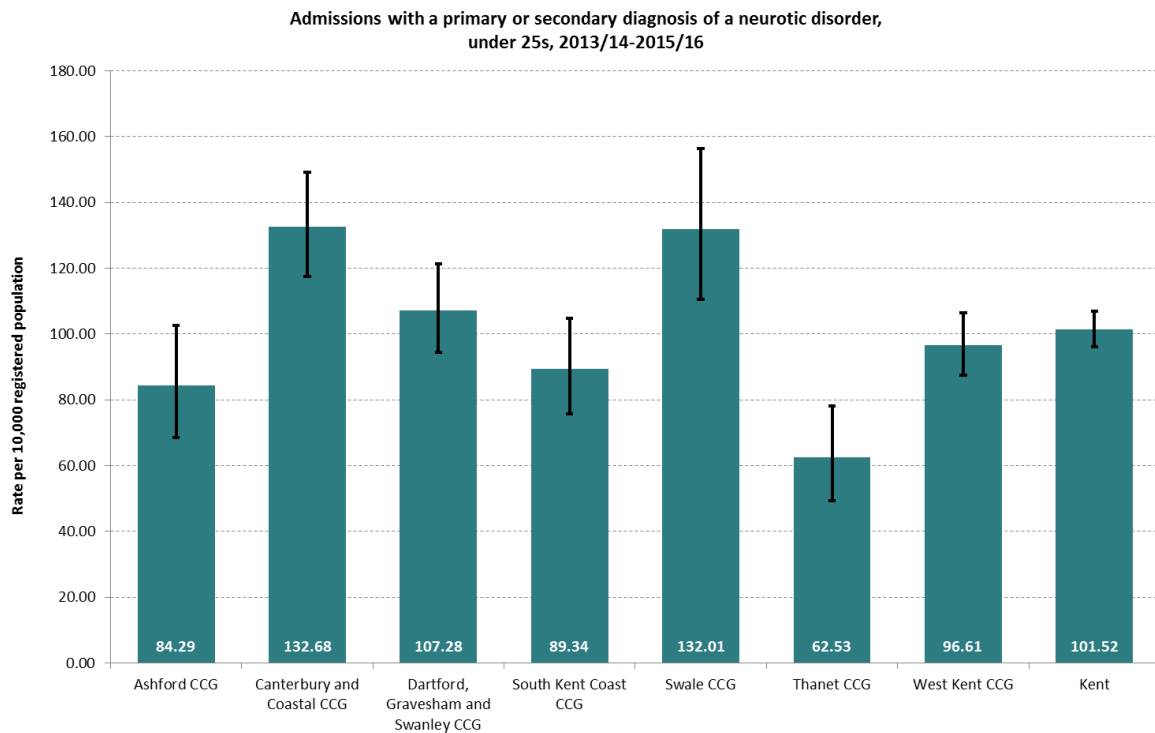
The admission rate with a primary or secondary diagnosis of a neurotic disorder has increased from 28.0 per 100,000 registered population aged under 18 in 2006/07-2008/09 to 101.5 in 2013/14-2015/16. Swale and Canterbury and Coastal CCGs have had higher rates than Kent since 2006/07-2008/09, and continue to increase.

**Table 18 Admissions with a Primary or Secondary Diagnosis of a Neurotic Disorder\* (neurotic, stress-related and somatoform disorders) for 18-24s from 2006/07- 15/16 by CCG**

CCG	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11	2009/10-2011/12	2010/11-2012/13	2011/12-2013/14	2012/13-2014/15	2013/14-2015/16
Ashford CCG	32	35	28	42	47	53	67	98
Canterbury and Coastal CCG	74	94	128	153	165	171	193	278
Dartford, Gravesham and Swanley CCG	39	64	77	104	114	140	189	251
South Kent Coast CCG	49	50	58	70	84	92	111	150
Swale CCG	34	48	66	84	82	78	88	133
Thanet CCG	30	31	30	50	70	77	67	78
West Kent CCG	101	133	149	212	253	286	335	401
Kent	359	455	536	715	815	897	1050	1389

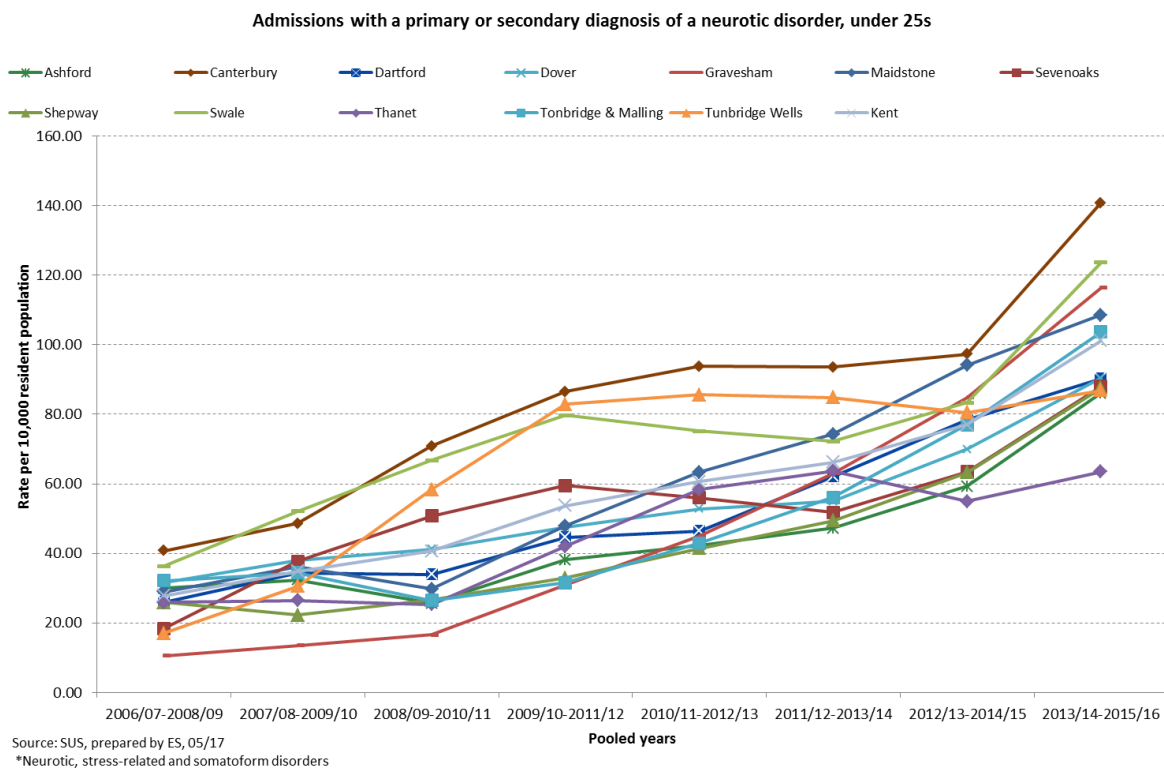
Source: SUS

**Figure 62 Admissions with a Primary or Secondary Diagnosis of a Neurotic Disorder\* (neurotic, stress-related and somatoform disorders) for under 25s pooled from 2013/14-15/16 for Kent and by CCG**



There were 101.5 hospital admissions per 100,000 registered population aged under 25 years in 2013/14-2015/16 with a primary or secondary diagnosis of a neurotic disorder in Kent. This ranged from 62.5 in Thanet to 132.7 in Canterbury and Coastal CCG; significantly higher than Kent (95% confidence intervals). Swale CCG (132.0) also had a significantly higher rate than Kent.

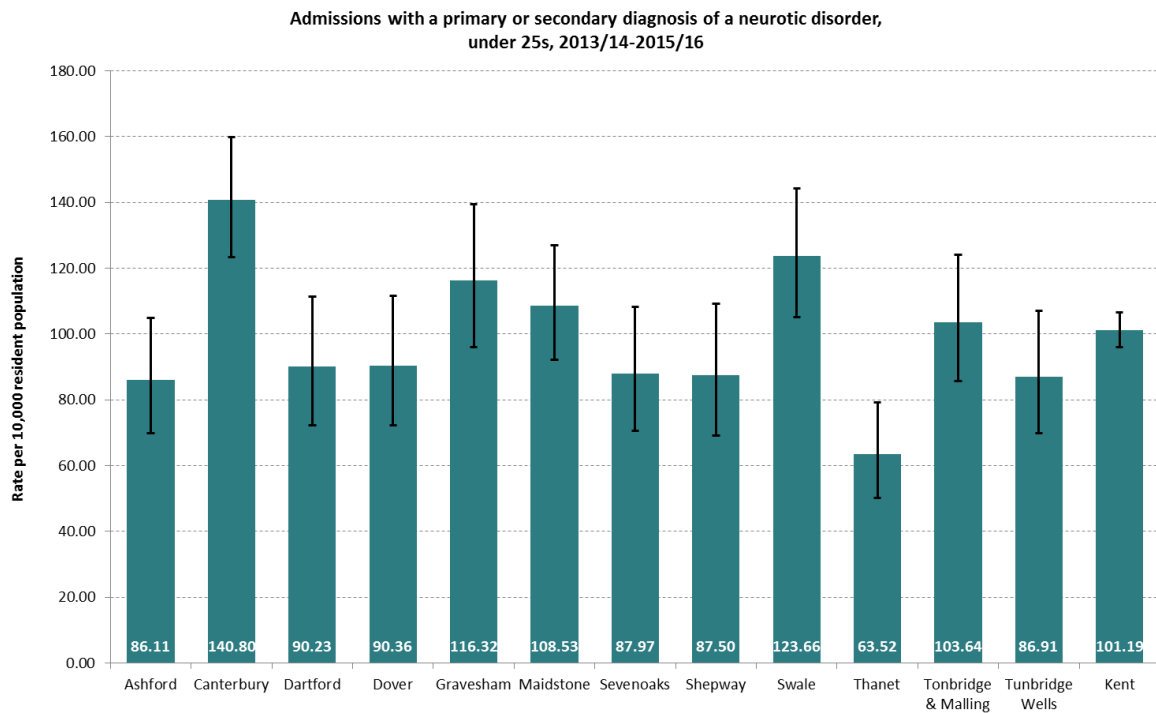
**Figure 63 Admissions with a Primary or Secondary Diagnosis of a Neurotic Disorder\* (neurotic, stress-related and somatoform disorders) for under 25s from 2006/07- 15/16 by District**



The admission rate with a primary or secondary diagnosis of a neurotic disorder has increased from 27.8 per 100,000 resident population aged under 25 in 2006/07-2008/09 to 101.2 in 2013/14-2015/16. Canterbury and Swale had a higher rate than Kent since 2006/07-2008/09, and continue to increase.



**Figure 64 Admissions with a Primary or Secondary Diagnosis of a Neurotic Disorder\* (neurotic, stress-related and somatoform disorders) for under 25s from 2013/14- 15/16 pooled for Kent and by District**



Source: SUS, prepared by ES, 05/17  
\*Neurotic, stress-related and somatoform disorders

In Kent, were 101.2 hospital admissions per 100,000 resident year olds in 2013/14-2015/16 with a primary or secondary diagnosis of a neurotic disorder. This ranged from 63.5 in Thanet to 140.8 in Canterbury; significantly higher than Kent (95% confidence intervals).

## Appendix 5

This table below provides a checklist of interventions suggested by NICE guidance for the prevention and treatment of children and young people’s mental health

Interventions	Check List
Parenting education programmes for children with symptoms of ADHD	
Individual treatment for children with ADHD	
Training for teachers / pastoral support staff in behavioural management of ADHD	
Individual parenting interventions	
SEAL for children 3-7 years old	
Parenting programmes for CYP with indicated conduct, ODD and anti-social behaviour (including those in contact with YOS) –(manualised programmes included IY for primary aged children )	
Training for foster carers in CD and ODD	
Group work for children 9-14 with ODD, CD	
Offer multimodal interventions, for example, multisystemic therapy, to children and young people aged between 11 and 17 years for the treatment of conduct disorder.	

Interventions	Check List
Attachment intervention – 0-5	
Attachment interventions – school age	
School Plans for school aged children with attachment disorders	
Training for schools in attachment	

Video feedback interventions for early years at risk of or with attachment disorders	
Parental sensitivity and behavior training for children with disordered attachment diagnosis	
Group based training for foster carers, guardians and children in care of primary age and secondary age to support placement stability	
Group based play therapy for primary age children at the end of placement (check)	
Training in risks associated with and identification of depression in children	
Depression: Able to deliver 'active listening' and watchful waiting	
Training for staff in risks associated with and identification of and support for depression in children, priority training should be provided for primary care, schools and relevant community settings, priority should be given to the training of pastoral support staff in schools (particularly secondary schools), community pediatricians and GPs	

Interventions	Check List
Training to enable school staff to develop plans for children who have experienced single adverse events	
Development of plans at school level to respond to single adverse events	
Primary mental health workers (or CAMHS link workers) should establish clear lines of communication between CAMHS and tier 1 or 2, with named contact people in each tier or service, and develop systems for the collaborative planning of services for young people with depression in tiers 1 and 2 (NICE Guidance Depression)	
individual CBT, interpersonal therapy for depression,	
Systemic family therapy	
Inpatient care for children with severe depression, self-harm, risk of suicide or where the intensity of the psychological therapy cannot be achieved in the community.	

CBT for social anxiety disorder	
A specialist obsessive-compulsive disorder (OCD)/body dysmorphic disorder (BDD) multidisciplinary team	
CBT (including ERP) for OCD and BDD	
Policy around admission for CYP who present in A and E and MIU with self-harm	
Children's and young people's triage nurses should be trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed	

<b>Interventions</b>	<b>Check List</b>
Psychiatric liaison / rapid response to presentations for self-harm in acute	
Trauma-focused psychological treatment	
Anorexia-nervosa-focused family therapy for children and young people (FT-AN),	
Individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN) and for binge eating and bulimia	
Self help and support programme for binge eating	
Bulimia-nervosa-focused family therapy (FT-BN)	
Family therapy for first episode of psychosis or newly diagnosed bipolar	
Interpersonal or CBT for CYP with a first episode of psychosis or newly diagnosed bipolar disorder	
Family therapy for recurrent psychosis or bipolar	
Interpersonal or CBT for CYP for recurrent psychosis or bipolar disorder or schizophrenia	
Arts based therapy for CYP with recurrent psychosis or schizophrenia	

Disorder	Guidance code	Last date reviewed
	CG26	

## | Appendix 6

### **Mental Health Services Dataset (MHSDS)**

The Health and Social Care Information Centre has developed a new Mental Health Services data set (MHSDS). It replaces and incorporates the CAMHS data set as well as data sets relating to adult mental health and learning disabilities. It incorporates requirements in support of Children and Young People's Improving Access to Psychological Therapies (CYP IAPT), elements of the Learning Disabilities Census (LDC). From 01 February 2016, providers of NHS-funded Mental Health Services began submitting to MHSDS.

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