Suffolk Child and Adolescent Mental Health Services

Needs Assessment Refresh

Full report of findings and recommendations

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Authors: Maija Huttunen-Lenz (PhD), Programme Manager, Public Health
         Ian Diley - Public Health Specialty Registrar

Consultant & Report Owner: Dr Mashbileg Maidrag, Consultant in Public Health
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Executive Summary

This report is a refreshed version of the previous needs assessment completed in 2013. Main objectives were to assess and report unmet needs (detailed assessment is provided in Table 18) of local children and young people who require mental health services for different service level (tier) at any given time, identify gaps in current provision in terms of access and availability (detailed assessment provided in Table 19) and make recommendations for further improvement.

It should be noted that the principal service provider, Norfolk and Suffolk Foundation Trust (NSFT), has initiated some changes since December 2015. It has been reported that the Suffolk Access and Assessment Team (AAT) has developed improved links with Child and Adolescent Mental Health Services (CAMHS) Consultant/s with some regular sessions in the diary. In addition, the Suffolk AAT is engaged on clinical improvements by working to the standards highlighted within “Delivering with, delivering well”.

Unmet needs at each Tier

While unmet need cannot be precisely estimated, it can be estimated whether the current services can respond to the potential need on each service Tier. When estimating unmet need it is important to differentiate between the point prevalence of diagnosable mental health disorders and the service need on the other hand.

In this needs assessment evaluation of unmet need is based on the estimations of children requiring different service level at any given time, not based on the mental health disorder prevalence. This is because not every child with a mental health disorder requires constant access to services, while there are a number of children with transient mental health needs who may need to access services.

It is not known how accessible the Tier 4 services are, as they are commissioned by the NHS England. However, when evaluating the locally commissioned Tier 3 and 2 services, questions should be raised about the services capacity to respond to the current demand.

Rough estimate suggested that one third of the children who may require Tier 3 service may not be accessing the services. The Tier 3 services are mainly accessed via the Access and Assessment Team (AAT) within NSFT. The AAT seems to be overwhelmed by the number of referrals, as it appears to have become seen as a single point of access to mental health services.

Furthermore, the capacity of the IDTs appears to be relatively fixed, which indicates that the system has limited amount of flexibility to respond to any fluctuations in the referral numbers. However, the AAT team assured that regardless of the referral volume, the number of referrals assessed as requiring the attention of the IDTs remains relatively stable.

As discussed above, some services that could be understood as Tier 3 CAMH services are provided by the Suffolk Community Healthcare (SCH). This includes, for example, assessment, diagnosis and support for children aged 0-11 with ASD. Further, SCH provides Tier 2 and 3 specialist psychological services. However, it is important to note that the NSFT also provides psychological services, for example, children aged 13 and over are able to access psychological services through the Suffolk Wellbeing Service.
Similarly to the Tier 3 CAMH services, the SCH has reported increasing referral pressure to the services (figure 4). While increased referral numbers to a service tend to indicate increased service need, or at least perceived need, currently it is not possible to estimate how many of the referrals may not be appropriate.

The new PMHW service in Tier 2 is still being imbedded in the East and West Suffolk system. Therefore, it cannot be reliably estimated the effect the PMHWs have on the overall system, access to services, and volume of referrals to the AAT. However, some early indicators have shown that referrals to the PMHWs have picked up. It is, however, unlikely that PMHWs are able to respond to the all estimated demand of the Tier 2 services.

However, while children might also be able to access Educational Psychology (SCC) and Psychological Services provided by the SCH, these services tend to be for children with more defined needs, such as for those with problems in schools. Furthermore, Educational Psychology service is offering only core services. This means that a child’s access to wider Educational Psychology services is dependent on, for example, schools’ willingness to purchase services from Schools’ Choices, placing children potentially in unequal position.

It is also difficult to assess how underlying issues that contribute to children and young people’s mental health disorders should be addressed in Suffolk. Issues such as family dysfunction, emotional abuse, anti-social behaviour, and family in acute distress may contribute to the children and young people’s mental health needs. There is no reliable data to show the level of need or access to services for the children and young people who, while not having a mental health disorder, may nevertheless need Tier 1 mental health support.

Main Service Gaps

- There is insufficient support at Tiers 1 and 2 for those whose referrals are rejected for Tier 2 or 3.
- Children aged 13 and over can access Suffolk Health and wellbeing service. However, there is no CCG funded self-referral CAMH service for children under the age of 13 within the NSFT.
- For children with conduct disorders there is no designated provision or clear pathways to access assessment and support services timely.
- Non-statutory Community Educational Psychology Services have become payable. Therefore, the access to the non-statutory EP services depends on the schools ability and willingness to pay.
- Stakeholder feedback from both referrers and providers suggested that children requiring Tier 4 inpatient or residential services are often placed too far from home to maintain good familial contact.
- Lack of support, intervention, and follow-up services for children aged 11-17 with ASD.
  - Children with dual diagnosis of autism and mental health disorder have difficulties in accessing services for mental health problems.
  - Increased demand on service resources for CYP making the transition from primary to secondary education and is concerned over its capacity to meet this demand.
- There appears to be some uncertainty among the referrers for the correct referral pathway to access ADHD specific services. The AAT follows NICE pathway guidance\(^2\) in determining a response to a ADHD referral.
• Access to Mental Health Acute Liaison Service for those in acute hospitals requiring mental health assessment depends on the individual hospital arrangements.

• CAMHS specific experience in the AAT
  o Although the AAT service has tried to improve availability of a psychiatrist with CAMHS expertise, the team does not have 24/7 access to a CAMHS psychiatrist.

Recommendations
• Although the NSFT service has been restructured, there has been no marked change in how referrers perceive the access to services. This suggests that clear criteria for referral and care pathways are either not in place or not well known to professionals. This in turn means that referrers are not always confident in knowing how to access Tier 3 specialist care or whether Tier 2 services would be more appropriate. Therefore, improved clarity about referral criteria and the application of these criteria could significantly alleviate this frustration.
  o A system wide Single Point Access and Assessment model could be the way forward to remove duplication within the system and lift the existing barriers. A Single Point Access and Assessment model has a potential of reducing the need for multiple referrals and improve timely access to right level of support to CYP and families.

  o Currently access to Tier 3 services is through the ATT. Based on the available evidence, the service commissioners should consider whether:
    ▪ the function of the AAT should change to a single point of access for all CAMH services with adequate resources or
    ▪ the function of the AAT should be re-aligned as access to Tier 3 services only.

• PMHW performance data from the beginning of the year 2015 indicated considerable disparity between the referral numbers for East and West Suffolk. The service commissioners should ensure that children have equal access to PMHWs across East and West Suffolk. Based on the available data, it was not possible to evaluate whether the PMHW service in Waveney is able to respond to the local demand.
  o The service commissioners should further clarify whether part of the remit of the PMHWs role should be:
    ▪ offering support for children with behavioural difficulties and
    ▪ widened from a consultative role to more direct interventions.

• The service commissioners should explore possibilities to develop clear assessment and support pathway for children with conduct disorders at Tiers 1 and 2.
1. Introduction
This exercise is undertaken to refresh the needs assessment of Child and Adolescent Mental Health completed in 2013.

The purpose of this refreshed work is three-fold:

1. Refresh the epidemiology and background section of the previous needs assessment. Identify changes in services in the last two years.
2. Gather and analyse any new available data in relation to the access to services for children and adolescents that are not meeting the threshold for Tier 3 and 4 services, and examine any changes in boundaries between Tier 2 and 3 services.
3. Update on the progress and impact of the recommendations suggested in the previous 2013 needs assessment.

Data and information has been checked in each section of the document, and has been refreshed where new data or information is available. While this refreshed needs assessment follows the overall structure of the 2013 needs assessment, there has been some changes to the format. Therefore, paragraph and table numbers differ from the previous document. In the end of the document two summary tables have been added. These tables show, firstly, the estimated current service need in numbers, and secondly, the current service provision.

1.1. What is the issue and why is it important for Suffolk?
The exercise assessed whether the current Child and Adolescent Mental Health Services (CAMHS) provision is sufficiently meeting the needs of children and adolescents in Suffolk. National-level evidence has suggested that access to services and service quality varies geographically and for specific population groups. Concerns continue to be raised by local commissioners and referrers that access to suitable services can be difficult. Service providers have expressed concerns regarding the number of referrals to the Tier 3 services, most of which are considered as not needing Tier 3 CAMHS interventions.

Research evidence suggests that mental health disorders can have a devastating impact across an individual’s life course if their emotional wellbeing needs are not addressed at an early stage. Lack of early intervention can also increase societal costs through the requirement for more people to require health and social care of greater duration and intensity.

The previous CAMHS needs assessment of 2013 identified areas for development relating to services for children with conduct disorders, increased support for early intervention (Tier 1 and 2 services) and further support for members of vulnerable groups. An update on this is provided in this report.

2. Which population is this needs assessment about?
This needs assessment relates to the mental health and wellbeing needs of Suffolk’s children and young people aged 0-18, where data available.

3. What is the focus of this needs assessment?
Tier 1 services are provided by professionals from different backgrounds in Suffolk. However, information is not collected and collated systematically for these services therefore it is a challenge to know how many children have been receiving a service at Tier 1. Therefore this assessment will focus primarily on Tier 2 and 3 and examine the boundaries and links between the two tiers. It will
seek to identify groups whose needs should be met by Tier 2-3 services and who experience difficulties in accessing these services or where there is no service to meet their specific needs.

4. Expected numbers, distribution and pattern by person, place and time

4.1. Population estimates

Table 1 shows current population estimate. Population change estimates in Suffolk are included in tables 2 to 5.

Table 1: Population estimates for children and young people in Suffolk in 2013

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male 2013</th>
<th>Female 2013</th>
<th>Total 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>21,661</td>
<td>20,799</td>
<td>43,460</td>
</tr>
<tr>
<td>5-9</td>
<td>21,417</td>
<td>20,492</td>
<td>41,909</td>
</tr>
<tr>
<td>10-14</td>
<td>20,693</td>
<td>19,546</td>
<td>40,239</td>
</tr>
<tr>
<td>15-18</td>
<td>18,193</td>
<td>17,099</td>
<td>35,292</td>
</tr>
<tr>
<td>19</td>
<td>4,006</td>
<td>3,444</td>
<td>7,450</td>
</tr>
</tbody>
</table>

In comparison with the population estimation included in the previous needs assessment, the current estimate indicates that there has been no significant change in the total number of children in Suffolk. However, the estimated number of children aged 0 to 9 has slightly increased, while the estimated number of children aged 10 to 18 has slightly decreased.

Table 2: Population change estimates for children aged 0 to 4 in Suffolk in 2020

<table>
<thead>
<tr>
<th>District</th>
<th>Population estimate 2015</th>
<th>Population estimate 2020</th>
<th>Change percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>4146</td>
<td>3950</td>
<td>-4.7</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>4889</td>
<td>4943</td>
<td>1.1</td>
</tr>
<tr>
<td>Ipswich</td>
<td>9686</td>
<td>9689</td>
<td>0.0</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>4967</td>
<td>4896</td>
<td>-1.4</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>6459</td>
<td>6348</td>
<td>-1.7</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>5765</td>
<td>5640</td>
<td>-2.2</td>
</tr>
<tr>
<td>Waveney</td>
<td>6242</td>
<td>6124</td>
<td>-1.9</td>
</tr>
</tbody>
</table>

Population change estimates for the next five years for children aged 0 to 4 indicate that apart from Forest Heath district, number of children in this age group is expected to decline across Suffolk.

Table 3: Population change estimates for children aged 5 to 10 in Suffolk in 2020

<table>
<thead>
<tr>
<th>District</th>
<th>Population estimate 2015</th>
<th>Population estimate 2020</th>
<th>Change percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>6027</td>
<td>5778</td>
<td>-4.1</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>4701</td>
<td>5753</td>
<td>22.4</td>
</tr>
<tr>
<td>Ipswich</td>
<td>10483</td>
<td>11239</td>
<td>7.2</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>6785</td>
<td>6640</td>
<td>-2.1</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>7862</td>
<td>7994</td>
<td>1.7</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>8277</td>
<td>8022</td>
<td>-3.1</td>
</tr>
<tr>
<td>Waveney</td>
<td>7467</td>
<td>7682</td>
<td>2.9</td>
</tr>
</tbody>
</table>

The number of children aged 5 to 10 is forecasted to increase in Forest Heath, Ipswich, and St Edmundsbury districts in the next 5 years with the biggest changes in Forest Heath and Ipswich.
While the number of younger children is estimated to decrease, the number of older children (aged 11-16) across Suffolk is expected to grow (Table 4). The largest increases are expected to be seen in the Forest Heath and Ipswich districts. Although it cannot be said with certainty why the largest increases are within Forest Heath and Ipswich districts, some possible explanations include an increase in the number of migrant families include a number of migrant families with young children and higher number of families from minority ethnic groups.

Table 5 shows that the number of young adults (aged 17-19) across Suffolk is expected to decline during the next five years. Districts of Suffolk Coastal, Waveney, and Babergh are all expected to see over 10% reductions in the number of 17 to 19 year olds residing in their area.

4.2. National prevalence estimates for childhood mental disorder

National prevalence rates for childhood mental disorder have been estimated by the ONS in 2004, and no updated prevalence estimates were found. Using the available rates, the estimated number of children aged 5 to 10 and adolescents aged 11 to 16 experiencing mental health disorders in Suffolk in 2015 are provided in Table 6. For Suffolk’s child and adolescent population as a whole (aged 5-16), it is estimated that 9.6% have one or more mental health disorders amounting to over 9,600 cases at any one point in time. While we can categorise childhood mental ill health into a number of different disorders, the most common disorder diagnosed is conduct disorder. It is estimated that this affects over 5,800 children or around 5.8% of the county’s 5 to 16 year old population. Anxiety disorders, hyperkinetic disorders and autistic spectrum disorders also have prevalence in excess of 1% of the population, suggesting numbers of cases in excess of a thousand. However, caution should be taken while interpreting the prevalence figures. Firstly, the estimates are based on the 2004 figures. Secondly, Green et al. have suggested that overall prevalence of
emotional disorders has significantly reduced between 1999 and 2004. Finally, the changes in diagnostic criteria and improved diagnostic practice (e.g. autism) could influence changes in the overall estimated prevalence of the mental health disorders among CYP. Table 6 provides age specific population prevalence and estimated numbers of CYP that are likely to experience a mental disorder in 2015 and 2020. These estimates suggest that numbers of CYP experiencing mental health disorders will be on the rise in both age groups in 2020. There would be an increase of 116 in the age group 5 to 10 and up to 430 in the age group 11 to 16 year olds. Separate tables for boys and girls can be found at the end of the report. Diagnosis specific data needs to be interpreted carefully, as this would not provide population level estimation.

Table 6: Prevalence and estimated numbers in 2015 and 2020 for mental disorders in children and young people (aged 5-10 years and 11-16 years) in Suffolk

<table>
<thead>
<tr>
<th>Total Suffolk</th>
<th>Estimated prevalence (%) 2004</th>
<th>Estimated numbers 2015</th>
<th>Estimated numbers 2020</th>
<th>Estimated prevalence (%) 2004</th>
<th>Estimated numbers 2015</th>
<th>Estimated numbers 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 5-10</td>
<td></td>
<td></td>
<td>Age 11-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated total population</td>
<td>51,603</td>
<td>53,108</td>
<td>48,816</td>
<td>52,545</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emotional disorders (Total)</td>
<td>2.4</td>
<td>1238</td>
<td>1275</td>
<td>5.0</td>
<td>2441</td>
<td>2627</td>
</tr>
<tr>
<td>• Anxiety disorders (Sub-total)</td>
<td>2.2</td>
<td>1135</td>
<td>1168</td>
<td>4.4</td>
<td>2148</td>
<td>2312</td>
</tr>
<tr>
<td>- Separation anxiety</td>
<td>0.6</td>
<td>310</td>
<td>319</td>
<td>0.3</td>
<td>146</td>
<td>158</td>
</tr>
<tr>
<td>- Specific phobia</td>
<td>0.7</td>
<td>361</td>
<td>372</td>
<td>0.9</td>
<td>439</td>
<td>473</td>
</tr>
<tr>
<td>- Social phobia</td>
<td>0.1</td>
<td>52</td>
<td>53</td>
<td>0.5</td>
<td>244</td>
<td>263</td>
</tr>
<tr>
<td>- Panic</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.4</td>
<td>195</td>
<td>210</td>
</tr>
<tr>
<td>- Agoraphobia</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.3</td>
<td>146</td>
<td>158</td>
</tr>
<tr>
<td>- Post-traumatic stress</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
<td>0.3</td>
<td>146</td>
<td>158</td>
</tr>
<tr>
<td>- Obsessive compulsive</td>
<td>0.2</td>
<td>103</td>
<td>106</td>
<td>0.2</td>
<td>98</td>
<td>105</td>
</tr>
<tr>
<td>- Generalised anxiety</td>
<td>0.3</td>
<td>255</td>
<td>372</td>
<td>1.2</td>
<td>586</td>
<td>631</td>
</tr>
<tr>
<td>- Other anxiety</td>
<td>0.7</td>
<td>361</td>
<td>372</td>
<td>1.2</td>
<td>586</td>
<td>631</td>
</tr>
<tr>
<td>• Depression (Sub-total)</td>
<td>0.2</td>
<td>103</td>
<td>106</td>
<td>1.4</td>
<td>683</td>
<td>736</td>
</tr>
<tr>
<td>- Depressive episode (full ICD criteria)</td>
<td>0.2</td>
<td>103</td>
<td>106</td>
<td>1.1</td>
<td>537</td>
<td>578</td>
</tr>
<tr>
<td>- Other depressive episode</td>
<td>0.1</td>
<td>52</td>
<td>53</td>
<td>0.4</td>
<td>195</td>
<td>210</td>
</tr>
<tr>
<td>• Conduct disorders (Total)</td>
<td>4.9</td>
<td>2529</td>
<td>2602</td>
<td>6.6</td>
<td>3222</td>
<td>3468</td>
</tr>
<tr>
<td>- Oppositional defiant disorder</td>
<td>3.5</td>
<td>1806</td>
<td>1859</td>
<td>2.6</td>
<td>1269</td>
<td>1366</td>
</tr>
<tr>
<td>- Unsocialised conduct disorder</td>
<td>0.6</td>
<td>310</td>
<td>319</td>
<td>1.0</td>
<td>488</td>
<td>525</td>
</tr>
<tr>
<td>- Socialised conduct disorder</td>
<td>0.3</td>
<td>155</td>
<td>159</td>
<td>2.2</td>
<td>1074</td>
<td>1156</td>
</tr>
<tr>
<td>- Other conduct disorder</td>
<td>0.5</td>
<td>258</td>
<td>266</td>
<td>0.8</td>
<td>391</td>
<td>420</td>
</tr>
<tr>
<td>• Hyperkinetic disorder (Total)</td>
<td>1.6</td>
<td>826</td>
<td>850</td>
<td>1.4</td>
<td>683</td>
<td>736</td>
</tr>
<tr>
<td>• Less common disorders (Total)</td>
<td>1.3</td>
<td>671</td>
<td>690</td>
<td>1.4</td>
<td>683</td>
<td>736</td>
</tr>
<tr>
<td>- Autistic Spectrum Disorder</td>
<td>1.0</td>
<td>516</td>
<td>531</td>
<td>0.8</td>
<td>391</td>
<td>420</td>
</tr>
<tr>
<td>- Tic disorders</td>
<td>0.1</td>
<td>52</td>
<td>53</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Eating disorders</td>
<td>0.3</td>
<td>155</td>
<td>159</td>
<td>0.4</td>
<td>195</td>
<td>210</td>
</tr>
<tr>
<td>- Mutism</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
<td>0.3</td>
<td>146</td>
<td>158</td>
</tr>
<tr>
<td>• Any Disorder (Grand Total)</td>
<td>7.7</td>
<td>3973</td>
<td>4089</td>
<td>11.5</td>
<td>5614</td>
<td>6043</td>
</tr>
</tbody>
</table>

Based on Green et al. (2005)

In order to paint a picture on the estimation of CYP with one or more mental health disorders we have created the following graph for Suffolk child population. According to the 2004 prevalence study (combining the 1999 and 2004), one in five children with a mental health disorder were diagnosed with more than one of the main categories of mental disorder (emotional, conduct, hyperkinetic or less common disorders). This figure represents 1.9% of all children aged 5 to 16. Using the Suffolk population estimates this would suggest approximately 1,900 (figure 1) children in Suffolk experience at least 2 diagnosable disorders.
Characteristics of children with multiple disorders in Suffolk included:

- **Being a boy** – 72% of children with multiple disorders were boys reflecting the high proportion of boys with conduct disorder.
- **Having a physical or developmental problem** - 76 per cent of children with multiple disorders had a physical developmental problems compared with two-thirds (66 per cent) of those with a single disorder.
- **Being behind with schooling** - 63 per cent of children with multiple disorders were behind with their schooling and 40 per cent of them were more than a year behind. Among children with a single disorder, these proportions were 49 per cent and 27 per cent.
- **The Strengths and Difficulties Questionnaire (SDQ)** - This questionnaire is used to identify behavioural and emotional problems in children and adolescents. Nearly four-fifths (88 per cent) of children with multiple disorders had scores in the bottom quartile on a scale measuring strengths compared with three-fifths (61 per cent) of those with a single disorder.

It should be noted, however, that the estimated number of children in Suffolk with multiple mental health disorders does not present the service level need. The service level need is discussed more in the sections 4.4. and 11.

### 4.3. The estimated ranges of childhood mental health disorders

Table 7 provides ranges for potential numbers of cases of diagnosable mental health disorder for pre-school and school age children in Suffolk, both in 2015 and 2020 respectively. Estimated national prevalence indicates that mental ill health rate is lower for children aged 0 to 4 than for children aged 5 to 16.

<table>
<thead>
<tr>
<th>Estimated prevalence – cases per 100 residents (95% CI)</th>
<th>Projection Year 2015</th>
<th>Projection 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimated population</td>
<td>Estimated range of cases</td>
</tr>
<tr>
<td></td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Any disorder: (Age 0-4)</td>
<td>5.0 (4.8 - 5.2)</td>
<td>42,152</td>
</tr>
<tr>
<td>Any disorder: (Age 5-16)</td>
<td>9.6 (9.4 - 9.8)</td>
<td>51,603</td>
</tr>
<tr>
<td>Any disorder: (Age 0-16)</td>
<td>93,755</td>
<td>6,874</td>
</tr>
</tbody>
</table>
Based on the projected population estimates, it is not expected that there will be significant changes in total number of children experiencing childhood mental health disorders during the next five years.

4.4. Estimated need for services at each Tier in Suffolk

The National Child and Maternal Health Intelligence Network (ChiMat) has estimated 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 for the population aged 17 and under in Suffolk. These numbers, however, do not necessarily equate with the figures of diagnosable mental health disorder provided in Tables 6 and 7.

Table 8: Estimated number of children and young people who may experience mental health problems appropriate to a response from CAMHS, 2014

<table>
<thead>
<tr>
<th>CAMHS Tier</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Suffolk Population under 17 requiring services in each tier</td>
<td>22,700</td>
<td>10,595</td>
<td>2,800</td>
<td>115</td>
</tr>
<tr>
<td>Estimated percentage of Suffolk population under 17</td>
<td>15.9%</td>
<td>7.4%</td>
<td>2.0%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>


The estimated proportional need for each tier of service is shown in Figure 2. There is no current national guidance for how service spend should be divided proportionally across tiers of service but it would generally be that the cost per case would increase with each tier of service.

4.5. Risk factors

Risk factors for developing childhood mental health disorder can be divided between individual, family, community and cultural factors. It is important to recognise that risks to mental health difficulties may appear already during prenatal period. Further parents’ own mental health problems as well as family’s socio-economic situation can increase risk of developing mental health difficulties during childhood. Risks to mental health over the life course are presented in the table below.

The figure 2 presents the interconnectedness of the risk factors through life course.

Figure 2: Life time risk factors
The age and gender related risk factors for specific types of mental health disorder are discussed in paragraphs 4.19 to 4.30. Socio-economic risk factors to the stability of home environment have been shown to increase the risk of both emotional and conduct disorders (Meltzer et al, 2003) and an unstable home environment may prevent access to certain CAMH services.\textsuperscript{11,12}

The evidence suggests that there is a correlation between childhood or adolescent experience of mental health disorder and mental illness in adult life. This is confirmed, for example, in Annual Reports of Chief Medical Officer \textsuperscript{13,14}.

Although relative costs for different agencies and a child’s family are difficult to estimate, it is suggested that in 2008\textsuperscript{15} a child with mental health difficulties required yearly extra funding between £11,030 and £59,130. Furthermore, it is estimated that, for example, successful early intervention to prevent the causes for development of conduct disorder can make life-long savings between £75,000 and £150,000 per child.\textsuperscript{16}

5. Groups of CYP at higher risk for developing mental health disorder

5.1. Children in Care - Increased risk of mental health illness

There is strong evidence to suggest that Children in Care (CIC) are at increased risk of mental health disorder. A 2007 briefing paper from NICE which reviewed the available evidence base suggested that around 45% of all CIC in the United Kingdom have a diagnosable mental health disorder, and that 70-80% have mental health problems that are recognisable to carers, teachers and social workers\textsuperscript{17}. CIC with a mental health disorder are more likely to be in a residential placement (27% compared with 10% of non-residential placements), more likely to have been in their current placement for less than one year (40% compared with 34%) and less likely to have been placed with foster carers (58% compared with 75%). They were also more likely to be boys and more likely to be aged between 11 and 15\textsuperscript{18}.

Current evidence suggests that CIC across a range of placement arrangements experience more negative mental health outcomes than the general child population. This applies to children who have spent any time in CIC services, not simply those currently within the system and includes those of older ages as well as younger\textsuperscript{19,20}.

For the UK, studies have found that the prevalence of mental health disorder in CIC is significantly higher than the general child population for both the 5-10 age range (42% compared with 8%) and the 11-17 age range (49% compared with 11%)\textsuperscript{21}, that children in foster care attract greater mental health service use cost than the general child population\textsuperscript{22} and that there is an association between higher prevalence of mental health disorder and increased frequency of placement change within the CIC population\textsuperscript{23}. Additionally, risk of suicide is greater for children who have experienced time with CIC services (being 4 to 5 times more likely to be hospitalised after suicide attempts than the general population)\textsuperscript{24}.

5.2. Children in care - the Strengths and Difficulties Questionnaire

As detailed in the previous report, an audit of the Strength and Difficulties Questionnaire (SDQ) with children in care was undertaken by Public Health in 2012. The Audit identified a higher proportion of Children in care in Suffolk having high SDQ scores in comparison to regional neighbours. The audit also identified that there was no pathway for a child assessed as having an emotional or mental
Further, the audit established that there was no systematic repeated assessment using the SDQ, annually or otherwise. Annual re-assessment using the SDQ has been established for all children in care. However, completion of the SQDs is currently not monitored and there is no process in place to ensure that assessors have been trained to use the tool. According to the latest information, only half of current children in care have an SDQ score recorded on the Care First (Social Care) IT database. According the recent audit of the SDQs scores was available for 30 children across Suffolk. The available scores ranged for 27 to 38, indicating risk of significant problems.25

5.3. Children with Autistic Spectrum Disorder (ASD)

Children or adults with Autistic Spectrum Disorder (ASD) commonly have difficulties with social interaction, social communication and social imagination. They may therefore have difficulties relating to others, expressing themselves verbally and non-verbally or understanding these actions in others, and may have difficulties working in a flexible and imaginative way, sometimes showing obsessive or repetitive behaviour. These children also have increased rates of conduct disorder and can present with challenging behaviour for their families and for services.

The estimations of prevalence of ASD among children up to the age of 11 range from 0.5% to 1.6%26-28. Overall, it is estimated that the prevalence of children diagnosed with autism is around 1%26,27, but increases to 1.6% when children with un-diagnosed autism are taken into account27. In the other words, it is estimated that among children the ratio of known:unknown autism cases is 3:227. The prevalence of autism is higher among male (2%) population than among female (0.3%) population.28 Although estimates vary, it is suggested that up to 50% of individuals with ASD have some additional learning difficulties.29,30 However, even higher proportion of autistic individuals (up to 70%) have been estimated to have at least one, often unrecognised, mental health or behavioural disorder.31

Table 9: Estimated prevalence of children with ASD

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Prevalence (rate per 10,000)</th>
<th>Estimated number in Suffolk (rounded to nearest 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avon Longitudinal Study of Parents &amp; Children29</td>
<td>ASD</td>
<td>51.1</td>
</tr>
<tr>
<td>South Thames Study26</td>
<td>Childhood autism and all ASDs</td>
<td>116.1</td>
</tr>
<tr>
<td>UK school-based population study27</td>
<td>Adjustment of SEN register to account for non-observed cases</td>
<td>157.0</td>
</tr>
</tbody>
</table>

We have decided to use UK school-based population study estimates based on its external validity – that is, the applicability of its results to a defined population i.e. Suffolk CYP. Based on this, it is estimated that in total there are up to 3,400 children and young people aged between 0-25 with autism in Suffolk. These estimates could range between 510 and 1,550 for younger children (aged 0-11) and 270 and 820 for older children (aged 12-17) respectively.

As discussed above27, it is estimated that about 60% of those with autism receive diagnosis, while 40% remain undiagnosed. Using the highest prevalence estimates26 for Suffolk that include unobserved cases, this would mean that among 12 to 17 olds there are potentially around 320
children with undiagnosed autism. For younger children, this would mean potentially 620 children without formal autism diagnosis which brings the total to 940. However, this estimate should be interpreted with caution, as availability of diagnostic services in Suffolk for children aged 11 and over has improved during last few years.

5.3.1. Estimating prevalence of ASD among school aged children in Suffolk

In addition to evaluating the overall prevalence of the ASD, prevalence was additionally estimated for children and young people at school age. As is shown in the Table 10, different studies provide a range of estimates for ASD for 5-18 year olds in Suffolk.

Table 10: Prevalence of ASD in Suffolk (including Waveney)

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Prevalence (rate per 10,000)</th>
<th>Estimated number in Suffolk (rounded to nearest 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avon Longitudinal Study of Parents &amp; Children&lt;sup&gt;28&lt;/sup&gt;</td>
<td>Estimate for CYP with diagnosed and undiagnosed ASD</td>
<td>51.1</td>
</tr>
<tr>
<td>ditto&lt;sup&gt;26&lt;/sup&gt;</td>
<td>Estimate for CYP diagnosed with ASD</td>
<td>100</td>
</tr>
<tr>
<td>South Thames Study&lt;sup&gt;26&lt;/sup&gt;</td>
<td>Childhood autism and all ASDs</td>
<td>116.1</td>
</tr>
<tr>
<td>UK school-based population study&lt;sup&gt;27&lt;/sup&gt;</td>
<td>Adjustment of SEN register to account for non-observed cases</td>
<td>157.0</td>
</tr>
</tbody>
</table>

Based on 2014 mid-year population estimates, Office for National Statistics

As discussed above<sup>27</sup>, it is estimated that about 60% of those with autism receive diagnosis, while 40% remain undiagnosed. Using the highest prevalence estimates<sup>26</sup> for Suffolk that include unobserved cases, this would mean that among 5 to 18 year olds there are potentially around 736 children with undiagnosed autism, while around 1,104 children is estimated to have received diagnosis.

The above ASD prevalence estimates were compared with available Special Educational Needs and School Action Plus data for Suffolk<sup>32</sup>. According to the 2014 data<sup>32</sup>, in total, there were 883 children in Suffolk schools with ASD specific needs. So we assume the rest of 221 (1,104-883) could be counted for under 5s. Yet again, this estimate should be interpreted with caution, as availability of diagnostic services in Suffolk for children aged 11 and over has improved during last few years.

5.3.2. Incidence of ASD

Incidence rate of ASD has stabilised since the observed five-fold increase in incidence of ASD cases in the 1990s. From early 2000s through to 2010 there has been no further increase in autism incidence for children aged eight in the UK<sup>29,30,33</sup>. Based on this information, it is not expected that there will be any increase in relative number of children and young people with autism in Suffolk. This, however, does not mean that the number of referrals for suspected ASD cases may not increase. Furthermore, any increases in referral numbers may translate to an increase in diagnosed cases, as previously undetected cases are identified.

The yearly incidence of ASD cases among eight year olds in the UK has been estimated as 1.2 per 1000 for boys and 0.2 per 1000 for girls<sup>29,30,34</sup>. However, it is not known whether the autism incidence is same for all the age groups. Although it should be interpreted cautiously, a rough
estimate of yearly incidence in Suffolk can be calculated by applying the known incidence across age groups. In Suffolk, this would mean that each year there are 164 new cases among children and young people age 5-18. These numbers, however, should be taken as indicative. As ASD is a developmental disorder, children are born with it, but diagnosed at different ages. Therefore, evaluating yearly incidence is difficult as this is partly dependent on when a child is diagnosed.

5.3.3. Modelling incidence for the known service data in IESCG and WSCCG

A report from 2015-2016 Youth ASD service (11-17 inclusive) was received and the data period covered 12 months from March 2015 to the end of Feb 2016. According to the report 182 assessments were completed over the 12 months. Of these assessments, 63 received a diagnosis of Autism Spectrum Disorder (ASD), 105 received an alternative explanation and signposting, and 14 were withdrawn or DNA’d. Further, the assessments were for 113 males and 69 females, and the service noted that: “Of note the ratio between male and female assessments is just under 2:1. National estimates suggest that over 5 times more common in males and so our ratio of female assessments is significantly higher than average. We believe this is because within the age range we assess, 11 -18 years, the symptoms of Autism are more highly prevalent for girls in older age group than in the lower age group. Those children under 11 are typically seen in Community Paediatrics.”

According to the service the most common diagnosis (for those seen and diagnosed by the team) is Asperger’s Syndrome. Over the year, of those young people who were fully assessed (182), the number diagnosed with an Autism Spectrum Condition was 38% (63 cases). These numbers, however, should be interpreted cautiously as this may be slight under estimation. Numbers in the report include cases diagnosed by the time point, meaning that diagnostic information trails considerably behind the referral information due to length of the assessment/waiting for assessment. Limited diagnostic information from the SCH was available (under 11 service), making it difficult to assess the whole picture. A cautious assessment from the SCH (Audit based on 50 cases in 2014) did suggest that 58% of referrals were diagnosed with ASD. However, this should not be taken anything else than a cautious estimate.

In conclusion, modelling suggests that there could be around 164 new cases of ASD yearly. However, comparing the estimated incidence or prevalence to the service data is complex. For example, youth service is a relatively new (2 years) and may be picking a backlog of cases. Therefore, this information cannot be reliably used for incidence calculation. Furthermore, the youth service appears to be identifying especially those with Asperger’s syndrome. Considering the available data and the uncertainties in identifying the children and young people with ASD, prevalence estimates appear the best suited for estimating the number of children with ASD in Suffolk. Prevalence gives a population level estimate of the total number of potential cases rather than relying on the yearly incidence.

5.4. Children with learning disabilities – Estimated prevalence

Latest prevalence studies estimate 2.46% of girls and 4.01% of boys among children aged 7-15 within the state funded education system in England have learning disabilities. Prevalence of leaning difficulties among children aged 2 and younger is estimated as being 0.39% for girls and 0.60% for boys. When this estimate is applied to local child population aged 0-2, there are just under 80 boys and 50 girls with a learning disability. For older children, aged 7 to 15 this would mean that 1510 boys and 884 girls will have a learning disability in Suffolk.
There was no new significant evidence found regarding the prevalence of mental health disorders among children with learning difficulties. It appears that the estimated number of children and young persons aged 5-19 with learning disabilities might have reduced to just under 2,500 since the last estimation due to slight decline in the number of children and young persons among these age groups.

5.5. Children with mental health difficulties - Estimated mortality
The largest single risk factor for suicide in young people is depression. Using the most contemporary data, a 2004 study estimated that global suicide rates for young people (aged 15-19 years) were 4.1 per 100,000 for girls and 10.4 per 100,000 for boys. Further, Wasserman et al. also estimated that rates in the UK (using data from 1999) were 6.5 per 100,000 for boys and 1.8 per 100,000 for girls. The Department of Health report No Health Without Mental Health cites a 2009 study by Mykleton et al. indicating that over the full life course, depression increased the relative risk of mortality (hazard ratio) by 50%. High levels of suicidal ideation have been observed in children accessing CAMHS, with one study showing as many as one quarter of CAMHS cases being examined having engaged in suicidal acts in the six months prior to referral. Further, there is evidence to suggest that children in care are at increased risk of suicide, being 4 to 5 times more likely to be hospitalised after suicide attempts than the general population.

5.6. Children with acute episodes of mental health disorder and mortality
Acute episodes of mental health disorder carry greatly increased risk of mortality for young people. For young people experiencing an inpatient mental health admission in the UK, there is a six-fold increase in the death rate within one year of discharge in comparison to the general population of the same age.

5.7. Mental illness in childhood increases the risk of chronic physical conditions in adulthood
There is empirical evidence to suggest that mental illness in childhood increases the risk of chronic physical conditions in adult life. Across the life course, it has been suggested that the mean standardised mortality ratio for all forms of mental disorder is a minimum of 1.5 rising to between 3.0 and 4.0 for schizophrenia. This then suggests that there are four times as many deaths from respiratory, circulatory, endocrine and digestive disorders for people with schizophrenia as the general population.

6. Equality and risk factors
There is a strong evidence base for a multitude of risk factors for childhood and adolescent mental health disorder. These can be categorised as modifiable and non-modifiable.

6.1. Non-modifiable risk factors
The Office of National Statistics (ONS) has estimated that prevalence of mental illness in children and adolescents is higher in males (11%) than females (8%). Additionally in terms of types of mental health disorder, boys are more likely to have a conduct disorder (8% as opposed to 4% for girls) or a hyperkinetic disorder (3% as opposed to 0.4%) while emotional disorders are more frequent in girls (4% as opposed to 3%). These differences have been replicated in an autumn 2012 audit of potential mental health disorder in children in care in Suffolk.
6.2. Prevalence of mental health disorder between age ranges

The same 2004 ONS report also estimated differences in prevalence of mental health disorder between age ranges. For both genders, prevalence of any mental health disorder was higher for children aged 11-16 (12%) than for 5-10 year olds (8%). The prevalence for children aged under 5 was estimated to be 5%. Emotional and conduct disorders were estimated to be more prevalent in 11-16 year olds than younger children but hyperkinetic disorders were more frequently found in the younger cohort.

6.3. Prevalence of mental disorder among children in different ethnic groups

There is some evidence to suggest small differences in prevalence or incidence rates for mental disorder in children between ethnicities in the United Kingdom. The 2004 ONS report included small numbers of minority ethnic children in the sample and as such inferences of differences between those of white British ethnicity and other ethnicities are weak. However, there was some suggestion that children of Indian ethnicity had a lower rate of mental health disorder than other ethnicities (3%) and that hyperkinetic disorders were less frequent in all non-white British ethnicities. A systematic review of the evidence base for childhood mental health disorder and ethnicity found that, for common mental health disorders, Black African and Indian children may have a lower prevalence than other ethnicities.

For specific categories of common mental health disorder, while children of Indian ethnicity displayed a higher frequency of emotional disorders than the mean and a lower frequency of behavioural disorders, the converse was true for Black Caribbean and children of mixed white and Black Caribbean ethnicity. The evidence base for ethnic differences in the prevalence of less common mental health disorders in children is small and Goodman et al. for example, were not confident in making inferences without further research.

The systematic review by Goodman et al. notes that utilisation of mental health services by children of Bangladeshi or Pakistani origin is significantly below the estimated prevalence for those groups, suggesting that there may well be particular unmet need for these ethnicities. The activity information provided by the Norfolk and Suffolk NHS Foundation Trust for CAMHS in Suffolk does not distinguish between Indian, Pakistani and Bangladeshi ethnicity.

6.4. Modifiable risk factors

The presence of a physical illness has been identified as a risk factor for childhood and adolescent mental health disorder. A report in response to the 1999 National Survey of Childhood Mental Health in the UK estimated that children with a physical illness were more than twice as likely to develop an emotional disorder (OR = 2.62). However, the suggestion remains that this correlation is moderated by social adversity and social support with minimal association between physical disability and mental health disorder for those children with robust social and financial support. There is little evidence available to suggest that sight or hearing impairment is a particular risk factor for mental health disorder.

6.5. Modifiable risk factors - Children with special educational needs

For children with special educational needs (SEN), studies indicate an association with onset of emotional or behavioural disorders. Meltzer et al.’s large scale UK study found that children with SEN were nearly three times as likely as non-SEN children to also have an emotional disorder and over four times as likely to have a behavioural disorder.
6.6. Modifiable risk factors - socio-economic status of the family
Meltzer et al.\textsuperscript{50} found associations between the composition and socio-economic status of the family and mental health disorder in children. This national study found statistically significant associations between the following familial factors and increased risk of childhood emotional disorder:

- Living in a one parent household,
- Living with step-siblings,
- Mother having no educational qualifications,
- No parent working,
- Living in a flat or maisonette (as opposed to a detached property),
- Renting a property (as opposed to owning a property),
- Household income of less than £300 per week (in 2003)

Other studies have found contradictory evidence for any association between increased deprivation of residential neighbourhood and increased risk of childhood emotional and behavioural disorder\textsuperscript{54,55}.

6.7. Modifiable risk factors - Faith and mental health
A 2008 literature review of studies on potential links between faith and mental health suggested that there was some evidence of a positive association between public religious practice and more positive mental health outcomes in adolescents\textsuperscript{56}. However, while the evidence for substance misuse was relatively strong, the results for associations with depression or anxiety were equivocal. The authors also acknowledge the potential for publication bias in this area. There is also some evidence to suggest a positive association between active religious practice and mental health service use for those with a mental health disorder in the United States\textsuperscript{57} although this may not be fully applicable to the United Kingdom.

6.8. Modifiable risk factors – Children in Care
As discussed in the section 5, there is strong evidence for a positive linear association between CIC and increased mental health disorder. This means that with each incremental increase in cumulative risk, the greater the risk of mental ill health\textsuperscript{58}. The risks with the greatest association with mental disorder for CIC are older age at entry into care, developmental disability, sexual, physical or emotional maltreatment and a lack of permanence in placement\textsuperscript{59}.

6.9. What are the trends?
There is little evidence available relating to trends in incidence or prevalence of general childhood mental health disorder. However, there is some evidence to suggest that diagnoses of autistic spectrum disorders in children are increasing. Atladottir et al.\textsuperscript{60} found statistically significant increases in incidence of hyperkinetic disorder, autistic spectrum disorders and tourettes syndrome disorders between 1992 and 1999 although it is not possible to identify whether this increase is a true rise in incidence or due to changes in diagnostic practice. A Swedish study\textsuperscript{61} also found an increase in the rate of adolescent mental health disorder between 1985 and 2005 while finding little change over the period for younger children.
7. Existing services

7.1. Child and adolescent mental health services in Suffolk
Since April 2013 the commissioning of the majority of the mental health services in Suffolk have been inherited by Ipswich and East Suffolk CCG and West Suffolk CCG from former NHS Suffolk. Also, from April 2013, CAMHS Tier 4 mental health services have been defined as specialised services and consequently commissioned nationally by NHS England. Some services are also commissioned by Suffolk County Council (SCC). Although the services provided by SCC tend to be linked with adult social care such as mental capacity, social services emergency duty service can respond to requests for children who are at risk of harm due to health problems.

In the context of children and young people’s mental health services, the term ‘CAMHS’ can be used to refer either to all services and agencies that contribute to the mental health care of children and young people, or to the specialist CAMHS services at tiers 2, 3, and 4. Traditionally, tiers of CAMHS have been described as having four tiers (figure 3) of increasing need and complexity. Generally, while decreasing number of children require treatment as the tier of service increases, cost associated with each service user increase with each increase of tier. However, it is recognised that there is increasing critique for the tier-based approach, which is seen as reinforcing distinctions between different services and hindering move towards integrated model.

Figure 3: CAMHS service tiers

7.2. Overview of the current CAMHS provision in Suffolk
Tier 1:
Primary care services e.g. GPs, Health Visitors, Teachers, and Youth Workers, School nurses. These services can be accessed by drop-in, self-referral, or referral from other professionals and organisations.

Tier 2:
Services such as: Primary Meal Health Workers (PMHW), Community Education Parenting groups, Sure Start, Family Welfare Association, Paediatric Services, Social Care Services, Community Education Information & Support Services, School Counsellors, Educational Psychology, and Youth Offending Team. Depending on access criteria, these services can be accessed by drop-in, self-
referral, or referral from other professionals and organisations. It should also be noted that while the core work of school nurses is at the tier 1, they may also deliver interventions within tier 2.

**Tier 3:**
Services in this tier are delivered by multi-disciplinary teams of Specialist CAHMS Professionals. These services are accessed mainly through Access and Assessment Team (AAT) single point referral system through a professional referral. Services at this tier are delivered primarily in the community through Integrated Delivery Teams. Specialist services such as the Learning Disability Service for children and young people aged 14 to 18, and Autism Assessment Diagnosis Service for children and young people aged 11 to 17 can be also accessed via the AAT. Some specialist services are also provided outside the CAMHS services, such as ASD diagnostic pathway in the SCH for 0-11 year olds.

**Tier 4:**
Since April 2013 Tier 4 services have been commissioned by NHS England. Tier 4 services are specialised in-patient services for children and young people, organised and delivered regionally. Children and young people in Suffolk have access to the Adolescent in-patient unit based in Oulton, which accepts children and young people aged 12-18.

### 7.3. Tier 1 services
Children and young people’s mental health needs can be met by family, friends and professionals. Professionals providing Tier 1 services are mainly front-line staff (e.g. GPs, School Nurses) working directly with children and young people within universal services. These services are provided by the NHS, the private healthcare sector, local authorities and the charity/voluntary sectors. The aim of the frontline services is to address risk factors for developing mental disorders, identify early signs, deal with less serious disorders and seek support from appropriate specialist provision on timely manner before the issues escalate.

Tier 1 services are generally accessed through self-referral, a referral from another service, or on a drop-in basis. Practitioners at Tier 1 level are able to access advice from or refer children on to Tier 2 services as required. However, children whose mental health difficulties manifest mainly through behaviour (e.g. conduct disorder) may struggle to gain access to more specialist services.

Suffolk Wellbeing Service provides Tier 1 and 2 care and provision, which is delivered through a multi-agency collaboration with NHS and voluntary sector organisations. However, it is challenging to present a full picture of services provided at this level as cumulative data are not collected systematically within Suffolk.

### 7.4. Tier 2 services

#### 7.4.1. Behaviour Support Service
The Suffolk Behaviour Support Service (BSS) offers support in schools for children and young people (aged 5 to 16) who are displaying social, emotional and behavioural difficulties. The service works in partnership with schools and other agencies to provide a package of strategies and support. The service offers direct work individually, in pairs, or in groups to help children better manage their own behaviour. The service also offers advice and support for schools to help them increase capacity to meet the needs of pupils who present challenging behaviour. Difficulties covered by the service include; anger management, conflict resolution, emotional literacy, social skills, playground issues, bullying, friendship issues, self-esteem, behaviour management, and assertiveness. The BSS also
works in partnership with the County Inclusion Co-ordinators to provide support for managed moves and transition into/out of Pupil Referral Units.  

7.4.2. County Inclusive Resource
The County Inclusive Resource (CIR) is a Suffolk County Council outreach service that can be accessed by mainstream schools to support the inclusion of pupils on their roll with a diagnosis of Autistic Spectrum Disorder (ASD). The service is available for children and young people aged 5 to 16. Satellites of the service have been established in schools across the county and from these satellites teams of CIR staff deliver support to schools in their locality. The service has three main aims. Firstly, support mainstream schools in promoting the inclusion of ASD pupils. Secondly, improve the skill, knowledge and understanding of staff working with ASD pupils. And, thirdly, enable schools to provide high quality education for pupils with ASD that meet their needs.

7.4.3. Pupil Referral Units
There are thirteen Pupil Referral Units in Suffolk which support pupils from 5 to 16 years of age. Pupil Referral Units (PRU’s) usually work with young people who have been excluded from school, or who are at risk of exclusion. Some also help children and young people who find it difficult to cope in a local school. Staff in the PRU’s supports children and young people to develop a range of skills so that they can manage with the demands of school as well as supporting them with their learning.

7.4.4. PMHWs
Tier 2 services are predominantly provided by Primary Mental Health Workers (PMHW). The service is jointly commissioned by the CCGs and Suffolk County Council and is provided by NSFT. The newly restructured PMHW service provides a countywide provision supporting professionals who work with children and young people experiencing emotional, psychological, and mental health difficulties, up to the age of 18 (in exceptional cases up to the age of 25).

The service aims to support professionals through a referrals helpline, advice and consultation, liaison and training, joint assessment and intervention with short term individual therapeutic work. As a major component of the Tier 2 service, PMHWs are in a position to provide vital early intervention work to reduce the need for access to Tier 3 or 4 services. A 2005 guidance recommended that a CAMHS service should consist of at least 20 whole time equivalent (wte) clinical staff per 100,000 population, of whom at least 5 should be PMHWs. For Suffolk’s population of 160,000 children (0-18), this would equate to a requirement of at least 32 wte clinical staff for Tier 2-3 services and at least 8 wte PMHWs.

However, the above PMHW model reflects only psychiatric need which would not include much of the need relating to conduct disorders and emotional wellbeing. Additionally, at the time of the guidance development, it was not always the case that CAMHS provided treatment up to age 18. The current PMHW service in East and West Suffolk, according to the service specification, consists 12 wte PMHWs across East and West Suffolk and a further 1 wte in the NSFT Access and Assessment Team (which appears not be in place). In addition, there are 6 wte psychology assistants / support posts across East and West Suffolk. There is also a full time PMHW in the Connect Team for East and West Suffolk and a full-time PMHW co-located with the Youth Offending Teams covering East and West Suffolk. PMHWs are linked to GP practices and schools and model across the county is aligned. However, it was not possible to have a conformation from the service whether all the posts were filled.
The PMHW service is available from Monday to Friday from 09.00 to 17.00. Any professional working with children and young people can contact their allocated PMHW via telephone to seek advice. There is no requirement for a formal referral for the initial contact, and the service will advise the type of contact or need for a more formal referral depending on need.\textsuperscript{[1]}

7.4.5. Early Intervention in Psychosis Service
Since the re-organisation of the services in Suffolk, the early intervention in psychosis service is available in Great Yarmouth and Waveney CCG, but not in East and West Suffolk CCGs. This function has been overtaken by Integrated Delivery Teams (IDTs), which provide Tier 3 services for children with non-psychotic and psychotic disorders in the East and West Suffolk CCGs.

7.4.6. Educational Psychology Service
As a result of an ongoing transformation programme within Suffolk County Council, a new Education and Learning Service was established in Autumn 2015. The Community Educational Psychology (CEP) Service has transferred across to Schools’ Choice. The CEP service continues to work with schools and colleagues within Education & Learning to provide an Educational Psychology core offer which fulfils the Local Authority’s statutory duties for children and young people with Special Educational Needs & Disability (SEND). Further, CEP Service continues to provide a wide range of services through Schools’ Choice.

The core statutory work of Educational Psychologists (EPs) continues to be free at the point of delivery, and is designed to meet the needs of children and young people with SEND. Requests for psychological assessment as part of the Education, Health and Care Plans (EHCP) continue to come through the SEN panel and the SEN Service as before. The EP core offer permits some work in relation to young people with complex needs, such as with those in risk of permanent exclusion. This work is allocated through the In-Year Fair Access Panel meetings (IYFAP). The CEP Service is no longer accepting direct referrals from schools for core (non-statutory complex) work. Instead, referrals for core (non-statutory complex) work should be directed to EPs via IYFAP. Currently the CEP Service is continuing to offer Critical Incident Support.

Schools can purchase further Educational Psychology services through School’s Choice. This work continues to be tailored to meet the requirements of an individual school or group of schools. Schools can purchase one-off services or an annual support package. (Personal Communication)

7.5. Tier 3 services
Since 2013 service re-structuring means that CAMHS have been integrated in the new service structures in Suffolk. The specialist services for children and young people are delivered through Integrated Delivery Teams (IDTs) both in East and West Suffolk. Services are co-funded by IESCCG and WSCCG.

7.5.1. Children with learning disabilities – Community Nursing
The Community Nursing Team for Children and Young People with Learning Disabilities is commissioned by CCGs and provided by SCC. The service is located with Suffolk Community Health (SCH). The service has bases in both Ipswich and Bury St. Edmunds and provides care for children aged up to 18 who have a moderate, severe or profound learning disability, as defined by the Department of Health (IQ of less than 70). The team provide support for behaviour management, continence promotion, health surveillance, self-esteem promotion, post-diagnosis support, family
maintenance, accessing services, skill development, sexuality issues and care transition. It operates within office hours, Monday to Friday, but can work to flexible hours where needed.

7.5.2. Suffolk Child and Adolescent Mental Health Services (East and West)

In Suffolk there are five locality specific IDTs responsible for coordinating and delivering community mental health services for all age groups. There are two IDTs in the West and three in the East. Within the IDTs are different pathways, depending on the age and need;

- Adult pathway
  - From the age of 25
- Enhanced Community Pathway
  - for those not requiring acute care but needing ongoing support with mental health difficulties in the community
- Youth Pathway: 14-25 year olds
- Neuro- Developmental Pathway
  - Mental Health Difficulties in people with Learning Difficulties and ADHD in over 14 year olds
- Child and Family Pathway
  - 0-14 year olds
  - Within this pathway:
    - PMHW Team (who still work with 0-18 year olds)
    - Connect Team for Children in Care
    - Tier 3 practitioners for children
    - ADHD nurses
- Complexity in Later Life – older adults with mental health difficulties such as dementia.

In the East Suffolk, the Child and Family Pathway is located in the Ipswich IDT and covers all the three East IDTs. The IDTs offer clinical interventions for complex mental health needs and some defined difficulties such as ADHD or Autism. The conditions that the IDTs can offer help include the following;

- Non-psychotic and psychotic disorders, such as schizophrenia and bipolar affective disorder
- Severe depression
- Anxiety
- Obsessive compulsive disorder (OCD)
- Eating disorders
- Learning disabilities
- ADHD
- Autism spectrum disorders.

The services via the IDT are available from Monday to Friday, between 09.00 and 17.00. Services are accessed via referrals to the Access and Assessment Team. For further information, please see the section below.

7.5.3. A Single Gateway to services for Children and Young People (East and West)

Tier 3 services provided by the IDTs are accessed via referral to the Access and Assessment Team (AAT) located in Ipswich. Professional referrals only are encouraged by the AAT. The AAT operates a routine team that is available daily from 08.00 to 20.00 and an emergency team that is available
24/7. All referrals are assessed and triaged according to their urgency. The screening is used to decide whether there is a need for further information gathering, telephone consultation, face to face assessment, or if a referral is declined. The referrals assessed requiring tier 3 services are directed to the relevant IDT team. It is recognised in the AAT that there is a limited amount of specialist expertise in child and youth mental health. Although steps have been taken to increase the available clinical specialist time, due to funding issues child and adolescent mental health specialist time is currently limited which will negatively impact the quality and outcome of the assessments.

7.5.4. CONNECT
This is a specialist service for young people up to age of 18 in Suffolk, who are adopted, children in care, or in Special Guardianship, Child Arrangement or Kinship Care. The service also supports carers and families and is available from Monday to Friday between 09.00 and 17.00. Referrals to service are through the AAT, but drop in sessions are available once a week both in East and West Suffolk offering an opportunity to discuss a child’s needs.

7.5.5. Eating Disorder Service
Community eating disorder services are located with the IDTs and are available for both East and West Suffolk. The eating disorder service was opened for the West Suffolk during 2014 which makes this provision now countywide.

7.5.6. Warren Hill Youth Offending In-reach Service
Currently there is no youth offender accommodation in Warren Hill. It was decommissioned by the decision of Youth Justice Board in September 2013.

7.5.7. Hollesley Bay Youth Offender Institute
Hollesley Bay Youth Offender Institute is part of the HMP Hollesley Bay Prison in Suffolk. According to the latest inspection report, mental health services within this Institute are provided by Care UK. According to the report, mental health team’s liaison with community services was good, and no care transfers due to mental health difficulties to community mental health services were reported at the time of the inspection.

7.5.8. Leapfrog
The Leapfrog Service has not existed as a separate service since October 2012. The Leapfrog pathway was revised and integrated into the SCH Child & Family Psychological Therapies Service – ‘Specialist Attachment Pathway’. Referrals for this pathway are accepted from Consultant Community Paediatrician within ICPS. Currently the service accepts children ages of 3 and 8, but trials extending the service up to the age of 11. Referral criteria for the service states that:

“Children accepted for the specialist attachment clinic will be presenting in the context of one or more of the following difficulties:

- Developmental difficulties including physical disabilities (e.g. Cerebral Palsy) or Global Developmental Delay.
- Communication difficulties including specific Speech and Language Disorders requiring intervention within ICPS.
- Self-regulation difficulties (i.e. difficulties in managing feelings and behaviour) resulting from any of the above issues which may include a history of trauma, neglect or abuse.”
The funding for this pathway is integrated within the SCH funding stream from CCGs, and is no more co-funded by the SCC.

### 7.5.9. Autistic Spectrum Disorder (ASD) Service and ADHD Service

In Suffolk (excluding Waveney), services for children with ASD are commissioned together by the IESCCG and WSCCG. Assessment, diagnosis, and interventions for children under the age of 11 are provided by the Suffolk Community Healthcare (SCH) within the diagnostic pathway. However, it should be noted that the SCH does not provide a specific service for children with mental health difficulties. The service has children on caseload with long term health conditions, including children with mental health difficulties. Assessment, diagnosis, and short-term post-diagnostic support for the children and young people aged 11-17 are provided by the NSFT. These services were recently reviewed by Public Health (October 2015) and the report is accessible below.

ASD Review 2015

**Figure 4: ASD Service Review 2015**

Arrangements for services for children with ADHD have not changed. And remain as described in the 2013 report:

“ADHD services are provided by NSFT based in Ipswich and Bury St Edmunds. This service was implemented in 2008 and there remains a legacy ADHD caseload for West Suffolk treated by Suffolk Community Healthcare. In the case of dual diagnosis between ADHD and autistic spectrum disorder, community paediatricians will manage the care where the primary diagnosis is ASD.”

### 7.6. Tier 4 services

Since April 2013 CAMHS tier 4 services and tier 3 specialist services (e.g. community services for deaf children) have been commissioned by NHS England. In the current system, Suffolk children and adolescents should be admitted to the nearest available unit on the NHS England list who are able to take them. Children and adolescents placed long-distances from home are moved to units nearer home if a place comes available and this can be done without contraindicating their treatment.

The following units are placed in the region, though they are administered as part of the national resource through NHS England.

**NHS units:**

- The Darwin Unit, Cambridge, General Adolescent Unit
- The Pheonix Centre, Cambridge, Adolescent Eating Disorder
- The Croft, Cambridge, Children's mental health unit, under 13s
- St Aubyn's Centre, Colchester, 2 wards, Larkwood ,PICU and Longview general admissions
- 5 Airey Close, Lowestoft, girls’ adolescent unit.

**Private units:**

- Priory Chelmsford, General Adolescent Unit
- Cambian Willows, Wisbeach, General Adolescent Unit
• Oakview, Attleborough, LD/ASD
• Huntercombe Norwich, low secure adolescent unit.

Locally, a Suffolk innovation called the Belhaven project has just commenced. The Belhaven is an innovation for children and young people, jointly provided by the Priory Group and the Spring Consortium, and will provide five beds locally for young people with a mixed social and mental health difficulties. 78

8. Services for Lowestoft and Waveney
Services for Lowestoft and Waveney are commissioned by the Great Yarmouth and Waveney CCG (GYWCCG) from the NSFT. Although the provider organisation for mental health services is the NSFT throughout the Suffolk, the service model is different between Waveney and the rest of the Suffolk. Tier 1 and 2 services are provided by PMHWs, which are co-funded by health and social care. Tier 3 mental health services are provided by Youth (0-25) Service. In the Waveney area, the plan is to develop the Youth Service so that services can be offered for those with mental health needs and learning disabilities, as well as for children in care. Within the Youth Service there are two pathways; children aged 0-14, and youths aged 15-25. Interventions within the pathways include, for example, early intervention and early psychosis services. Children have also access to services that offer intensive and enhanced support, and an all-age eating disorder service which is run by a band 7 nurse with a psychiatrist support.

In acute hospital settings a psychiatric liaison service is being developed. Currently the service is operational from Monday to Friday from 9.00-17.00, and on Saturday mornings. The purpose of the service is to assess children and youths admitted to wards and in A&E department due to mental health issues, such as suicidal ideation. The service offers follow-up support and sign-posting to other relevant services.

The mental health services in the GYWCCG are moving away from the tiered model and aim to develop a “one stop shop” for children mental health needs. The service also aims to transform overall mental health support by innovative models. For example, services provided by CAMHs professional are bought by a CAMPUS-educational facility that is providing support for children in risk of exclusion or who have behavioural difficulties. In this setting CAMHs professionals provide therapeutic element of the support. Support for perinatal mental health is provided in partnership with “Edge of Care”.

Current development challenges for the CAMHs services within the GYWCCG are identified as: crisis pathways, self-harm, and perinatal mental health. In addition, the local commissioners recognise that the current service provision for ASD diagnosis and support are not thought through. Access to services is also described as difficult to navigate, and confusing for both service users and professionals. Service fragmentation may be partly due to recruitment problems, which has led to a situation where professionals are engaged with a number of different service parts.

9. Service use and performance
At the time of writing this report, limited amount of service specific data were available. There was especially lack of data for services covering Waveney, and until otherwise specified, the following discussion refers only to data from IESCCG and WSCCG. The lack of service specific data for IESCCG and WSCCG is partly attributable to the introduction of a new computer system at the beginning of
the 2015 and associated operational challenges for the new system. Changes to service structures and processes, as described above, make direct comparison of service data between this and the previous needs assessment difficult.

9.1. Tier 2 service data

The PMHW service is a relatively new service, which is still been embedded in to the CAMHS structures. Currently service performance data is available from January to May 2015 (May data incomplete, data provided by Public Health Suffolk). The available data is presented in the tables below. For the first five months of 2015, the most of the PMHW activity was concentrated in East Suffolk area. There appears to be considerable fluctuation in referral numbers, with a peak in March 2015. As data was not available about the referral source, it is not possible to identify where the referrals originated. However, as presented in table 9 below, the AAT saw also a peak in referral numbers to the Tier 3 services. As the referrer information is not known, it cannot be estimated whether the peak in referral numbers to PMHWs is caused by AAT directing more referrals to the PMHWs or did both services experience independently increase in demand.

Table 11: Number of new referrals to Primary Health Worker Teams

<table>
<thead>
<tr>
<th>Locality</th>
<th>Month 2015</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk East Primary Mental Health Workers</td>
<td></td>
<td>73</td>
<td>33</td>
<td>97</td>
<td>23</td>
<td>9</td>
<td>235</td>
</tr>
<tr>
<td>Suffolk West Primary Mental Health Workers</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>73</td>
<td>33</td>
<td>98</td>
<td>23</td>
<td>9</td>
<td>236</td>
</tr>
</tbody>
</table>

Service also monitors the length of the time that an individual case stays within their caseloads. This information is indicative, as only limited number of cases has been discharged from the service during the five month period that the data relates to. There is no clear pattern emerging whether children tend to stay in the caseload under or over 11 weeks. It is, however, not clear how long a child should stay within a caseload, as this is likely to be needs, not time, based.

Table 12: Length of Closed Referral Status for Primary Mental Health Worker Team Referrals

<table>
<thead>
<tr>
<th>Locality</th>
<th>Month 2015</th>
<th>Jan</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk East Primary Mental Health Workers</td>
<td></td>
<td>1</td>
<td>1</td>
<td>13</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>Over 11 Weeks</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Under 11 Weeks</td>
<td></td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Suffolk West Primary Mental Health Workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Under 11 Weeks</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>1</td>
<td>1</td>
<td>13</td>
<td>12</td>
<td>27</td>
</tr>
</tbody>
</table>

During the data period, only fraction of the cases (3%) needed the level of care to be stepped up from Tier 2 to Tier 3. Even smaller number of referrals was passed to the AAT. This would indicate that the cases referred to and seen by the PMHWs are on the appropriate level of complexity and intensity.
Table 13: Number of PMHW Service Users Stepping up to Tier 3 Services or staying in Tier 2

<table>
<thead>
<tr>
<th>Moving to Tier 3 Services</th>
<th>Month 2015</th>
<th>Jan</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Not known</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step up to Tier 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Still Active at Tier 2</td>
<td></td>
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<tr>
<td>Discharged at Tier 2</td>
<td></td>
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<td></td>
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<tr>
<td>Passed to Access &amp; Assessment</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Although the PMHW service for West Suffolk recorded only one referral during the data collection period, there were considerably more contacts with service users. This is likely to reflect contact with the individuals previously accepted in the caseload. While the service provided information of the type and count of attended contacts, it is not known whether these are contacts with the individual referred or consultative contact, for example, with a teacher. Face to face contacts accounted for 85% of all the attended contacts. This would indicate that the preferred method of contact was face to face contact instead of telephone consultation. Data, however, does not provide information about the percentage of missed appointment.

Table 14: The number of attended service user contacts with Primary Mental Health Worker Teams

<table>
<thead>
<tr>
<th>Area and contact type</th>
<th>Month 2015</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk East PMHW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face to Face with Client</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>4</td>
<td>37</td>
<td>48</td>
<td>20</td>
<td>9</td>
<td>118</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>3</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Suffolk West PMHW</td>
<td>2</td>
<td>6</td>
<td>22</td>
<td>21</td>
<td>13</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>2</td>
<td>6</td>
<td>17</td>
<td>19</td>
<td>13</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>6</td>
<td>47</td>
<td>77</td>
<td>50</td>
<td>25</td>
<td>205</td>
<td></td>
</tr>
</tbody>
</table>

The available data indicated that the service activity of the PMHWs was concentrated in the East Suffolk for the beginning of the 2015. Whether this was due to staff illness, unfilled vacancies, or lack of referrals was not clear from the data. It is also possible that the East Suffolk may have picked some of the West Suffolk workload during this period. It is also not known how many referrals the service accepts for longer term work after the initial assessment. Comparison of the referral numbers and cases open to PMHWs would, however, indicate that the service is accepting majority of the referrals at least for an assessment. While limited data of service performance were available, it nevertheless displayed a picture of service that is still in development, especially in West Suffolk. Type of referrals received by the service appears to be well-matched with the service purpose, with a majority of referrals accepted by the service.

9.2. Tier 3 service data
The discussion below presents currently available data for the financial year 2014-2015. The available data relates to performance of the Access and Assessment Team (AAT) in processing referrals for under 18s. Currently no data was available for the performance or caseloads of the Integrated Delivery Teams (IDTs). The data in this section has been provided by the NSFT, Ipswich and East Suffolk CCG and West Suffolk CCG.
Comparison of the referral numbers (table 13) indicated that during the finance year 2014-2015 there has been a quarterly increase in referral numbers. Notably, the number of referrals received during the last quarter of the finance year was nearly 40% more than the number of referrals received during the first quarter. Although the number of referrals increased towards the end of the finance year, opposite pattern was observed for the number of referrals forwarded to the IDTs. There was a considerable variation in the number of referrals that are forwarded to IDTs after initial assessment. On average, 40% of the referrals were forwarded to the IDTs during the first quarter of the finance year. However, during the last quarter, only 22% of the referrals were forwarded to the IDTs. Proportionally, there was nearly 80% reduction in the number of referrals being passed to the IDTs.

When interpreting the data it should be noted that data reporting limitations meant the referrals directed to the IDTs include both IDT referrals and referrals for PMHWs within the IDTs. According to the AAT, historically approximately 50% IDT referrals are for the attention of the PMHWs located within the IDTs. This means that referrals for the IDTs are not necessarily for the Tier 3 services, but also for the Tier 2 services, however, for the purposes of this review referrals for the IDTs are considered as specialist Tier 2/3 referrals.

In the table 15 are the percentages and numbers of the referrals for each month forwarded to IDTs after screening and assessment. In numerical terms, after the first quarter the total number of children referred to the IDTs reduced from an average of 110 referrals per month to an average of 90 referrals per month. This means that after an initial reduction of 25%, referral numbers to the IDTs were stabilised.

The AAT has provided the latest estimates for the referral numbers for under 18s between April 2015 and September 2016 (Table 14). The service estimates that the numbers provided are on the low end, but indicate the workload during the last six months. The referral data illustrates that the AAT service is under increasing pressure for under 18s referrals.

The referral data showed that compared to the first six months of the 2014/15 financial year, there has been 10% increase in referral numbers during the beginning of the 2015/16 finance year. As data is not available for the number of referrals directed to IDTs, it is not possible to evaluate whether the volume of referrals for the IDTs has changed.

Table 15: Number of under 18s referrals for Access and Assessment Team (Excluding Waveney)

<table>
<thead>
<tr>
<th>Month 2014-15</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>258</td>
<td>290</td>
<td>281</td>
<td>344</td>
<td>226</td>
<td>307</td>
<td>389</td>
<td>301</td>
<td>342</td>
<td>365</td>
<td>373</td>
<td>422</td>
</tr>
<tr>
<td>Triaged within 1 operational day %</td>
<td>96.9</td>
<td>98.3</td>
<td>91.5</td>
<td>91.3</td>
<td>92.5</td>
<td>95.8</td>
<td>82.0</td>
<td>92.7</td>
<td>94.2</td>
<td>93.7</td>
<td>90.3</td>
<td>84.6</td>
</tr>
</tbody>
</table>

Table 16: Referral numbers for under 18s for the first six months 2015/16 finance year

<table>
<thead>
<tr>
<th>Month 2015</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>358</td>
<td>326</td>
<td>353</td>
<td>337</td>
<td>238</td>
<td>293</td>
</tr>
</tbody>
</table>
The AAT service is designed as an access point for Tier 3 and 4 Services, and some Tier 2 services, such as PMHWs, may be accessed via the service. In total, the service received 3,898 referrals during 2014-2015, of which total 1,127 were accepted for the services. It has been estimated that in total 2,915 children in Suffolk may require Tier 3 or 4 services in Suffolk. This would indicate that there are potentially a large number of children (1,788) in Suffolk who may not have been able to access the appropriate level of CAMHs services, even if referred to the AAT. However, more detailed analysis of the number of children accessing services is provided in the table 18.

Table 17: Number and percentage of referrals directed to the IDTs (Excluding Waveney)

<table>
<thead>
<tr>
<th>Month 2014-15</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals forwarded to the IDTs</td>
<td>107</td>
<td>111</td>
<td>111</td>
<td>90</td>
<td>67</td>
<td>107</td>
<td>105</td>
<td>75</td>
<td>96</td>
<td>72</td>
<td>94</td>
<td>92</td>
</tr>
<tr>
<td>Percentage of referrals forwarded to IDTs %</td>
<td>41</td>
<td>38</td>
<td>40</td>
<td>26</td>
<td>30</td>
<td>35</td>
<td>27</td>
<td>25</td>
<td>28</td>
<td>20</td>
<td>25</td>
<td>22</td>
</tr>
</tbody>
</table>

The available performance data indicated that the AAT team is meeting the set time-frames for urgent assessments, but for routine assessments there is more variation in meeting the set-time scales. Of the referrals forwarded to Integrated Delivery Teams (IDTs), performance data argued that most of the forward referrals to the IDTs are delivered within agreed time frames.

Table 18: Access and Assessment Team Service Performance Key Indicators under 18s (Excluding Waveney)

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Referral to intervention times: 72 hours for urgent assessment</th>
<th>Referral to intervention times: 28 calendar days for routine assessments</th>
<th>Mental Health referrals for under 18 year olds to IDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 2014-15</td>
<td>Referral to intervention times: 72 hours for urgent assessment</td>
<td>Referral to intervention times: 28 calendar days for routine assessments</td>
<td>Mental Health referrals for under 18 year olds to IDT</td>
</tr>
<tr>
<td>Number of Urgent Assessments</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Time-scales met %</td>
<td>50</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of Routine Assessments</td>
<td>80</td>
<td>80</td>
<td>94</td>
</tr>
<tr>
<td>Time-scales met %</td>
<td>43.8</td>
<td>26.3</td>
<td>19.1</td>
</tr>
<tr>
<td>Referrals to IDTs</td>
<td>107</td>
<td>111</td>
<td>111</td>
</tr>
<tr>
<td>Time-scales met %</td>
<td>93.5</td>
<td>96.4</td>
<td>92.8</td>
</tr>
</tbody>
</table>

Available referral data indicates that the referral volumes have continued to increase towards the end of the financial year. Although the percentage of children referred to the IDTs has decreased, the overall number has remained stable over last three quarters of the finance year. This indicates that the service is struggling with increasing number of referrals that may be more suitable for Tiers 1 and 2. Furthermore, the AAT indicated that according to their experience, the number of referrals directed to the IDTs tends remains relatively stable, while the number of referrals more suited to the
Tiers 1 and 2 fluctuates. However, evaluation of the IDTs was not in the scope of this needs assessment.

9.3. Tier 4 Data
As discussed previously, tier 4 services are commissioned by the NHS England Area team. For the Suffolk CCGs the NHSE East Anglia Area Team is the responsible commissioner.

9.4. Service costs
The value of the block contract for the CAMHs element of the NSFT is not known. However, CAMHS programme budget estimate per head in Suffolk is lower than regional and national average as shown in the following table 19:

<table>
<thead>
<tr>
<th>Area</th>
<th>Programme budget per head (2011/12)</th>
<th>Programme budget per head (2012/13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk</td>
<td>£ 70.79</td>
<td>£ 46.42</td>
</tr>
<tr>
<td>East of England</td>
<td>£ 63.72</td>
<td>£ 53.06</td>
</tr>
<tr>
<td>England</td>
<td>£ 59.35</td>
<td>£ 58.84</td>
</tr>
</tbody>
</table>

10. Stakeholder Experience
As with the previous section, information in this section is not updated paragraph by paragraph. Instead, two short summaries of a recent stakeholder feedback of on accessing CAMHs and specialist services are provided. The information presented in the section 7 of the 2013 CAMH needs assessment has not significantly changed, and the issues discussed in that needs assessment remain relevant.

10.1. Service user views
The following feedback was collected during a mental health workshop with pupils from Stowmarket High and Farlingaye School in July 2015. Pupils’ experience of accessing mental health support is summarised below:

- Long waiting time for an appointment
- Feeling that duration of treatment was too limited
- Treatment didn’t feel personal, and pupils didn’t feel listened
  - No choice over who to talk to, lack of trust
  - Felt misunderstood by professionals, felt that problems were belittled
  - Power imbalance, being patronised
- Information sharing - When starting with someone new there is a need to tell one’s life story
- Expectation is that really personal stuff is shared with others, even when one does not feel comfortable with it.

As with this updated needs assessment, the previous needs assessment included limited amount of information regarding the service users’ experiences in accessing CAMHS. A comparison with the previous service user information indicated that very little appears to have changed in how young people perceive the services. As previously, some young people expressed their frustration of the length of wait for an appointment. However, what was not included in the previous needs assessment was the worry felt by some young people that their concerns were not being taken seriously by the services. The question of trust was also raised, with mixed views regarding the need to share information between professionals and information being kept confidential.
10.2. The views of referrers
During June and July 2015, Public Health undertook a survey of professionals working with children, young people and their families in order to understand the needs of those children experiencing emotional or behavioural difficulties.

The obvious limitation with the survey results is that the survey was not specific to CAMHS, but included all services for children and young people with behavioural or emotional difficulties. However, as many children with behavioural or emotional difficulties are referred to CAMHS (Tier 1-4) services, it is argued that the stakeholder views from referrers and specialist services provide an accurate presentation. While comparing the latest information with the previous (2013) needs assessment, the impression was that there has been little change in how referrers and those working in specialist services view referral pathways and access to services.

Concerns continue to be expressed about unclear referral pathways and access criteria, delays in accessing the service and perceived complexity of the service structures. Professionals working in the specialist services perceived referral pathways as generally well-functioning and expected referrers to be aware of the correct processes. Professionals in the specialist services expressed some concerns for the number of referrals not suitable for their service. Stakeholder views about CAMHS indicate that there is potentially a considerable pressure on the accessing the services, while it is unclear how and which service should be accessed.

11. Evidence of effectiveness
In order to assess the effectiveness of CAMHS provision in Suffolk, it is necessary to assess both the achieved outcomes for patients across the services and the extent of unmet need in patients unable to access provision.

Anecdotal data on unmet need has been supplied by stakeholders (see Section 7). This suggests there is a common perception in referrers that access to mental health services is not always straightforward for children with a recognised need relating to emotional wellbeing or behaviour. Provider staff responders have been concerned that children without treatable mental health diagnoses are referred to Tier 3 CAMHS where the problems relate solely to social care. Qualitative data does suggest that there is a significant number of patients whose mental health or emotional wellbeing needs are difficult to provide for within the current framework of services. Of the 3,898 referrals to CAMHS specialist services in 2014/15, only 1,127 (29%) were forwarded to the IDTs after assessment in the AAT.

11.1. Estimating unmet need
It has been estimated that in 2015 there were between 6,874 and 7,249 children aged 0-16 in Suffolk with a mental health disorder. Chimat has also provided an estimation of level of need based on the service tier. We have attempted to estimate the level of unmet need on each service tier in the table below using CHIMAT estimates. It should be noted that the numbers in the table 18 are based on available information provided to us at the time of writing this report. Therefore, the numbers should be treated and interpreted cautiously.
Table 20: Estimated level of unmet need

<table>
<thead>
<tr>
<th>Service Tier</th>
<th>Estimated number of children requiring services in 2014</th>
<th>Service Evidence of number of children accessing the services (Based on the numbers available at the time of writing)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 4</td>
<td>115</td>
<td>Not known</td>
<td>No data available as this is NHS England commissioned service.</td>
</tr>
<tr>
<td>Tier 3</td>
<td>2,800</td>
<td>Access and Assessment Team &amp; IDTs (2014-2015)</td>
<td>The estimate shows that in Suffolk there are 2,800 CYP aged 0-17 require specialist service at Tier 3 at any given time. It means 2,800 children should be receiving support at this level or at least should be known to services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tier 3 referrals for under 14’s service: 110</td>
<td>Available data from exiting services (listed in the left column) indicates that approximately 1,890 children aged 0-17 accessed tier 3 services in 2014-2015. This would include children living in Waveney. However, as no information was available for specific provisions like CONNECT service, therefore it is likely that the real number of children accessing tier 3 services could be higher.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referred to AAT: 3898</td>
<td>ASD is commonly included in the evaluation of mental health disorders.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referred to IDTs from AAT: 1127</td>
<td>In East and West Suffolk, ASD provision for children aged 0-11 is imbedded in Community Psychological pathway, while older children’s ASD service is part of the NSFT. There is no specific ASD service available in Waveney.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waveney Oct - Sep 2014</td>
<td>All referrals for mental health services including ASD are processed by AAT team within NSFT and those with suspected ASD are directed to the dedicated ASD provision. During the first 11 months of the 2014-2015 there were 168 referrals were made to the ASD service for 11-17 year olds and the service was forecast to exceed 180 referrals per year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tier 3 referrals for under 14’s service: 110</td>
<td><strong>Conclusion:</strong> Available data indicates that two third (1,890) of 2,800 children who require Tier 3 service are referred to these services after assessment process. One third of children in East and West Suffolk who might have needed to access specialist provision in Tier 3 were triaged as not requiring assessment by these services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accepted for assessment: 48</td>
<td>Reliable information was not available whether alternative Tier 1 or 2 services were offered to these children who were not accepted for Tier 3 services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suffolk Community Healthcare</td>
<td>At the time of writing this report there was no information available about capacity of the Tier 3 IDTs. It should, however, be noted that regardless of the referral volume, in East and West Suffolk, the number of referrals for IDTs appear to be between 90 and 111 per month.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASD / Specialist Sleep Pathway / Preschool Complex Needs Pathway</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Individual Psychological Therapy (2014-2015)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referrals: 179</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASD pathways (2014-2015)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Estimated to exceed 300 referrals</td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td>10,595</td>
<td>PMHWs</td>
<td>Estimate shows there are approximately 10,595 children and young people aged 0-17 Suffolk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Estimate shows there are approximately 10,595 children and young people aged 0-17 Suffolk</td>
<td></td>
</tr>
<tr>
<td>Service Tier</td>
<td>Estimated number of children requiring services in 2014¹</td>
<td>Service Evidence of number of children accessing the services (Based on the numbers available at the time of writing)</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
</tbody>
</table>
| Tier 1       | 22,700                                                 | Tier 1 mental health services are generally provided by universal services. There is no common database to assess the universal service use for mental health difficulties. Different agencies working within universal services collect data about the reasons for contact. Data is available for Multi Agency Safeguarding Hub and Social Service Care First service regarding the contacts with children.  
**Care First Contact Data:**  
2014-2015 Total 7,709 contacts  
Socially unacceptable behaviour: 303 contacts  
**MASH Data:**  
2014-2015 Total 37,470 contacts  
**MASH Contacts related to mental health:**  
Child mental health: 547  
Parent mental health: 743 | requires support in Tier 2 level due to their emotional and mental health problems.  
Lack of data from the service hinders evaluation of how well the PMHW service is able respond to the Tier 2 CAMHS service demand.  
The PMHW service is still being embedded into the Suffolk system, but should be (in November 2015) up and running. It is too early to make any meaningful conclusion on well this provision is responding to the demand.  
While the PMHW service is the principal Tier 2 service provided by the NSFT, children with mental health problems might also access services such as Educational Psychology (SCC) and Psychological Services provided by Suffolk Community Health.  
It is also not known how many children with mental health problems may be accessing other services such as Suffolk Wellbeing Service or other services organised by third sector providers.  
**Conclusion:** There is a lack of data to reliably estimate any gap between service provision and need at this point in time. |

| Tier 1       | 22,700                                                 | • In rough estimation this is divided between:  
- GYWCCG (15%): 1590  
- IESCCG & WSCCG: 9005  
- Jan 2015 to Mar 2015: 203 referrals in three months (over 800 children if annualised)  
**Suffolk Wellbeing Service / Suffolk Community Health:**  
- No available data  
**Community Educational Psychology:**  
- Waveney: 500  
- IESCCG & WSCCG: 1474  
**Behaviour support service (Suffolk wide):**  
- 758 pupils supported in 2014/15  
**Parenting programmes (Suffolk wide):**  
- 1138 parents started programme over two year period, this is equivalent to 569 parents per year  
**In Year Fair Access Panel (Suffolk wide):**  
- 400 children reviewed in the first quarter 2015  
**County Inclusive Service (CIR) Suffolk wide:**  
- Case load of 943 – however, all cases are not active. It is also suggested that CIR and BBS provide support for a number of same pupils.  
**Pupils referral unit:**  
- During 2014/15 supported estimates 450-460 children | requires support in Tier 2 level due to their emotional and mental health problems.  
Lack of data from the service hinders evaluation of how well the PMHW service is able respond to the Tier 2 CAMHS service demand.  
The PMHW service is still being embedded into the Suffolk system, but should be (in November 2015) up and running. It is too early to make any meaningful conclusion on well this provision is responding to the demand.  
While the PMHW service is the principal Tier 2 service provided by the NSFT, children with mental health problems might also access services such as Educational Psychology (SCC) and Psychological Services provided by Suffolk Community Health.  
It is also not known how many children with mental health problems may be accessing other services such as Suffolk Wellbeing Service or other services organised by third sector providers.  
**Conclusion:** There is a lack of data to reliably estimate any gap between service provision and need at this point in time. |
11.2. Summary of unmet needs on each Tier

While unmet need cannot be precisely estimated, it can be estimated whether the current services can respond to the potential need on each service Tier. When estimating unmet need it is important to differentiate between the point prevalence of diagnosable mental health disorders and the service need on the other hand. In this needs assessment evaluation of unmet need is based on the estimations of children requiring different service level at any given time, not based on the mental health disorder prevalence. This is because not every child with a mental health disorder requires constant access to services, while there are a number of children with transient mental health needs who may need to access services. It is not known how accessible the Tier 4 services are, as they are commissioned by the NHS England. However, when evaluating the locally commissioned Tier 3 and 2 services, questions should be raised about the services capacity to respond to the current demand.

Rough estimates suggested that one third of the children who may require Tier 3 service may not be accessing the services. The Tier 3 services are mainly accessed via the AAT within NSFT IESCCG & WSCCG, which seems to be overwhelmed by the number of referrals. The available evidence indicated that the AAT appears to have become seen as a single point of access to mental health services. Furthermore, while the capacity, of the IDTs appears to be relatively fixed, the AAT has indicated that the actual number of referrals that require attention of the IDTs remains relatively stable. However, the fluctuating number of referrals does raise the question of the capacity in the system. Therefore, it is possible that the access to the services may have been restricted due to the need to prioritise those children with the most urgent needs.

As discussed above, some services that could be understood as Tier 3 CAMH services are provided by the Suffolk Community Healthcare (SCH). This includes, for example, assessment, diagnosis and support for children aged 0-11 with ASD. Further, the SCH provides Tier 2 and 3 specialist psychological services. However, the SCH does not provide a specific service for children with mental health difficulties. Similarly to the Tier 3 CAMH services, the SCH has reported increasing referral pressure to the services (figure 4). While increased referral numbers to a service tend to indicate increased service need, or at least perceived need, currently it is not possible to estimate how many of the referrals may not be appropriate.

As discussed previously, the new PMHW service in Tier 2 is still being imbedded in the East and West Suffolk system. Therefore, the effect the PMHWs have on the overall system, access to services, and volume of referrals to the AAT cannot be reliably estimated. However, some early indicators have shown that referrals to the PMHWs have picked up. It is, however, unlikely that PMHWs are able to respond to the all estimated demand of the Tier 2 services. In addition, while children might also be able to access Educational Psychology (SCC) and Psychological Services provided by SCH, these services tend to be for children with more defined needs, such as for those with problems in schools. Furthermore, Educational Psychology service is offering only core services. This means that a child’s access to wider Educational Psychology services is dependent on schools’ choices, i.e. willingness to purchase additional services, placing children potentially in unequal position. Children and young people aged 13 and over may also be able to access psychological therapies through Suffolk Health and well-being Service.
It is also difficult to assess how underlying issues that contribute to children and young people’s mental health disorders should be addressed in Suffolk. Issues such as family dysfunction, emotional abuse, anti-social behaviour, and family in acute distress may contribute to the children and young people’s mental health needs. There is no reliable data to show the level of need or access to services for the children and young people who, while not having a mental health disorder, may nevertheless need Tier 1 mental health support.

12. Summary of the current provision with comments

We have provided some detailed explanations on current provisions, their gaps and attempted to capture the progress in addressing emotional and mental health of CYP in Suffolk since 2013 needs assessment.
### Table 21: Description of current services at each tier, gaps and progress since 2013 CAMHS needs assessment

<table>
<thead>
<tr>
<th>Service Level</th>
<th>Provision</th>
<th>Gaps/comments</th>
<th>Progress since 2013 needs assessment</th>
</tr>
</thead>
</table>
| Tier 1 services | Tier 1 services are mainly provided by frontline staff such as health visitors, teachers, school nurses, social workers and General Practitioners (GPs) who work directly with children and young people. These services are provided by the NHS, the private healthcare sector, local authorities and the charity/voluntary sectors. | There is insufficient support at Tiers 1 and 2 for those whose referrals are rejected for treatment allocation at Tier 2 or 3. | Each child in Suffolk has an access to the Universal Offer. In addition each child benefits from the Making Every Intervention Count (MEIC) Programme. The MEIC Programme is driven by the SCC and aims to provide help with parenting, relationships, behaviours and disabilities, domestic violence, drink and drugs, emotional well-being, neglect and child abuse. The purpose of the MEIC Programme is to enable delivering effective early help and, where needed, intervention. Services provided include:  
- Early Help services  
- Health Visiting  
- School Nursing  
- Education & Learning  
- Special Education Needs  
- Social Care Services  
- Fostering & Adoption  
- Disabled Children’s  
- Services  
- Youth Offending  
So far the MEIC Programme has trained over 1,000 people from Suffolk County Council and 200 staff from partner agencies in Suffolk Signs of Safety & Wellbeing. Further, the Suffolk Multi-Agency Safeguarding Hub (MASH) has been set up to provide a single point of contact in Suffolk for Adult Protection concerns and contacts to Children’s Social Care to improve information sharing and decision-making.

There is a large number of CYPS with conduct disorders requiring support from parents, frontline staff and specialist services. Currently there is no designated provision or clear pathways which prevent timely assessment by and access to appropriate services. At the present, CYP/families and professionals have to approach multiple providers to get support creating unnecessary demand within the system with no positive outcome for a CYP. As conduct disorder is often expressed through behavioural difficulties, the access to services is further complicated by services tending to reject referrals for primarily behavioural difficulties. In addition, current health provisions are diagnosis based with higher thresholds which makes access very challenging for CYP who are at risk for developing mental health disorders.  

A system wide One door/A single point access and assessment model could be the way forward to remove duplication within the system and lift the existing barriers. Several other LAs are adopting such models that bring further benefits in reducing the need for multiple referrals and improve timely access to right level of support to CYP and families. |

| Tier 2 services | These are primarily provided by PMHWs (ages 0-18), the Educational Psychology Service (0-19). School nurses may also be able to provide some services. | The best available information for the PMHW suggested that the current strength of the service is 6WTE PMHWs and psychology assistants. Compared to the available staffing recommendations, there would be need for two further WTE equivalent PMHWs. However, this model reflects only psychiatric need which would not include much of the need relating to conduct disorders and emotional wellbeing. There is also need for clarity whether part of the remit of the PMHWs role is offering support for children with behavioural difficulties. | Based on the stakeholder feedback and activity data, the current resource at the Tier 2 is not sufficient to meet demand. There is a risk that especially children with conduct or emotional disorder may struggle accessing services at Tiers 1 and 2, which may lead to escalation of difficulties and increased pressure at Tier 3 specialist services.  
While, for example, schools can purchase resources through Schools’ Choice, this is dependent on the spending decisions of the individual |

---

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- Early Help services
- Health Visiting
- School Nursing
- Education & Learning
- Special Education Needs
- Social Care Services
- Fostering & Adoption
- Disabled Children’s
- Services
- Youth Offending

So far the MEIC Programme has trained over 1,000 people from Suffolk County Council and 200 staff from partner agencies in Suffolk Signs of Safety & Wellbeing. Further, the Suffolk Multi-Agency Safeguarding Hub (MASH) has been set up to provide a single point of contact in Suffolk for Adult Protection concerns and contacts to Children’s Social Care to improve information sharing and decision-making.

Based on the stakeholder feedback and activity data, the current resource at the Tier 2 is not sufficient to meet demand. There is a risk that especially children with conduct or emotional disorder may struggle accessing services at Tiers 1 and 2, which may lead to escalation of difficulties and increased pressure at Tier 3 specialist services.

While, for example, schools can purchase resources through Schools’ Choice, this is dependent on the spending decisions of the individual.
<table>
<thead>
<tr>
<th>Service Level</th>
<th>Provision</th>
<th>Gaps/comments</th>
<th>Progress since 2013 needs assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3 services</td>
<td>These are primarily provided by NSFT in the East and West and can be accessed through AAT. CAMHS outpatient services are provided by IDTs both for East and West Suffolk. For those with suspected ASD, SCH provides a service for 0-11 old children, while NSFT provides ASD service for children aged 11 to 17. NSFT is proving a specialist service for those with ADHD. SCH is providing Child &amp; Family Psychological Therapies Service – ‘Specialist Attachment Pathway’.</td>
<td>Stakeholder feedback and performance data from the Tier 3 AAT service (West and Ipswich and East) shows that the service receives a large number/proportion of “inappropriate” referrals. Stakeholder feedback from the previous report suggested that there is frequent frustration in referrers at a perceived difficulty in access to Tier 3 services for children without a stable home/family life or for children with conduct disorders. Although the NSFT service has been restructured, there has been no market change in how referrers perceive the access to services. This suggests that clear criteria for referral and care pathways are not in place. This in turn means that referrers are not always confident in knowing how to access Tier 3 specialist care or whether Tier 2 services would be more appropriate.</td>
<td>Previously known as the Leapfrog Service does no longer exist as a separate service since October 2012. The Leapfrog pathway was revised and integrated into the SCH Child &amp; Family Psychological Therapies Service – now called ‘Specialist Attachment Pathway’. Available referral data indicated that the Tier 3 services continue to receive a considerable volume of referrals for under 18s each month. While the referral volumes continued to increase towards the end of the financial year, the latest referral number from beginning of the financial year 2015-2016 suggested that numbers dropped slightly for April. Referral data showed that the AAT service is struggling with increasing number of referrals, while questions regarding the capacity in the system, especially in the IDTs, are raised. Stakeholder feedback suggested that referrers continue to be frustrated in lack of perceived capacity and high threshold for the access. The AAT has indicated that the Suffolk Wellbeing service has been relieving pressure from the AAT.</td>
</tr>
<tr>
<td>These services are available countywide.</td>
<td>Further, PMHW performance data from the beginning of the year 2015 indicated considerable disparity between the referral number for East and West Suffolk, potentially indicating unequal access to PHMW service. Anecdotal evidence has also suggested that apart from consultative role, there is a wish for more direct interventions from PMHWs. The Community Educational Psychology (CEP) provides an Educational Psychology core offer which fulfils the Local Authority’s statutory duties for children and young people with Special Educational Needs &amp; Disability (SEND). The core statutory work of Educational Psychologists (EPs) continues to be free at the point of delivery, and is designed to meet the needs of children and young people with SEND. While the CEP Service continues to provide a wide range of services through Schools’ Choice, these services have become payable. Therefore, the access of the non-statutory EP services depends on the schools ability and willingness to pay for the services.</td>
<td>It is recognised that there is no extra funding available. However, stakeholder feedback and activity data suggested increased (or better use of) resource in Tier 2 services would bring further benefits in reducing the need for later and more intensive treatment. Available service data for PMHWs suggested that the service is still evolving, especially in West Suffolk. However, while the service model is still embedding itself in the local system, it appears that the type of referrals received by the service appears to be well-matched with the service purpose. The service also appears to be able to accept and respond to the majority of new referrals.</td>
<td></td>
</tr>
<tr>
<td>Service Level</td>
<td>Provision</td>
<td>Gaps/comments</td>
<td>Progress since 2013 needs assessment</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
<td>---------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Tier 4 services</td>
<td>Tier 4 services are commissioned by the NHSE as specialist services.</td>
<td>There are no NSFT Tier 4 inpatient-based services in Suffolk. All Suffolk children requiring inpatient care are placed in facilities based out of county in Essex or Cambridgeshire. Stakeholder feedback from both referrers and providers suggested that children requiring Tier 4 inpatient or residential services are often placed too far from home to maintain good familial contact. While Royal College of Psychiatrists standards for CAMHS note that commissioners are expected to ensure that young people are not placed out of area, the local commissioners have currently no influence on commissioning decisions. Locally, a Suffolk innovation called the Belhaven project has commenced. The Belhaven is an innovation for children and young people, jointly provided by the Priory Group and the Spring Consortium, and will provide five beds locally for young people with a mixed social and mental health difficulties.</td>
<td></td>
</tr>
</tbody>
</table>
| Autistic Spectrum Disorder/ ADHD | ASD | Main gaps:  
- Lack of support, intervention, and follow-up services for children aged 11-17 with ASD.  
- Stakeholders from both NSFT and the SCH Autism Service report difficulties in finding consensus over appropriate allocation of services for children with dual diagnosis of autism and mental health disorder  
- Additionally, the SCH service report increased demand on service resources for CYP making the transition from primary to secondary education and is concerned over its capacity to meet this demand.  
SCC has multi-disciplinary Autism pathways supporting CYP in schools and community, so it would be beneficial to link up SCH and NSFT provisions with these pathways. Or this could be resolved through multi-agency event/communications on who does what. ADHD  
A dedicated ADHD service has been provided by NSFT in Ipswich since 2008 but SCH also retain a West Suffolk caseload. The SCH also manages children in their case if ADHD is diagnosed for a child in their caseload.  
**Main gap:**  
Based on the referral data from the SCH, there appears to be confusion among the referrer for the correct referral pathway to access ADHD specific services. Again such confusion can be solved through effective multi-agency communication/events etc. | All children in Suffolk have now access to ASD diagnostic services. |
<table>
<thead>
<tr>
<th>Service Level</th>
<th>Provision</th>
<th>Gaps/comments</th>
<th>Progress since 2013 needs assessment</th>
</tr>
</thead>
</table>
| Children in Care (CIC) | Dedicated mental health services for CIC is provided by CONNECT for both East and West Suffolk. | There are two Connect services:  
• East and West Suffolk  
The Service is included within the NSFT Specialist Mental Health Integrated Delivery Teams but recognised as a specific service for children in care and their carers requiring early intervention and support as outlined above. Suffolk County Council (SCC) contributes additional funding to ensure the specific role of the Connect Service is protected, but it is managed under the overall contract with the Ipswich and East Suffolk CCG and West Suffolk CCG for mental health services.  
• Waveney  
The Service is included within the NSFT Specialist Mental Health Integrated Delivery Team for Waveney but recognised as a specific service for children in care and their carers requiring early intervention and support as outlined above. SCC contributes additional funding to ensure the specific role of the Service is protected but it is managed under the overall contract held by Great Yarmouth and Waveney CCG.25  
The following issues have been identified as challenges in the current service provision:  
• Performance monitoring, reporting and management  
• Lack of follow up to Strengths and Difficulties Questionnaire (SDQ) initial assessment and routine re-assessment  
• Scope of Connect service  
• Effectiveness of Connect service  
• Differences in service between East and West Suffolk Team and that covering Waveney. | Due to lack of performance data it is difficult to estimate any changes to the service provision. |
| Other service issues | CAMHS treatment across the majority of disorders is provided for children. | Stakeholder feedback suggested that some of the service-user accessed areas of clinical bases were not age appropriate in their decoration and facilities for older children. Royal College of Psychiatry CAMHS quality standard 9.1.4 notes that consideration of this factor is expected for CAMHS locations. | There is no available evidence to assess any changes in service-user accessed areas of clinical bases. |
| Out of hours services | The AAT provides 24/7 emergency service for all age groups requiring urgent mental health assessment. | Currently children have access to out of hours emergency assessment teams across East and West Suffolk. Access to services (IDTs) offering routine Tier 3 treatment is limited to working hours.  
The NHS England commissioned Tier 4 services (i.e. in-patient services) can be access 24/7 via psychiatric emergency services. | Access to emergency assessment teams is now available 24/7 for children. |
<table>
<thead>
<tr>
<th>Service Level</th>
<th>Provision</th>
<th>Gaps/comments</th>
<th>Progress since 2013 needs assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Young People with mental health problems presenting in A&amp;E</td>
<td>Ipswich Hospital and West Suffolk Hospital Mental Health Acute Liaison Service for those in acute hospitals requiring mental health assessment. This is not a 24/7 service.</td>
<td>Access to Mental Health Acute Liaison Service for those in acute hospitals requiring mental health assessment depends on the individual hospital arrangements. Psychiatric Liaison Teams are not specific to CAMHS patients and not accessible 24/7. CAMHs patients can be referred directly from hospital wards to AAT acute services when required.</td>
<td>Hospitals have arrangements with CAMHS for CYP presented with mental health disorders (self-harm, overdosing) at A&amp;E</td>
</tr>
<tr>
<td>Communication</td>
<td>A frequent response of stakeholders concerned a perceived deficiency in communication between CAMHS services and referrers or service users and carers at key points in the care process. A lack of communication about referral decisions and at points of transfer or discharge was noted as a source of frustration. Improved clarity about referral criteria and the application of these criteria could potentially significantly alleviate this frustration.</td>
<td>There continues to be frustration in how decisions to allocate CAMHS are communicated to referrers.</td>
<td></td>
</tr>
</tbody>
</table>
13. Conclusions and recommendations

The previous needs assessment provided a list of recommendations for the service improvement. As the service has undergone a transformation during the last view years, the present needs assessment has provided an update of the changes since the previous 2013 needs assessment in the previous section (Section 12). Based on the available evidence, the main findings and gaps raised in this needs assessment are detailed below. Due to lack of available information from the Waveney area (within GYWCCG), the main findings and recommendations concern mostly East and West Suffolk.

13.1. Main findings

- It is not known how many children have accessed the Tier 4 services.
- AAT Single Access Point for Tier 3 Services
  - AAT is designed as a gateway to Tier 3 services. However, available evidence indicates that this has become to be seen as a single point of access to CAMH services by many referring professionals.
  - The AAT aims to sign-post or organise Tier 1 or 2 services for those not assessed as requiring Tier 3 services.
  - The AAT has limited CAMHS specific expertise.
  - However, since 2015 a consultant with child and adolescent mental health expertise provides a regular session.
  - There continues to be frustration among referring professionals about the perceived difficulties to access Tier 3 services.
- IDTs and other specialist teams
  - Referrals to IDTs include both those to the PMHWs and more specialist services. However, evaluation of the IDTs was not in the scope of this needs assessment.
  - There appears to be a risk that during the times of increased referral volumes, the capacity of the IDTs to respond to the demand may be impacted.
  - Specialist Teams (ASD assessment service, CONNECT) appear to accept most of the referrals.
- Suffolk Community Health
  - SCH does not provide a specific service for children with mental health difficulties. The service has children on caseload with long term health conditions, including children with mental health difficulties. However, the service feels that access to specialists mental health support can be difficult due lack of agreed referral criteria.
  - There appears to be a need to clarify referral pathways for children with ADHD. Based on the available evidence, some confusion was observed among referrers regarding to which service, i.e. NSFT or SCH, children with ADHD should be referred to.
- PMHWs at Tier 2
  - Currently there is not enough data to evaluate reliably the effectiveness of the PMHWs.
  - The East Suffolk appeared to have better service coverage during the beginning of the 2015.
  - The PMHWs are still being imbedded in to the system.
- While the CEP Service continues to provide a wide range of services through Schools’ Choice, these services have become payable. Therefore, the access of the non-statutory EP services depends on the schools ability and willingness to pay for the services.
• Tier 1 Services
  o Conduct disorder is often expressed through behavioural difficulties. Therefore, the
    access to services is complicated by services tending to reject referrals for primarily
    behavioural difficulties.
  o Current health provisions are diagnosis based with high thresholds making access very
    challenging for CYP who are at risk for developing mental health disorders.

13.2. Service Gaps
• There is insufficient support at Tiers 1 and 2 for those whose referrals are rejected for treatment
  allocation at Tier 2 or 3.
• Children aged 13 and over can access the Suffolk Health and Wellbeing Service. However, there
  is no CCG funded self-referral CAMH service for children under 13 year olds within the NSFT.
• There is a large number of CYPS with conduct disorders requiring support from parents, frontline
  staff and specialist services. Currently there is no designated provision or clear pathways to
  access assessment and services timely.
• Stakeholder feedback from the previous report suggested that there is frequent frustration in
  referrers at a perceived difficulty in access to Tier 3 services for children without a stable
  home/family life or for children with conduct disorders.
• Community Educational Psychology Service continues to provide a wide range of services
  through Schools’ Choice. However, these services have become payable. Therefore, the access
  of the non-statutory EP services depends on the schools ability and willingness to pay for the
  services.
• Stakeholder feedback from both referrers and providers suggested that children requiring Tier 4
  inpatient or residential services are often placed too far from home to maintain good familial
  contact.
• Children with ASD
  o Lack of support, intervention, and follow-up services for children aged 11-17 with ASD.
  o Children with dual diagnosis of autism and mental health disorder have difficulties in
    accessing services for mental health problems.
  o Increased demand on service resources for CYP making the transition from primary to
    secondary education and is concerned over its capacity to meet this demand.
• Children with ADHD (East and West Suffolk)
  o There appears to be confusion among the referrers for the correct referral pathway to
    access ADHD specific services.
• Access to Mental Health Acute Liaison Service for those in acute hospitals requiring mental
  health assessment depends on the individual hospital arrangements.
  o Psychiatric Liaison Teams are not specific to CAMHs patients and not accessible 24/7.
• Access to a Psychiatrist with CAMHS specific experience in the AAT
  o The AAT team has limited access to a psychiatrist with CAMHS specific expertise.
    Although the AAT service is keen to improve the access to a psychiatrist with CAMHS
    specific expertise, the team does not have 24/7 access to a CAMHS specialist.

13.3. Recommendations
• Although the NSFT service has been restructured, there has been no market change in how
  referrers perceive the access to services. This suggests that clear criteria for referral and care
pathways are not in place. This in turn means that referrers are not always confident in knowing how to access Tier 3 specialist care or whether Tier 2 services would be more appropriate. Therefore, improved clarity about referral criteria and the application of these criteria could significantly alleviate this frustration.

- A system wide Single Point Access and Assessment model could be the way forward to remove duplication within the system and lift the existing barriers. A Single Point Access and Assessment model has a potential of reducing the need for multiple referrals and improve timely access to right level of support to CYP and families.

- Based on the available evidence of the current AAT, the service commissioners should consider whether:
  - the function of the AAT should change to a single point of access for all CAMH services with adequate resources or
  - the function of the AAT should be re-aligned as access to Tier 3 services only.

- PMHW performance data from the beginning of the year 2015 indicated considerable disparity between the referral numbers for East and West Suffolk. The service commissioners should ensure that children have equal access to PMHWs across East and West Suffolk. Based on the available data, it was not possible to evaluate whether the PMHW service in Waveney is able to respond to the local demand.
  - The service commissioners should clarify whether part of the remit of the PMHWs role should be:
    - offering support for children with behavioural difficulties and
    - widened from a consultative role to more direct interventions. However, as PMHWs come from a variety of backgrounds, type of direct interventions or therapy that may be offered by the PMHWs is likely to be dependent on the skills of an individual PMHW.

- The service commissioners should explore possibilities to develop clear assessment and support pathway for children with conduct disorders at Tiers 1 and 2.
References


12. Champion L. Referral criteria and process for Oxfordshire CAMHS community services. 2015.


47. Academy of Medical Royal Colleges and Royal College of Psychiatrists. No Health without Mental Health: The Supporting Evidence.; 2009.


72. Osbourne C. *NSFT / New Changes in CAMHS Structure.*


### Appendix 1 Population Prevalence Estimates

Population prevalence and estimated numbers in 2015 and 2020 for mental disorders in boys (aged 5-10 years and 11-16 years) in Suffolk

<table>
<thead>
<tr>
<th>Boys Suffolk</th>
<th>Age 5-10</th>
<th>Age 11-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated total population</td>
<td>26,447</td>
<td>27,198</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>2.2</td>
<td>582</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>2.1</td>
<td>555</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td>0.4</td>
<td>106</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>0.8</td>
<td>212</td>
</tr>
<tr>
<td>Social phobia</td>
<td>0.1</td>
<td>26</td>
</tr>
<tr>
<td>Panic</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Post-traumatic stress</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>0.1</td>
<td>26</td>
</tr>
<tr>
<td>Generalised anxiety</td>
<td>0.2</td>
<td>53</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>0.6</td>
<td>159</td>
</tr>
<tr>
<td>Depression</td>
<td>0.2</td>
<td>53</td>
</tr>
<tr>
<td>Depressive episode (full ICD criteria)</td>
<td>0.1</td>
<td>26</td>
</tr>
<tr>
<td>Other depressive episode</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Conduct disorders</td>
<td>6.9</td>
<td>1825</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>4.5</td>
<td>1190</td>
</tr>
<tr>
<td>Unsocialised conduct disorder</td>
<td>0.9</td>
<td>238</td>
</tr>
<tr>
<td>Socialised conduct disorder</td>
<td>0.6</td>
<td>159</td>
</tr>
<tr>
<td>Other conduct disorder</td>
<td>0.9</td>
<td>238</td>
</tr>
<tr>
<td>Hyperkinetic disorder</td>
<td>2.7</td>
<td>714</td>
</tr>
<tr>
<td>Less common disorders</td>
<td>2.2</td>
<td>582</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder</td>
<td>1.9</td>
<td>502</td>
</tr>
<tr>
<td>Tic disorders</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>0.5</td>
<td>132</td>
</tr>
<tr>
<td>Mutism</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Any Disorder</td>
<td>10.2</td>
<td>2697</td>
</tr>
</tbody>
</table>

### Population prevalence and estimated numbers in 2015 and 2020 for mental disorders in girls (aged 5-10 years and 11-16 years) in Suffolk

<table>
<thead>
<tr>
<th>Girls Suffolk</th>
<th>Age 5-10</th>
<th>Age 11-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated total population</td>
<td>25,156</td>
<td>25,909</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>2.5</td>
<td>629</td>
</tr>
<tr>
<td>Disorder</td>
<td>Prevalence</td>
<td>12 Month</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>2.4</td>
<td>604</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td>0.7</td>
<td>176</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>0.7</td>
<td>176</td>
</tr>
<tr>
<td>Social phobia</td>
<td>0.1</td>
<td>25</td>
</tr>
<tr>
<td>Panic</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Post traumatic stress</td>
<td>0.1</td>
<td>25</td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>0.2</td>
<td>50</td>
</tr>
<tr>
<td>Generalised anxiety</td>
<td>0.3</td>
<td>75</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>0.7</td>
<td>176</td>
</tr>
<tr>
<td>Depression</td>
<td>0.3</td>
<td>75</td>
</tr>
<tr>
<td>Depressive episode (full ICD criteria)</td>
<td>0.2</td>
<td>50</td>
</tr>
<tr>
<td>Other depressive episode</td>
<td>0.1</td>
<td>25</td>
</tr>
<tr>
<td>Conduct disorders</td>
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<td>704</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>2.4</td>
<td>604</td>
</tr>
<tr>
<td>Unsocialised conduct disorder</td>
<td>0.3</td>
<td>75</td>
</tr>
<tr>
<td>Socialised conduct disorder</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other conduct disorder</td>
<td>0.1</td>
<td>25</td>
</tr>
<tr>
<td>Hyperkinetic disorder</td>
<td>0.4</td>
<td>101</td>
</tr>
<tr>
<td>Less common disorders</td>
<td>0.4</td>
<td>101</td>
</tr>
<tr>
<td>Autistic Spectrum Disorder</td>
<td>0.1</td>
<td>25</td>
</tr>
<tr>
<td>Tic disorders</td>
<td>0.1</td>
<td>25</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>0.2</td>
<td>50</td>
</tr>
<tr>
<td>Mutism</td>
<td>0.1</td>
<td>25</td>
</tr>
<tr>
<td>Any Disorder</td>
<td>5.1</td>
<td>1283</td>
</tr>
</tbody>
</table>
Of these 240 were Children in Care, 622 children with a child protection plan. Of the child protection plans 9 (CPP) and 8 (CIC) were due to a child’s unacceptable behaviour.

<table>
<thead>
<tr>
<th>Reason for being a Child in Need</th>
<th>District</th>
<th>Abuse or neglect</th>
<th>Child’s disability</th>
<th>Parental disability or illness</th>
<th>Family in acute stress</th>
<th>Family dysfunction</th>
<th>Child’s socially unacceptable behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>District</td>
<td>Babergh</td>
<td>328</td>
<td>21</td>
<td>14</td>
<td>68</td>
<td>157</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Ipswich</td>
<td>841</td>
<td>54</td>
<td>9</td>
<td>655</td>
<td>518</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td>Mid Suffolk</td>
<td>168</td>
<td>39</td>
<td>12</td>
<td>180</td>
<td>107</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>St Edmundsbury</td>
<td>399</td>
<td>38</td>
<td>7</td>
<td>100</td>
<td>502</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Suffolk Coastal</td>
<td>349</td>
<td>39</td>
<td>35</td>
<td>199</td>
<td>149</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Waveney</td>
<td>834</td>
<td>34</td>
<td>11</td>
<td>118</td>
<td>642</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>Grand Total</td>
<td>3214</td>
<td>245</td>
<td>90</td>
<td>1393</td>
<td>2351</td>
<td>303</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Reason for contact</th>
<th>District</th>
<th>Absent parenting</th>
<th>Antisocial behaviour</th>
<th>Disability</th>
<th>Emotional abuse</th>
<th>Family dysfunction</th>
<th>Family in acute stress</th>
<th>Low income</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>MASH Data 2014-2015 Number of Contacts and Reason for the Contact</td>
<td>Babergh</td>
<td>8</td>
<td>374</td>
<td>39</td>
<td>247</td>
<td>369</td>
<td>85</td>
<td>9</td>
<td>126</td>
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<tr>
<td></td>
<td>Forest Heath</td>
<td>15</td>
<td>228</td>
<td>32</td>
<td>263</td>
<td>348</td>
<td>76</td>
<td>18</td>
<td>136</td>
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<tr>
<td></td>
<td>Ipswich</td>
<td>47</td>
<td>841</td>
<td>92</td>
<td>718</td>
<td>1117</td>
<td>269</td>
<td>81</td>
<td>389</td>
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<tr>
<td></td>
<td>Mid Suffolk</td>
<td>19</td>
<td>270</td>
<td>55</td>
<td>265</td>
<td>436</td>
<td>82</td>
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<td>131</td>
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<tr>
<td></td>
<td>St Edmundsbury</td>
<td>16</td>
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<td>65</td>
<td>411</td>
<td>629</td>
<td>156</td>
<td>27</td>
<td>186</td>
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<tr>
<td></td>
<td>Suffolk Coastal</td>
<td>12</td>
<td>438</td>
<td>75</td>
<td>356</td>
<td>557</td>
<td>135</td>
<td>18</td>
<td>168</td>
</tr>
<tr>
<td></td>
<td>Waveney</td>
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<td>690</td>
<td>79</td>
<td>546</td>
<td>856</td>
<td>182</td>
<td>24</td>
<td>293</td>
</tr>
<tr>
<td>Total</td>
<td>Grand Total</td>
<td>149</td>
<td>3301</td>
<td>437</td>
<td>2806</td>
<td>4312</td>
<td>985</td>
<td>187</td>
<td>1429</td>
</tr>
</tbody>
</table>

| District                        | Current Mental Health |                          | |                          |                          |
|---------------------------------|-----------------------|--------------------------||--------------------------|--------------------------|
|                                 | Child                 | Adult                    ||                          |                          |
| Babergh                         | 52                    | 75                       ||                          |                          |
| Forest Heath                    | 13                    | 62                       ||                          |                          |
| Ipswich                         | 130                   | 191                      ||                          |                          |
| Mid Suffolk                     | 61                    | 72                       ||                          |                          |
| St Edmundsbury                  | 83                    | 94                       ||                          |                          |
| Suffolk Coastal                 | 69                    | 82                       ||                          |                          |
| Waveney                         | 139                   | 167                      ||                          |                          |
| Total                           | 547                   | 743                      ||                          |                          |