Health Equity Audit of Islington’s Child and Adolescent Mental Health Services

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Acknowledgements
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Executive Summary

Background
1 in 10 children have a mental health condition, over half of mental ill-health experienced in adulthood has developed by the age of 14, 75% by the age of 18. NHS England and the Department of Health commissioned a Children and Young People Mental Health and Wellbeing Taskforce which published Future in Mind in 2015, proposing the development of local Transformation Plans for Children & Young People’s Mental Health and Wellbeing. Islington’s Child and Adolescent Mental Health Service (CAMHS) Transformation Plan 2015 – 2020 is a strategic delivery plan aimed at reducing waiting times, increasing capacity and access, developing flexible services centred around population need whilst addressing health inequalities. Conducting a health equity audit was an outstanding action from the 2012 – 2015 CAMHS Strategy.

Methodology
Health equity audit is a review process which assesses the fairness of the distribution of resources versus the needs of different groups. The overall aim of this Health Equity Audit is to assess and describe how Islington’s Child and Adolescent Mental Health Services are accessed and used by the local population of children and young people, and in relation to the need for those services by different groups.

A profile of those accessing and using the CAMHS overall was first established and following this, an assessment of equity of access to services and their use was conducted. This was achieved by comparing those in need of and those in contact with the service in relation to the following key equity dimensions – age, gender, ethnicity. Prevalence data was applied to Islington’s 0-18 year old population data to determine the level of expected mental health conditions, and this was compared to the number of children and young people accessing the service.

Key Findings
A large number of exclusions rendered the dataset smaller than was hoped, and therefore there are a number of limitations to the findings. The highest proportions of children and young people accessing the service were male, aged 11-16, white British and from the most deprived quintiles. 22% of all those aged 0-18 in Islington expected to have a mental health condition were in contact with the service (based on the dataset with exclusions applied).

There is a need to increase access and use of CAMHS across the under 18 population of Islington, regardless of sub-populations. This level of unmet need is likely to further increase the risk and consequences of mental ill-health for these children and young people as adults. However, the following populations are currently less well represented than others:

- Females aged 5-10
- Females of black and Asian ethnicity
- Males aged 17-18
- Males of Asian ethnicity
- All those of white British, black, mixed and white other ethnicity aged 17-18
- Those of Asian ethnicity and aged 5-10 and 11-16
Recommendations

- Increase awareness amongst children and young people, parents and carers and potential referrers, of all available services with a remit for mental health support for children and young people
- Coordinate the response of all services across Islington with a remit for mental health support for children and young people with improved (and documented) referral between services
- Adopt strategies for improving data collection and recording within the service and the services which feed in
- Repeat the HEA once the new ONS survey has been published, with a larger more recent dataset, based on the school population of Islington if possible
1. Background and Context

1.1 Mental Health in Children and Young People
It is frequently reported that 1 in 10 children have a mental health condition, and that over half of mental ill-health experienced in adulthood has developed by the age of 14, 75% by the age of 18. With the significant impact this has on the life chances of these children, effective intervention during childhood and adolescence provides an opportunity to improve outcomes for children and adults.

1.2 National Policy Context
Mental health has received considerable attention within Public Health Policy over the past six years, beginning with the Coalition Government’s 2011 No Health without Mental Health strategy introducing a commitment to a cross-departmental and life course approach to addressing the mental health needs of the population. Parity of esteem – the principle of giving equal priority to mental and physical health - was introduced and enshrined in law by the Health and Social Care Act of 2012. Alongside this focus on mental health, the 2012 Annual Report of the Chief Medical Officer highlighted the evidence for universal and targeted services for children and young people, in recognition of the importance of prevention and early intervention in improving long term outcomes. The following year the same report, switched its focus to mental health and the evidence for effective, including cost-effective, opportunities to impact on public mental health.

In 2014 the House of Commons Health Committee published a report into Child and Adolescent Mental Health and CAMHS, shortly after the launch of a joint NHS England and Department of Health Children and Young People Mental Health and Wellbeing Taskforce. They therefore directed their set of recommendations towards this taskforce, to address problems across all tiers of Child and Adolescent Mental Health services (CAMHS) with the organisation, commissioning and provision of services. The work of the taskforce culminated in the publication in March 2015 of Future in Mind which outlined the challenges that existed, including data availability and accessing services, and proposed the development of local Transformation Plans for Children & Young People’s Mental Health and Wellbeing. Further documents to support the development of these plans were published in the summer of 2015. A second Mental Health Taskforce was established in March 2015, addressing mental health care and support for all ages, whose output was the Five Year Forward View for Mental Health for the NHS in England in February 2016. This national strategy has outlined priority actions to be delivered by 2020/21; a seven day NHS, an integrated approach to mental and physical health and key moments for prevention.

1.3 Local context

1.3.1 Children and Young People in Islington
There are approximately 40,500 children and young people aged 0-18 in Islington, 18.5% of the total population; it is a densely populated and ethnically diverse borough. Islington is the 4th most deprived borough in London and the 12th in England, with high levels of many of the known risk factors for poor mental health – child poverty, living in workless and/or single parent households. For all ages, the largest ethnicity group in Islington is White British
(48%), followed by White-other, Black, Asian, mixed and finally other\textsuperscript{10}, although younger age groups are more ethnically diverse with a smaller proportion of people identifying as White British.

### 1.3.2 Local Strategy

There have been a number of publications locally in recent years which focus on children and young people and/or mental health and wellbeing. The 2014/15 Annual Public Health Report for Camden and Islington\textsuperscript{11} focused on mental health and wellbeing, as a key priority for both London boroughs and Health and Wellbeing Boards. Islington’s Joint Health and Wellbeing Strategy, for both 2013-2016\textsuperscript{12} and 2017–2020\textsuperscript{13}, has included the best start in life and improving mental health and wellbeing as two of its three key priorities, and in the latest edition a recognition of the importance of impacting on households and family outcomes.

The Children and Young People’s Health Strategy 2015-2020 – Improving the Health of Islington’s Children and Young People\textsuperscript{9} included within its vision a desire to improve the health and wellbeing of children, reduce inequalities and maximise their life chances. Islington’s CAMHS Transformation Plan 2015 – 2020\textsuperscript{14} is a strategic delivery plan overseen by the Islington Children and Young People Emotional Health & Wellbeing Advisory Group. It has six guiding principles including equal access for all, a choice of services where and when needed, and making the best use of resources based on population need and the available evidence. Priorities identified within this for improving CAMHS in Islington are reducing waiting times, increasing capacity and access, developing flexible services that are centred around population need, located in community settings, whilst addressing health inequalities. It follows on from a number of previous Islington CAMHS Strategies, and this health equity audit is an outstanding action from the 2012 – 2015\textsuperscript{15} version.

### 1.3.3 Islington CAMHS Providers

Islington Child and Adolescent Mental Health services are jointly commissioned by Islington Clinical Commissioning Group (CCG) and the London Borough of Islington, with funding from the Dedicated Schools Grant via the Islington Schools Forum. Whittington Health is the main provider of CAMHS in Islington, and has a number of teams working across tier two and three services, as well as providing a tier four inpatient service - Simmons House. These teams include:

- the main Community CAMHS service located at The Northern Health Centre and delivering the core service provision, such as duty, advice and Choice appointments following the Choice and Partnership approach and feeding into the Emotional, Behaviour and ADHD Care Pathways.
- CAMHS in Targeted Youth Service (TYS) and Youth Offending Service (YOS)
- CAMHS in Children Looked After (CLA) Health Team
- Neuro-Development Team (NDT)
- Adolescent Outreach Team (AOT)
- Priority 1 (P1) Team
- CAMHS Pupil Referral Unit (PRU) Team
- CAMHS in Early Years
- CAMHS in Children’s Centres
- CAMHS in Schools
- Growing Together
There are also three other organisations within the London Borough of Islington which provide mental health and wellbeing services for children and young people; The Tavistock and Portman NHS Foundation Trust, funded by Islington CCG, The Brandon Centre, commissioned by the CCG and the Refugee Therapy Centre which is funded by Islington Local Authority.

As well as these contracted providers, there are a number of voluntary organisations across Islington which offer support for this age group in a variety of ways.
2. Methodology

2.1 Health Equity Audit

Health inequity arises when different population groups do not have equal opportunities for good health outcomes or accessing services and can result in health inequalities. The Equality Act of 2010\textsuperscript{16} introduced the requirement for specific consideration to be given to ensuring equitable access and outcomes for those with the following protected characteristics – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. In 2012, the Health and Social Care Act\textsuperscript{3} placed a duty on the Secretary of State, NHS England and Clinical Commissioning Groups (CCGs), and by extension other bodies with delegated responsibility for care, to attend to the need to reduce health inequalities. There are a number of processes and tools which can be used to fulfil these duties.

Health equity audit is a review process which assesses the fairness of the distribution of resources versus the needs of different groups. This can influence the future distribution of services in relation to those needs, contributing to the narrowing of health inequalities and reflecting the principle of proportionate universalism\textsuperscript{17}. It has a number of stages, as indicated by the following diagram. This report will focus on stages two to four.

2.1.1 Aim

The overall aim of this Health Equity Audit is to assess and describe how Islington’s Child and Adolescent Mental Health Services are accessed and used by the local population of children and young people, and in relation to the need for those services by different groups.

2.1.2 Objectives

- To analyse a defined set of CAMHS data in order to quantify:
  - Who is accessing and using CAMHS?
  - Who are they being referred by?
  - How are appointments being offered to them and who is taking them up?
Which teams are they being seen by?

- To describe the need for Child and Adolescent Mental Health Services in Islington using prevalence and population data
- To compare the need for services with access, by different population groups
- To explore whether the findings are to be expected, and if some population groups are underrepresented within the service
- If indicated by the findings, develop recommendations for redressing any underrepresentation.

2.2 Equity of access to services and their use

Prior to an assessment of equity, a profile of those accessing and using the CAMHS overall was established. Service access and use has been defined as those who have had contact with CAMHS, to include referral, the offer of an appointment, attendance at an appointment(s) and the team seen by. It is hoped that this will reflect the choice and partnership approach taken by the service. Access and use of the service has been stratified by gender, age, ethnicity and deprivation.

Deprivation was measured using the English Indices of Deprivation 2015, which includes seven domains of deprivation, weighted and summed to give an overall index of multiple deprivation for lower super output areas (approximately 1500 people or 620 households).

Following this, an assessment of equity of access to services and their use was conducted, comparing those in need of the service with those in contact with the service. This was performed in relation to the following key equity dimensions – age, gender, ethnicity – as data is not collected on the other protected characteristics. Deprivation, an important determinant of health, could not be included in this assessment, which shall be explored within the limitations of the audit.

For the purpose of this health equity audit, need has been equated to the expected prevalence of mental health conditions in children and young people, as determined by survey responses matched with recognisable symptoms of a mental health condition. This definition of need is therefore a hybrid of felt and normative need, whereby the individuals surveyed have disclosed perceived symptoms which have been categorised by experts. Prevalence was then applied to the registered population data for 0-18 year olds in Islington to give the expected number of children and young people with a mental health condition.

Excel was used to calculate the proportions of children and young people accessing and using the CAMHS in 2015/16 within each equity dimension, with 95% confidence intervals to demonstrate whether there was strong or weak evidence for any differences in proportions in each group. Confidence intervals provide the range of possible values if samples were taken repeatedly from the population and allow inferences to be made about the population based on this sample of people. If the confidence intervals do not overlap it suggests strong evidence of a difference between groups at the 5% significance level (p=<0.05), and indicates that this observed difference would have occurred by chance less than 1 in 20 times. If the confidence intervals overlap however, this reflects weak evidence of a true difference and the possibility that it occurred due to chance.

This method was also used to compare the proportions of children and young people accessing CAMHS in 2015/16 according to each equity dimension, with the estimated need
in those groups. This provided the proportion of those expected to have a mental health condition accessing the service, and confidence intervals to suggest whether there is evidence for any difference observed as a result of gender, age or ethnicity.

2.2.1 Prevalence

The Office for National Statistics (ONS) conducted a survey of the Mental Health of Children and Young People in Great Britain in 2004\(^{18}\), and the statistics from this continue to be used to estimate the prevalence of mental health conditions amongst children and young people. This survey is now being repeated, the National Study of Health and Wellbeing having been commissioned by NHS Digital and carried out by ONS and NATCen. It was launched in November 2015 and will survey 9,500 children and young people aged 2 – 19, with publication expected in 2018. This will provide a more up to date measure of the prevalence of mental health conditions in children and young people, taking into account developments in technology and in particular social media, since the last survey, as well as a more recent population count for the denominator.

In 2004, Green et al\(^{18}\) found overall prevalence in Great Britain for children aged 5 – 16 to be 10% as well as the following (amongst other findings):

- Males were more likely than females to have a mental health condition overall, 11% compared to 8% (OR 1.52), and in both the 5 – 10 and 11 – 16 year old age groups (10% vs 5% and 13% vs 10% respectively)
- When looking at children as a whole, 12% of 11 – 16 year olds had a mental health condition compared with 8% of 5 – 10 year olds (OR 1.73)
- Stratified for ethnicity, white children were most likely to have a mental health condition (10%), followed by those with Black and mixed ethnicity (9%) with Indian children being least likely (3%)
  - These differences remained broadly similar for males separately from females, however black females had a marginally higher prevalence than white females (8.5% vs 8.1%), which was even more marked for 11 – 16 year old females (17% vs 11%)
  - Prevalence for Indian and Pakistani/Bangladeshi females was lower than their male counterparts (2% and 7% vs 4% and 9%)
  - Prevalence in black children was also higher than in those who are white for 11-16 year olds (14% vs 12%)
  - Against the trend of 11 – 16 year olds having a higher prevalence than 5 – 10 year olds, Indian and Pakistani/Bangladeshi males had a higher prevalence in the lower age group (5% and 10% vs 2% and 8%)
- Children in lone parent families were more likely to experience mental health problems than those in two parent families – 16% vs 8% (OR 1.23 for single lone parent and 1.75 for previously married)
- Prevalence was higher for children in families where no parent was working when compared with both parents working (20% vs 8% - OR 0.61)
- Children living in social rented housing had a higher prevalence of mental health conditions than those living in owned accommodation (17% vs 7%).
2.2.2 Prevalence in Islington

It was initially hoped that the most recent GP data set for Islington (2015) could be used to describe the prevalence of mental health conditions in young people in Islington. However, once the data was interrogated, it revealed a very small proportion of children and young people actually coded as having a mental health diagnosis, and therefore this hasn’t been possible.

Following this, the application of the national prevalence described in the Mental Health of Children and Young People in Great Britain survey as outlined above was considered, which when weighted for age, gender and social class gives an estimated prevalence in Islington of 10.1%\(^{19}\). This is a useful source of prevalence data due to the detailed breakdown by age and ethnicity. However, there are a number of limitations to using this data:

- It is now significantly out of date, although it is the only data of its kind until the repeated survey is published next year
- It is likely to be an underestimate of mental health conditions in children and young people, although adjusted for age, gender and social class; housing tenure is a better indicator of need due to its links with child poverty, school readiness and other related risk factors
- The ethnicity groupings used - White, Black, Indian, Pakistani/Bangladeshi and other - would result in large data in some groups and small in others, giving disclosive data in a number of the analyses, and therefore less informative than using broader categories such as Asian and mixed ethnicity

There are a number of factors that would indicate the overall prevalence of mental health conditions amongst children and young people in Islington being higher than that described in the 2004 ONS survey. The increased prevalence of mental health conditions in children from lone parent families when compared with those in two parent families is of particular relevance in Islington, where lone parent households are above the England average of 7.1%, at 9.2%\(^{19}\). Islington also has a higher proportion of families who are out of work than the English average (6.6% vs 4.2%)\(^{19}\), and 60% of children live in social housing compared to the English average of 20%\(^{20}\). In the Camden & Islington Annual Public Health Report 2015\(^{11}\) a preferred prevalence of 14% was applied to the population of 5 – 16 year olds, using the 10.1% prevalence and taking into account housing tenure (the percentage of children living in social housing). As housing tenure is considered to be a better predictor of the expected prevalence of mental health conditions in children and young people, the preferred prevalence has been applied in this instance. This carries the limitation that any differences in need between population groups based on gender, age and ethnicity would not be reflected.

The discussion so far regarding prevalence only relates to children aged 5 – 16 years, and therefore other prevalence figures were required in order to assess the equity for 0-4 and 17-18 year olds. The Adult Psychiatric Morbidity Survey\(^{21}\), last carried out in 2014, included young people from the age of 16, and in the 16 – 24 year old category 18.9% had experienced a common mental disorder in the past week, 28.2% for females and 10% for males. Therefore, a prevalence of 18.9% has been applied to the 17-18 year old Islington population to determine need in this group (separate male and female prevalence has not been used in line with the method for the other age groups). This does have some limitations:
• The prevalence figure has been calculated from a wider age group and therefore may not faithfully represent 17-18 year olds
• It is a national estimate which may not apply locally within Islington

0-4 year olds are an even more difficult group for which to determine prevalence. No survey has yet included this age group and so published studies were searched for evidence on which to base this prevalence statistic. The evidence was very limited but there was a review of prevalence studies in 2006 by Egger and Agnold22 which found prevalence ranging from 14 – 26%. The median value of this range, 20%, was considered for use in this analysis but may well be an overestimate of the prevalence – recognising that it is higher than that applied to all other age groups – and has the following limitations:

• Diagnosing mental health conditions in this age group is recognised to be difficult and so some misclassification may have occurred within the studies
• It may not represent the 0-4 year old population of Islington for a number of reasons – it is old data and internationally conducted

As a consequence of their not being an appropriate prevalence figure for 0-4 year olds an assessment of equity has not been performed here. In future analyses, the prevalence found in the National Study of Health and Wellbeing to be published next year could be used for 2-4 year olds, or the CAMHS access rates for 0-4 year olds across England.

In summary, the prevalence figures that have been applied to the 5-18 year old Islington population in order to determine the level of need for CAMHS were:

<table>
<thead>
<tr>
<th>Overall</th>
<th>14%</th>
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<tbody>
<tr>
<td>Gender</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>14%</th>
<th>14%</th>
<th>18.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17-18</td>
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</tr>
</tbody>
</table>

| Ethnicity | 14% |

### 2.3 Datasets
Data was requested from and provided by the following organisations for April 2015 to March 2016.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Data</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whittington Health</td>
<td>CAMHS tier 2 and 3 data 2015/16</td>
<td>n=2228</td>
</tr>
<tr>
<td>Whittington Health</td>
<td>CAMHS tier 4 data 2015/16</td>
<td>n=9</td>
</tr>
<tr>
<td>The Tavistock and Portman NHS Foundation Trust – via LBI Children’s Services</td>
<td>Aggregate data with no demographics for 2015/16</td>
<td>N=80</td>
</tr>
</tbody>
</table>
|                          | Refugee Therapy Centre | Camden & Islington PH Team          | recorded, other ethnicities 
|------------------------|-----------------------|-------------------------------------|--------------------------
|                         | Oct 15 – March 16, data for Apr – Sep 15 not available at time of analysis) Numbers disclosive | GP PH Dataset 2015, Islington GP registered population aged 0-18 | n=8

2.4 Action to inform recommendations

The draft report was shared with representatives from Public Health, Children’s Services and with CAMHS in order to disseminate the findings. Following this a presentation of the findings was given to CAMHS, with an opportunity to discuss and interpret them, and debate the need and potential opportunities for change. This has been used to inform the discussion and recommendations included in this report.

2.5 Limitations

The limitations regarding the data used to describe the need amongst children and young people in Islington for child and adolescent mental health services has been fully described in the prevalence in Islington section.

The other main limitation relates to exclusions:

- A significant proportion of the CAMHS data had elements missing and therefore had to be excluded - ethnicity, postcode of residence, registered GP.
- Exclusions were also made on the basis of registered with an Islington GP or not – this was necessary, despite Islington residents who are not registered with an Islington GP also being eligible for the service, in order for the numerator (Islington CAMHS data) and the population denominator (GP dataset) to be comparable within the assessment of equity.
- Outside of this assessment, it may have been possible to show who was accessing the service based on the school population, in order to reflect the commissioned service more accurately, but this information was not included in the dataset. It would have been possible to include all those who were either an Islington resident or registered with an Islington GP, but this would have only increased the numbers by 60, and could not have been included for the assessment of equity.
- When assessing equity within ethnicity, exclusions were also made to the GP dataset population data where ethnicity was unknown or unrecorded, in order to be comparable with the CAMHS data.

These exclusions have resulted in a small amount of data once stratified particularly for ethnicity, deprivation, and use of the service by team, referral source and appointments. This in turn has given wide confidence intervals, and therefore weaker evidence for any observed differences within population groups, and less ability to be confident about inferences regarding the service and the wider population.

Data on some protected characteristics are not routinely collected - disability, sexuality, religion – and therefore could not be included within this equity audit.
Deprivation could not be used within the assessment of equity as Lower Super Output Area was not included in the GP PH dataset extraction.

Given the large number of possible ethnicity categories, reducing them down to just six, in order to make the data more manageable, limits the insights available from this data. The categories are also subjective measurements of individual’s personal identification with a particular ethnicity or group, and two people of seemingly the same ethnicity may identify themselves differently. White other in particular is a category does not reflect the potential diversity within it.

It was not viable to include the data from the other providers as it was either provided in an aggregate format or was too small and potentially disclosive. Therefore it hasn’t been possible to capture whether these services are seeing people from similar population groups as Whittington Health or perhaps appealing to different children and young people, indicating more holistic provision across the whole of Islington and the different providers.
3. Results

3.1 Profile of those accessing and attending CAMHS

2228 people were in contact with CAMHS between April 2015 and March 2016, split evenly between females and males.

- Of these, 396 were over 18 and have been excluded from the analysis as they were outside of the commissioned service for 0-18 year olds, leaving 1832.
- Further exclusion of anyone not registered with an Islington GP left a total of 1205 in the analysis.
- 88% of these exclusions were as a result of unknown GP, and therefore only a minority were known to be registered with a GP outside of Islington.
- 60 were resident in Islington but were excluded for the reasons stated in the limitations section.

3.1.1 Gender

Of the total number included, 45% (42-48%, n=539) were female and 55% (52-58%, n=666) were male. As 87% of the over 18s were female their inclusion had served to skew the data regarding the gender split. There is evidence for the observed difference in proportions of males and females accessing the service.

Source: CAMHS data, 2015/16
Gender within age categories

- Males aged 0-4 (58%, 51-64%, n=126), and 5-10 (63%, 58-68%, n=255) were more likely to access the service than females of the same age, for which there was strong evidence.
- A higher proportion of females aged 17-18 (59%, 50-67%, n=77) were in contact with the service than males but evidence for this difference was weaker.

Source: CAMHS data, 2015/16
Gender within ethnicity

Those with unknown ethnicity were removed from the data (n=196), leaving 1,007 in the analysis.

A higher proportion of males were seen in all ethnicity groups; strong evidence was found for this difference in Black children and young people (66%, 58-73%, n=94) and weaker evidence for those of Mixed ethnicity (59%, 51-66%, n=94). Evidence for the observed difference was not found in the other ethnic groups.

Note: 196 service users were removed due to unknown ethnicity
Source: CAMHS data, 2015/16
Gender within deprivation

Those with unknown deprivation quintile were removed (n=70) leaving 1,135 in the analysis.

A higher proportion of males were seen across all quintiles, evidence for which was found for within the most deprived quintile (56%, 51-62%, n=178).

Note: 70 service users were removed due to unknown deprivation quintile. IMD 2015 used for deprivation quintile
Source: CAMHS data, 2015/16
3.1.2 Age

A higher proportion of children aged 11-16 (38%, 35-40%, n=453) were in contact with the service than those aged 5 – 10 years (33%, 31-36%, n=403), but with only weak evidence to support this finding.

There is evidence to support the observed difference in proportions of children accessing the service between these two groups and the 0-4 (18%, 16-29%, n=218) and 17-18 (11%, 9-13%, n=131) age groups.

Proportion accessing the service by age, Islington CAMHS service users aged <18, 2015/16

Source: CAMHS data, 2015/16
**Age within gender categories**

Of all females accessing the service, a higher proportion were aged 11-16 (41%, 37-45%, n=222) in comparison to all other age groups, whereas for males only a small difference was observed between those seen in age categories 5-10 and 11-16, for which there was weak evidence.

![Proportion accessing the service by gender and age, Islington CAMHS service users aged <18, 2015/16](source)

Source: CAMHS data, 2015/16
**Age groups within ethnicity**

- Within all ethnicity groups, the highest proportions of children and young people were aged 5-10 or 11-16. There is mixed evidence for this across the groups.
- White other children and young people are more likely to be 11-16 years old (42%, 35-48%, n=97), for which there is strong evidence.
- Within Asian ethnicity the age groups are more evenly distributed, but this could be due to the small numbers.
- There are slightly higher proportions of 0-4 year olds within Asian, Mixed and other ethnicity groups.

![Proportion accessing the service by ethnicity and age, Islington CAMHS service users aged <18, 2015/16](chart)

**Note:** 196 service users removed due to unknown ethnicity  
**Source:** CAMHS data, 2015/16
**Age groups within deprivation**

The highest proportion of children in most quintiles were aged 11-16, and across all quintiles most children accessing the service were aged 5-16.

In most quintiles the difference between the 5-10 and 11-16 year olds was small, except for the 3rd most deprived quintile, although the evidence for this larger difference was weak.

Although without evidence to support the finding, a slightly higher proportion of 0-4 year olds were seen in the 4th and 5th (least) deprived quintiles.

![Proportion accessing the service by deprivation and age, Islington CAMHS service users aged <18, 2015/16](image-url)

**Note:** 70 service users were removed due to unknown deprivation quintile. IMD 2015 used for deprivation

**Source:** CAMHS data, 2015/16
3.1.3 Ethnicity

Ethnicity was unknown or not stated for 196 of those in contact with the service, 16% of the 1205 included overall, and these were excluded leaving 1,009 in the ethnicity analysis.

Strong evidence for a higher proportion of those of White British ethnicity being in contact with the service than any other group (37%, 34-40%, n=372) was demonstrated. In comparison to the overall Islington population proportions, within which the proportions rank in descending order White-British, White-other, Black, Asian, Mixed and other, more children and young people of mixed ethnicity (16%, 14-18%, n=160) were seen than of Asian and Black. Those of Mixed ethnicity are potentially overrepresented compared to the younger Islington population, and those of Black and Asian ethnicity underrepresented.
Ethnicity within gender

The same distribution of ethnicity groups was seen within males and females separately; it is interesting to note that

- within males a higher proportion were Black (16%, 14-20%, n=94) in comparison to females,
- within females a higher proportion were White (40%, 35-44, n=174) in comparison to males

Proportion accessing the service by gender and ethnicity, Islington CAMHS service users aged <18, 2015/16

Note: 196 service users were removed due to unknown ethnicity
Source: CAMHS data, 2015/16
**Ethnicity within age groups**

- In all age groups, a higher proportion of children and young people were of White British ethnicity than any other ethnicity for which there was evidence in the 5-10 (42%, 37-47%, n=148) and 11-16 (39%, 34-44%, n=141) age groups.
- Much lower proportions of Black and Mixed ethnicities were observed in the 17 – 18 year olds in comparison to the other age groups.
- Conversely, in the 0-4 age groups the proportions were more evenly spread.

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**Proportion accessing the service by age and ethnicity, Islington CAMHS service users aged <18, 2015/16**

Note: 196 service users removed due to unknown ethnicity

Source: CAMHS data, 2015/16
**Ethnicity within deprivation**

In the analysis of deprivation and ethnicity 48 contacts had to be removed due to unknown deprivation quintile and 196 as a result of unknown ethnicity, leaving only 961 contacts. This resulted in disclosive numbers within the ethnicity group other, which has been removed from the charts.

The highest proportion of children and young people accessing the service within all quintiles were of White British ethnicity. There was evidence for this in the middle quintiles but not within the most and least deprived.

There is also good evidence for the observed difference in proportions between Black and Asian ethnicities within the most deprived quintile, with a higher proportion of Black children and young people seen (18%, 14-24%, n=49).

Within the most deprived quintile, children and young people of Black ethnicity are a larger proportion than those within the Mixed ethnicity group, which is the opposite representation to all other quintiles.

**Proportion accessing the service by deprivation quintile and ethnicity, Islington CAMHS service users aged <18, 2015/16**

- **White - British**
- **White - Other**
- **Black**
- **Asian**
- **Mixed**

**Note:** 196 service users removed due to unknown ethnicity and 48 due to unknown deprivation quintile. Other removed due to disclosive categories. IMD 2015 used for deprivation quintile.

**Source:** CAMHS data, 2015/16
3.1.6 Deprivation

Deprivation quintile was unknown for 6% (n=70) of the 1205 included who accessed CAMHS in 2015/16 – the majority due to the postcode of residence being outside of Islington. These children have been excluded, leaving 1,135 for this analysis.

A higher proportion of children in the most deprived quintile (28%, 25-31%, n=316), accessed the service than those in the least deprived quintile (13%, 11-15%, n=146), for which there was strong evidence.

Proportion accessing the service by deprivation quintile, Islington CAMHS service users aged <18, 2015/16

Note: 70 users were removed due to unknown deprivation quintile, IMD 2015 was used for deprivation quintile
Source: CAMHS data, 2015/16
Deprivation within gender

This was also true for males (28%, 25-32%, n=178) and females (27%, 23-31%, n=138) separately.

Note: 70 service users were removed due to unknown deprivation quintile. IMD 2015 used for deprivation quintile.
Source: CAMHS data, 2015/16
Deprivation within age groups

As with the service overall, the highest proportions of children and young people accessing the service across all age groups were from the most deprived quintiles.

- Within the 0-4 and 17–18 year old age groups this was the most deprived quintile, with good evidence to support this in the latter (32%, 24-41%, n=38).
- Within the 5-10 year old age group this was the two most deprived quintiles (28%, 24-32%, n=108 and 29%, 24-33%, n=111).
- Within the 0-4 age group all but the most deprived quintile were evenly distributed
- Within the 11-16 year old age group the first three quintiles were more evenly distributed
- Within the 17-18 year old age group there was a larger proportion from the least deprived quintile, compared with the proportions in the other age groups.

Note: 70 service users were removed due to unknown deprivation quintile. IMD 2015 used for deprivation
Source: CAMHS data, 2015/16
Deprivation within ethnicity

There were disclosive numbers within the ethnicity group other which has been removed from the charts.

Within White-British (25%, 21-30%, n=91), Black (27%, 29-45%, n=49) and Asian ethnicities, most children and young people accessing the service were from the two most deprived quintiles. Within black ethnicity, the difference between the most and least deprived quintiles is more marked than for the other groups.

Within White-other and Mixed the quintiles were more evenly distributed.

Note: 196 service users removed due to unknown ethnicity and 48 due to unknown deprivation quintile. Other removed due to disclosive categories. IMD 2015 used for deprivation quintile

Source: CAMHS data, 2015/16
3.1.5 Team Categories

The highest proportion of children and young people were seen by the Community CAMHS Service (39%, 36-42%, n=471), for which there is good evidence of a difference between this and the other teams. This was the case for males and females separately as well.

Proportion accessing the service by team, Islington CAMHS service users aged <18, 2015/16

Note: 1 service user was removed due to unknown team category and TYS/YOS due to disclosive numbers
Source: CAMHS data, 2015/16
Gender within team categories

Evidence was found for a difference in the proportions of males and females seen in most teams

- More males were seen by Growing Together (58%, 51-65%, n=114), CAMHS in Children’s Centres (60%, 50-70%, n=55), CAMHS in Schools (60%, 54-66%, n=130), and NDT (74%, 64-82%, n=68).
- More females than males were seen by AOT (63%, 50-74%, n=39), and Children Looked After (61%, 44-76%, n=19) services but the evidence for these observed differences was weak. This finding is interesting considering that more Islington Children Looked After are male than female (62% - March 2017 snapshot).

![Proportion accessing the service by team category and gender, Islington CAMHS service users aged <18, 2015/16](image)

**Note:** 1 service user removed due to unknown team category and TYS/YOS due to disclosive numbers

**Source:** CAMHS data, 2015/16
Gender within Behavioural and Emotional Pathway

Looking specifically within the behavioural and emotional care pathways that some children and young people are moved onto following a choice appointment, there is strong evidence that

- more males (69%, 59-78%, n=60) are seen within the behavioural pathway than females
- more females (70%, 61-77%, n=86) than males in the emotional pathway.

Source: CAMHS data, 2015/16
Age group and team category

Due to the number of team categories there were disclosive numbers in some and as a result the charts cannot be presented here, and most categories were subject to wide confidence intervals.

Ages seen within the different team categories were reflective of the service offered by that team, for example

- AOT saw higher proportions of 11-16 (47%, 35-59%, n=29) and 17-18 (52%, 39-64%, n=32) year olds
- CLA saw even proportions of 11-16 (39%, 24-56%, n=12) and 17-18 (42%, 26-59%, n=13) year olds
- CAMHS in Children’s centres saw more 0-4 year olds (84%, 75-90%, n=76) than any other age group
- Growing Together and Early Years saw higher proportions of 0-4 (63%, 56-69%, n=123 and 44%, 30-59%, n=18) and 5-10 (37%, 31-44%, n=73 and 56%, 41-70%, n=23) year olds
- NDT saw equal proportions of 5-10 and 11-16 year olds (46%, 36-56%, n=42)
- CAMHS in Schools saw higher proportions of 5-10 (41%, 35-48%, n=89) and 11-16 (55%, 48-61%, n=118) year olds, but this may have been skewed by the missing data.

Ethnicity and team category

- Due to the number of team categories there were disclosive numbers in some strata, therefore the charts cannot be presented here.
- The highest proportions seen within all teams except AOT were those of white British ethnicity, with evidence for this in Community CAMHS (42%, 37-47%, n=154) and CAMHS in Schools (39%, 32-46%, n=71).
- Within AOT the highest proportion seen were white other, but there wasn’t evidence to support this.
- Within all ethnicities apart from other, the highest proportion of children and young people were seen within Community CAMHS, for which there was evidence within white British (41%, 37-46%, n=154) and white other (38%, 32-45%, n=89) ethnicities.
- The highest proportion within other was CAMHS in Schools, but there wasn’t evidence to support this.
Ethnicity and Behavioural and Emotional Care Pathways

Service users with unknown ethnicity were removed from this analysis (n=36) as were the Asian and other ethnicity groups due to disclosive numbers.

There is strong evidence for the following differences within the behavioural and emotional care pathways when stratified by ethnicity:

- A higher proportion of black children and young people (78%, 58-90%, n=18) are following the behaviour compared to the emotional care pathway
- A higher proportion of children and young people from the White-other (81%, 67-90%, n=34) ethnicity group are on the emotional rather than the behavioural care pathway

Note: 36 service users were removed due to unknown ethnicity and Asian and Other categories due to disclosive numbers

Source: CAMHS data, 2015/16
Deprivation and team categories

Deprivation quintile was unknown for 70 contacts and team category for 1, which were removed from the analysis. This left disclosive numbers in Children Looked After and TYS/YOS which will not be presented here.

- Within each deprivation quintile, as was the case within the service overall, the highest proportion of children and young people were seen in Community CAMHS, for which there was evidence in all quintiles.

Within all teams apart from Early Years, the highest proportions of children were from the two most deprived quintiles

- with evidence of a difference between the most and least deprived quintiles in Community CAMHS (27%, 23-32%, n=122), Growing Together (27%, 21-34%, n=50), and CAMHS in Schools (28%, 23-25%, n=58)
- within NDT, the highest proportion were from the second most deprived quintile (38%, 28-48%, n=33), with evidence for a difference between this and the 3 least deprived quintiles
- within Early Years, the middle three quintiles were larger and more evenly distributed, as well as even proportions seen from the most and least deprived quintiles.
- within Children’s Centres, a higher proportion of children were seen from the least deprived quintile in comparison to other teams.

Note: 70 service users removed due to unknown deprivation quintile and 1 due to unknown team. CLA and TYS/YOS removed due to disclosive numbers. IMD 2015 used for deprivation
Source: CAMHS data, 2015/16 Removed = 70 unknown quintile and 1 team category
3.1.6 Referral Source

Referral category was unknown for 8 contacts, which were removed from the analysis.

The highest proportion of children were referred to the service via Education – which included schools, the education service and pupil referral unit – compared to any other referral source (26%, 23-28%, n=308), apart from GPs where the confidence intervals touch.

Evidence was also found for the observed difference between GPs as a referral source and the remaining nine possibilities (21%, 19-23%, n=249).

The lower proportions referred by services such as Health Visiting and Children’s centres is reflective of the smaller proportion of children aged 0-4 seen by the service.
Referral source within gender

The overall finding of the highest proportion being referred by Education compared to all other referral sources was reflected in males (29%, 26-33%, n=193).

For females a similar proportion were referred by Education and GP (21%, 18-25%, n=115 and 24%, 21-28%, n=129).

Proportion accessing the service by gender and referral source, Islington CAMHS service users aged <18, 2015/16

Note: 8 service users removed due to unknown referral source
Source: CAMHS data, 2015/16
**Gender within referral source**

A higher proportion of males than females were referred by all sources apart from GP, Local Authority and other, for which there was good evidence in

- CAMHS (64%, 54-73%, n=60)
- Children's Centres (65%, 54-74%, n=53)
- Education (63%, 57-68%, n=193),
- Other Health Services (67%, 53-78%, n=36)
- YOS (100%, 61-100%, n=6),

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*Note: 8 service users removed due to unknown referral source  
Source: CAMHS data, 2015/16*
Age groups within referral source

Due to the number of referral categories, there were disclosive numbers in some and therefore the charts cannot be presented here. As with team categories, the age groups most commonly referred by different services were reflective of the service offered by that provider, for example

- Children’s centres referred higher proportions of 0-4 (68%, 58-77%, n=56) and 5 – 10 (32%, 23-42%, n=26) year olds
- Health Visiting referred highest proportions of 0-4 year olds (79%, 65-89%, n=34)
- Education referred higher proportions of 5-10 (45%, 39-50%, n=138) and 11-16 (49%, 43-54%, n=150) year olds
- The highest proportion referred by GPs was 11-16 year olds (52%, 46-58%, n=43)

Referral source within age groups

- Within the 0-4 year old age group most referrals came from Children’s centres (26%, 21-32%, n=56)
- 5-10 year olds Education (37%, 32-42%, n=138)
- 11-16 year olds Education (36%, 31-41%, n=150) and GPs (31%, 27-35%, n=129)
- The highest proportion of referrals for 17-18 year olds came from GPs (39%, 30-48%, n=43).

Ethnicity and referral source

- Once those with unknown ethnicity – 196 – and referral category – 8 - were removed from this analysis, it left disclosive numbers in all ethnicity groups and all but four referral source. This aspect of the health equity audit cannot therefore be explored in detail here.
- The highest proportion of referrals within all ethnicities came from Education, except within White British, which saw equal proportions from Education and GPs.
- White British ethnicity was the highest proportion within all referral sources except those with very small numbers.

Deprivation and referral source

- Once 70 of unknown deprivation quintile and 8 of unknown referral source were removed, there were disclosive numbers within all quintiles, and within four of the 11 referral source categories.
- Within all deprivation quintiles, the highest proportions were referred by Education and GPs, as with the service overall.
- Within each referral source (except CAMHS) the highest proportions were from the most deprived quintile, as was with the service overall, with evidence for this within Education (27%, 22-32%, n=80)) and other (33%, 25-42%, n=41).
3.1.7 Appointments Offered

The largest proportion of children were offered one (25%, 23-28%, n=301), or two (15%, 13-17%, n=182) appointments in comparison to any other number of appointments. This was also true for males and females separately (see Appendix 1 for chart), within all age groups, ethnicity groups and deprivation quintiles.

Source: CAMHS data, 2015/16
3.1.8 Appointments attended

The highest proportion of children attended one appointment (32%, 29-34, n=383), for which there was evidence in comparison to all other categories. This was also true within males and females separately, all age groups, ethnicities and deprivation quintiles.

Age and appointments attended

- Due to the number of categories there were disclosive numbers in three of them, and therefore the charts won't be presented here. The distributions seen here reflected that of the overall service except interestingly higher proportions were observed for 0-4 year olds in the lower categories of number of appointments attended in comparison to the higher ones.
3.1.9 Appointments not attended (DNA’d)

The highest proportion of children and young people attended all their appointments (38%, 36-41%, n=461), and where appointments were DNA’d, this was most likely to be one (25%, 23-28%, n=303) or two appointments (14%, 12-16%, n=168). This was true for males and females separately, all age groups, ethnicities and deprivation quintiles.

Source: CAMHS data, 2015/16
3.2 Assessment of Equity - Service Utilisation According to Need

The overall proportion of those expected to have a mental health condition accessing the service in 2015/16 was 22% (21-23%). This was calculated using the 1205 contacts for whom all details were available. If it were to be calculated for all those seen who were aged 0-18 (n=1832), this would rise to 34% (32-35%). This figure should be compared to previous estimates of the percentage of those expected to have a mental health condition accessing CAMHS with caution; the numerator and denominators used are likely to be different.

3.2.1 Gender

A higher proportion of males (24%, 22-26%) expected to have a mental health condition accessed the service in comparison to females (20%, 19-22%), however there was only weak evidence for this observed difference as the confidence intervals touched.

Note: Expected number was based on data from the prevalence source
Source: CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)
A higher proportion of males aged 5-10 (27%, 25-30%) expected to have a mental health condition were in contact with the service in comparison to females, for which there was evidence.

Equal proportions of males and females aged 11-16 expected to have a mental health condition accessed the service.

A higher proportion of females aged 17-18 expected to have a mental health condition were in contact with the service but there was no evidence for this observed difference.
Within each ethnicity a higher proportion of males expected to have a mental health condition were in contact with the service, but there was only evidence for this within the black ethnicity group (22%, 18-26%).

**Proportion of those expected to have a mental health condition accessing CAMHS, by ethnicity and gender, Islington registered population aged <18, 2015-16**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>21%</td>
<td>23%</td>
</tr>
<tr>
<td>White Other</td>
<td>31%</td>
<td>34%</td>
</tr>
<tr>
<td>Black</td>
<td>11%</td>
<td>22%</td>
</tr>
<tr>
<td>Asian</td>
<td>11%</td>
<td>17%</td>
</tr>
<tr>
<td>Mixed</td>
<td>29%</td>
<td>38%</td>
</tr>
<tr>
<td>Other</td>
<td>33%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Note: 196 service users and 8161 from the registered population removed due to unknown ethnicity. Expected number was based on data from the prevalence source. Source: CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)
3.2.2 Age
A higher proportion of those aged 11-16 (30%, 28-32%) expected to have a mental health condition were in contact with the service in comparison to all other age groups.

Proportion of those expected to have a mental health condition accessing CAMHS, by age, Islington registered population aged <18, 2015-16

**Note:** Expected number was based on data from the prevalence source
**Source:** CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)
Within males and females separately, the highest proportions of those expected to have a mental health condition seen were aged 11-16 years (30%, 27-22% and 30%, 27-33%).

- In males, a higher proportion of 5-10 year olds is observed compared to the proportion for females.
- In females, a higher proportion of 17 – 18 year olds is observed compared to the proportion for males.

![Proportion of those expected to have a mental health condition accessing CAMHS, by gender and age, population aged <18, Islington, 2015-16](chart)

**Note:** Expected number was based on data from the prevalence source.  
**Source:** CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)
• Within White British (34%, 29-38%), White other (51%, 44-58%) and Mixed ethnicity groups, those aged 11-16 expected to have a mental health condition were the highest proportion accessing the service in comparison to the other age groups, for which there was evidence within the white ethnicities.
• For children of black or other ethnicity, the largest proportion of those expected to have a mental health condition in contact with the service were aged 5-10, but there was no evidence for this observed difference.
• Those expected to have a mental health condition aged 17-18 were the largest proportion accessing the service within the Asian ethnicity, for which there was no evidence of a difference in comparison to the other age groups.
• There was a higher proportion of 17-18 year olds expected to have a mental health condition accessing the service within the other ethnicity group compared to the other groups.

Proportion of those expected to have a mental health condition accessing CAMHS, by ethnicity and age, Islington registered population aged <18, 2015-16

Note: 196 service users and 8161 from the registered population removed due to unknown ethnicity. Expected number was based on data from the prevalence source
Source: CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)
3.2.3 Ethnicity

In line with the exclusions applied to the service data, all those with unknown ethnicity were removed from the population data (n=8,161).

Even proportions of children and young people of Mixed, White other (33%, 29-36%) and other (32%, 25-29%) ethnicities expected to have a mental health condition were in contact with the service

These proportions were higher than those from White British (22%, 20-24%), Black (17%, 14-19%) and Asian (14%, 11-18%) ethnicities.

This was reflected within males and females separately.
Within males and females separately:

- Higher proportions of Black, (22%, 18-26%) Asian (17%, 12-23%) and Mixed (38%, 32-44%) males expected to have a mental health condition accessed the service in comparison to females.

Note: 196 service users and 8,161 from the registered population removed due to unknown ethnicity. Expected number was based on data from the prevalence source.

Source: CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)
- For the 5-10 age group, mixed (36%, 29-44%) and other (34%, 23-46%) ethnicities were best represented, with evidence of a difference in comparison to white British (23%, 20-26%), black (19%, 15-23%) and Asian (11%, 6-17%).
- There were larger proportions of White British and White other ethnicities in the 11-16 year olds group in comparison to the 5-10 year olds. White other is particularly better represented in this age group (51%, 44-58%).
- For the 17-18 year olds, the largest proportion of those expected to have a mental health condition in contact with the service were of other ethnicity. All ethnicities were less well represented in this age group in comparison to 5-16 year olds, except for other.

Proportion of those expected to have a mental health condition accessing CAMHS, by age and ethnicity, Islington registered population aged <18, 2015-16

Note: 196 service users and 8161 from the registered population removed due to unknown ethnicity. Expected number was based on data from the prevalence source.
Source: CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)
4. Discussion

It is important to note prior to exploring these results that due to the large number of exclusions, what can be meaningfully inferred from the dataset to the service more generally is limited, and must be approached with caution. Consideration should be given to whether with a larger dataset the findings would be;

- the same or similar, with greater evidence for some of the observations that could not be supported here
- more in line with the overall picture as anomalies due to the small numbers would be corrected.

Most children and young people accessing the Islington CAMHS in 2015/16 did so through the Community CAMHS team. The majority were referred to the service by either an Education establishment or a GP Surgery, and were offered one appointment. Most of these children and young people attended one appointment and the majority attended all their appointments. It would be useful to explore within the service and with the services and agencies making referrals the finding that most children and young people are offered and attend just one appointment – is CAMHS the right service for them or might there be more suitable alternatives? Alternatively, as has been shown elsewhere and proposed by the CAMHS staff, a well delivered choice appointment can be an effective intervention in its own right, and all that is required for some children and young people.

22% of all those aged 0-18 in Islington expected to have a mental health condition were in contact with the service. This is in line with the findings concerning children with a mental illness being in treatment found in the 2004 ONS survey. From a brief search of the literature it is clear that there is very little evidence regarding how different population groups access CAMHS and their respective representation within services, and none was found evaluating the effectiveness of interventions to increase access to services and their use.

4.1 Gender

More males than females accessed the service, which tallies with the higher prevalence in this group found by Green et al in the last survey of the Mental Health of Children and Young People in Great Britain. This was also reflected within the separate age groups, except for 17-18 year olds, which saw more females in contact with the service – according to the Adult Psychiatric Morbidity Survey females aged 16-24 do have a higher prevalence than males. On discussion of this point, CAMHS staff thought more older females were referred for problems such as A-level exam stress. More males than females accessed the service across all ethnicity groups, as well as within all deprivation quintiles. This was more marked for Black, Asian and Mixed ethnicities.

There were no gender differences in the team most accessed by males and females - Community CAMHS - however more males than females were seen by Growing Together, CAMHS in Children’s Centres, Early Years, CAMHS in Schools and NDT, whereas more females than males were seen by AOT and Children Looked After teams. If this were probed further, it may provide insights into whether or not males and females are referred for different reasons, for example males behavioural and females emotional difficulties. This was born out when looking specifically at the behavioural and emotional care pathways
separately from the other services encapsulated by the Community CAMHS service. This was also supported by CAMHS staff, who felt that boys were more likely to be referred for behavioural reasons. It would be interesting to investigate further why more females than males are seen by the CAMHS in Children Looked After team, if there are more males in this service overall.

Education was the most frequent referral source for males, but for females it was both Education and GPs. The reasons for this would be interesting to explore, for example does this reflect perceived differences in behaviour within the school setting, and a willingness by females to access health services more readily than males, even at this age? CAMHS staff did feel schools were more likely to refer boys for behavioural reasons. Within the most common number of appointments offered, attended and not attended there were no gender differences. Higher proportions of males than females were observed in most if not all appointment categories, reflecting the greater number of males accessing the service.

When assessing equity, a greater proportion of males expected to have a mental health condition were seen by the service compared to females overall and within age and ethnicity groups. This has been calculated using the same prevalence for males and females which is unlikely to be the case; therefore in reality this may look different. It reflects the overall finding that more males are in contact with the service compared to females which at face value is appropriate considering the likely higher prevalence in 5-16 year olds. However the need for services within the female population must be met, and females should be given opportunities to access CAMHS; more females were seen within the 17-18 year old age group.

4.2 Age
The highest proportion of children and young people accessing the service overall were those aged 11-16, a finding echoed in females separately and across deprivation quintiles. This reflects the prevalence found in the 2004 survey; in males 5-10 year olds were the slightly larger proportion, and this smaller difference between 5-10 and 11-16 year old males is also similar to the prevalence survey18. 5-10 year olds being the largest proportion within some ethnicities is in contrast to the overall finding and the 2004 prevalence which is interesting to note and the possible reasons for this should be explored. 0-4 year olds are a larger proportion within Asian, Mixed and other ethnicities in comparison to the other groups, also seen in the 4th and 5th (least) deprived quintiles, the possible reasons for which were explored with CAMHS, including higher parental anxiety in some population groups compared to others.

As might be expected, the age distributions within teams and referral sources reflected the service being offered by that particular team or service. The number of appointments offered and not attended for the separate age groups reflected the overall service; there was some suggestion that 0-4 year olds were more likely to attend a fewer number of appointments, but this is likely to be in line with the team they were accessing and the usual number of sessions offered.

In terms of equity, a greater proportion of 11-16 year olds expected to have a mental health condition were in contact with the service compared to other age groups, overall and for males and females separately. The same prevalence was applied to all age groups, which is unlikely to be the case in the population and thus the findings must be viewed with this in
mind. For children and young people of black ethnicity expected to have a mental health condition 5-10 year olds were the largest proportion, and for those of Asian ethnicity 17-18 year olds; it isn’t possible to determine whether with a larger dataset the evidence for this difference would be more apparent, or whether it is an anomaly as a result of the small numbers within these groups. Attention therefore may be required to ensure more children and young people from other age groups are encouraged to access the service if required.

4.3 Ethnicity
The highest proportion of those accessing the service overall were of White British ethnicity. This was also the finding for males and females separately, all deprivation quintiles and the 5-10 and 11-16 year old age groups. It is in line with the highest prevalence seen in the 2004 survey, as well as being the largest ethnicity group within Islington. A higher proportion of black children and young people were in contact with the service in comparison to those of Asian ethnicity, overall and within the 5-10 and 11-16 year old age groups and all deprivation quintiles, which does reflect the higher prevalence expected to exist. Smaller proportions of Black and Mixed young people aged 17-18 accessed the service compared to the other age groups.

When accessing and using the service there were no observed differences according to ethnicity compared with the overall picture for the service. Those of white British ethnicity were the largest proportion within team categories, referral sources and appointment categories. Within each ethnicity, Community CAMHS were the team most likely to be seen by, Education the service to have been referred from, one appointment to be offered and attended, and no appointments unattended. Differences were found when the behavioural and emotional care pathways were separated out from the Community CAMHS service; significantly more black children and young people were on the behavioural care pathway and those from the White-other ethnicity group on the emotional one. It would be interesting to explore this further, perhaps through the reasons for referral and referral source. When discussed with CAMHS staff it was felt that this was socially constructed.

One study was found suggesting that children and young people from black and minority ethnic groups are more likely to be referred via Education or Social and other services than primary care in comparison to their white British counterparts23. This analysis was underpowered to detect any such difference but this is worth considering within the recommendations for increasing access by various ethnic groups.

When assessing equity, a higher proportion of those expected to have a mental health condition were in contact with the service for mixed, white other and other ethnicities in comparison to white British, black and Asian. This was mirrored within males and females and age groups separately, with some variation in the ranking between the three. Whether this is a true reflection of the service is impossible to say due to the large number of unknown and unrecorded ethnicities within the 2015/16 data. It is also important to remember the same prevalence was applied to all ethnicities, but in reality it is likely to differ between them which would impact on these results.

4.4 Deprivation
The highest proportion of children and young people accessing the service overall were from the most deprived quintiles. This is in line with what is known about the influence of child poverty on the development of mental health conditions. This was reflected in males and
females separately, across all age groups and ethnicities. There was some deviation from this observed within White-other and Mixed ethnicities, which showed children and young people from quintiles two and three being of more even proportions, which within a bigger dataset may be more apparent and worthy of some exploration. Within the most deprived quintile, more black children and young people than Mixed accessed the service, which is different to all other quintiles, in which the proportions are the other way around. Within age groups, the 0-4 year olds saw a more even distribution of the 2nd to 5th quintiles, and the 17-18 year olds a larger proportion from the least deprived quintile. When discussed with CAMHS they felt this could be a reflection of parental anxiety and of some older children and young people referring themselves to the service.

As with ethnicity, there was little deviation from the overall picture when it came to assessing access to and use of the service within deprivation quintiles; the most deprived quintiles were the highest proportions across team categories, referral sources and all appointment categories. Community CAMHS was the most accessed team and Education the most likely referral source within all quintiles. However, it would be interesting to explore why there were more even proportions of children and young people seen from the most and least deprived quintiles within the Early Years’ service, and higher proportions from the middle quintiles, and a larger proportion of those in the least deprived quintile in the Children’s Centre service. As these services will see mainly 0-4 year olds, it may be worth exploring the reasons for referral and how they play out across the population groups.

4.5 Summary
There is a need to increase access and use of CAMHS across the under 18 population of Islington, regardless of sub-populations. This level of unmet need is likely to further increase the risk and consequences of mental ill-health for these children and young people as adults. For example, the underrepresentation of males aged 17-18 years old could be feeding into the higher incidence of suicide in adult men. A discussion with relevant stakeholders will be required to debate the level of need it is possible to aspire to meeting within the constraints of current resources, and how this might be distributed with these findings in mind. CAMHS staff felt that the service is being affected by a lack of other services, resulting in children and young people being referred for social rather than specifically mental health needs. However, it will be important to consider the following populations within this, who are currently less well represented than others, in order not to further increase the differences between them and potentially widen inequalities:

- Females aged 5-10
- Females of Black and Asian ethnicity
- Males aged 17-18
- Males of Asian ethnicity
- White British, Black, Mixed and White other ethnicity aged 17-18
- Those of Asian ethnicity and aged 5-10 and 11-16

No differences between any of these groups were identified with regards referral sources, all were most likely to be referred to the service via Education and/or primary care, which is important to note when considering recommendations for potential interventions. This health
equity audit, with its limitations in mind, has shown that there is inequity across Islington, but does not explain why this might be. It is necessary to draw on other sources of knowledge and evidence as well as these findings when developing the recommendations. It would be useful to explore, perhaps as a separate undertaking, why there are gender differences within referral sources and gender and ethnicity differences within team categories. This would improve understanding of the level of need within Islington and how the service can best respond to it, in partnership with other services and agencies working with children and young people.
5. Recommendations
The following recommendations are for the consideration of not only CAMHS but all services with a remit for mental health support for children and young people in Islington, as well as the Childrens Mental Health and Emotional Wellbeing Advisory Group.

5.1 Service Provision
- Increase overall awareness of the service with children and young people, parents and potential referral sources, to ensure those in need of the service can access it
- Increase awareness of all available services with a remit for mental health support for children and young people, to foster a holistic and collaborative approach across Islington
- Increasing the awareness of referrers regarding those population groups currently underserved by services, to raise the level of met need for these groups via referral to appropriate services
- Coordinate the response of all services across Islington with a remit for mental health support for children and young people, working in partnership to ensure the right children are seen by the right service at the right time. Consider the adoption of a stepped system within Islington, with improved (and documented) referral between services
- Further audit into referral reasons and the pathways recommended for children from different population groups to identify specific issues, for example, behaviour in schools, young people and exam pressure, and female Children Looked After, in order to prioritise actions to address these particular needs in settings

5.2 Data Collection
- Consider requesting data from other services (The Brandon Centre and Tavistock and Portman) as disaggregated and anonymised, to analyse whether they are seeing different population groups in comparison to the Whittington Health Service, and whether taken together the proportion of those expected to have a mental health condition accessing a service would increase
- Adopt strategies for improving data collection and recording within the service and the services which also feed into the dataset, i.e. primary care and child health information services, with particular attention to recording ethnicity, registered GP and school attended

5.3 Future Health Equity Audit
Repeat the HEA once the new ONS survey has been published, in order to apply more up to date and relevant prevalence figures, and consider PH intelligence weighting them for housing tenure
- Repeat the HEA with a larger dataset, and a more recent one which may reflect improvements in data collection and therefore require less exclusions, better representing the children and young people seen by the service
- Consider repeating the HEA based on school population of Islington, if this data is available
6 References


9. **London Borough of Islington and Islington CCG.** *Islington Transformation Plan for Children and Young People’s Mental Health and Wellbeing 2015-2020*


11. **Camden and Islington Annual Public Health Report 2014/15.** *Healthy Minds Healthy Lives. Widening the focus on Mental Health*

12. **London Borough of Islington, Islington CCG and healthwatch Islington.** *Islington’s Joint Health and Wellbeing Strategy 2013-16*

13. **London Borough of Islington, Islington CCG and healthwatch Islington.** *Islington’s Joint Health and Wellbeing Strategy 2017-2020*

14. **London Borough of Islington and Islington CCG.** *Children’s Health Strategy 2015-2020*

15. **London Borough of Islington.** *Islington Child and Adolescent Mental Health Strategy 2012-15*


Appendix 1 – extra charts not included within main results

**Team categories within gender**

Within this analysis TYS/YOS had to be removed due to disclosive numbers.

For males and females, the highest proportions were within Community CAMHS (35%, 32-39%, n=236 and 44%, 40-48%, n=235), in comparison to all other services, as was the case overall.

![Proportion accessing the service by gender and team category, Islington CAMHS service users aged <18, 2015/16](image)

*Note: 1 service user removed due to unknown team category and TYS/YOS due to disclosive numbers
Source: CAMHS data, 2015/16*
Appointments offered within Gender

The numbers within the 0 category (i.e. no appointments offered) were disclosive and therefore this category has been removed from the charts.

Gender within appointments offered

A higher proportion of males were offered appointments in most categories, but there was no evidence to support these observed differences in any of the categories.
**Appointments attended within gender**

Proportion accessing the service by gender and number of appointments attended, Islington CAMHS service users aged <18, 2015/16

**Gender within number of appointments attended**

A higher proportion of males attended the range of number of appointments in comparison to females apart from 11-19, but there was only evidence for this in those attending two (59%, 51-67%, n=88) appointments.

Source: CAMHS data, 2015/16

**Proportion accessing the service by number of appointments attended and gender, Islington CAMHS service users aged <18, 2015/16**

Source: CAMHS data, 2015/16
Number of appointments not attended within gender

Gender within appointments not attended

A higher proportion of males than females did not attend all categories of appointments, except for four and five appointments.

There was only evidence for the difference observed between males and females attending all appointments (56%, 51-60%, n=258).

Source: CAMHS data, 2015/16