Islington CAMHS Transformation Plan 2018-19

Appendices

Appendix 1 – Whole System CAMHS Spend and Breakdown of CAMHS Funding by Service

Spend on CAMHS by Organisation	2014/15	2015/16	2016/17	2017/18	2018/19
Islington CCG	£4,251,156	£4.201,284	£4,143,095	£5,186,205	£5,761,531
Islington Council	£1,469,836	£1,363,474	£1,388,520	£1,275,453	£1,272,575
Schools Forum	£424,000	£519,000	£516,000	£424,000	£424,000
Individual Schools	£197,583	£199,583	£145,000	£142,000	£98,000
Others Organisations and Funding Streams (including NHSE Waiting Time initiative)	£43,200	£57,460	£107,300	£232,200	£163,200
Transformation Plan and Eating Disorders spend	-	£470,526	£713,718	£772,439	£926,350
Total	**£6,385,775**	**£6,811,330**	**£7,013,633**	**£8,033,297**	**£8,645,456**

Service	Provider	2014/15	2015/16	2016/17	2017/18	2018/19
Islington Community CAMHS	Whittington Health	£2,509,000 – CCG £375,000 – LBI £32,200 – Other	£2,509,000 - CCG £375,000 - LBI £49,200 - Other £372,754 - TP	£2,509,000 - CCG £375,000 - LBI £49,200 - Other £331,754 – TP £57,000 - NHSE	£2,609,000 - CCG £275,000 - LBI £49,200 - Other £344,514 – TP £57,000 – NHSE £127,000 - HEE	£2,609,000 - CCG £275,000 - LBI £49,200 - Other £520,425 – TP £114,,000 – HEE

CAMHS in Early Years	Whittington Health	£60,000 – LBI	£60,000 – LBI	£60,000 – LBI	£60,000 - LBI	£60,000 – LBI
CAMHS in Children's Centres	Whittington Health	£175,000 – CCG £74,000 – Schools Forum	£175,000 – CCG £74,000 – Schools Forum	£175,000 – CCG £74,000 – Schools Forum	£175,000 – CCG £74,000 – Schools Forum	£175,000 – CCG £74,000 – Schools Forum
CAMHS in Schools	Whittington Health	£350,000 – Schools Forum £73,000 – LBI £36,000 – CCG £185,000 – Indiv. Schools	£445,000 – Schools Forum £73,000 – LBI £187,000 – Indiv. Schools	£442,000 – Schools Forum £73,000 – LBI £132,500 – Indiv. Schools	£350,000 – Schools Forum £73,000 – LBI £134,000 – Indiv. Schools	£350,000 – Schools Forum £73,000 – LBI £98,000 – Indiv. Schools
CAMHS in TYS/YOS	Whittington Health	£79,000 – CCG	£79,000 – CCG	£79,000 – CCG	£62,000 - CCG	£62,000 – CCG
Neuro-Developmental Team	Whittington Health	£14,000 – LBI £12,583 – Indiv. Schools £11,000 – Other CCG and Schools Forum contribution included in Community CAMHS figure	£14,000 – LBI £12,583 – Indiv. Schools £11,000 – Other CCG and Schools Forum contribution included in Community CAMHS figure	£14,000 – LBI £12,500 – Indiv. Schools £11,000 – Other CCG and Schools Forum contribution included in Community CAMHS figure	CCG and Schools Forum contribution included in Community CAMHS figure	CCG and Schools Forum contribution included in Community CAMHS figure £77,000 - CCG

Social and Communication Team – ASD	Whittington Health			£101,000 - TP	£101.000 - TP	£101,000 – TP
CAMHS in Children Looked After Health Team	Whittington Health	£241,720 – LBI	£241,720 – LBI	£250,000 - LBI	£250,000 - LBI	£250,000 - LBI
Adolescent Outreach Team	Whittington Health	£283,000 – CCG	£283,000 – CCG	£283,000 – CCG	£283,000 – CCG	£283,000 – CCG
Parental Mental Health Service AMHS / CAMHS Growing Together: Support for Parents and Young Children.	Whittington Health and Camden and Islington NHS Trust	£340,000 – CCG	£340,000 – CCG	£340,000 – CCG	£340,000 – CCG	£340,000 – CCG
Adolescent Multi-Agency Support Service	Led by Safeguarding and Family Support	£92,542 – LBI	£95,000 - LBI	£90,410 - LBI	£98,935 - LBI	£98,935 - LBI
Islington Families Intensive Teams	Led by Safeguarding and Family Support	£159,084 - LBI	£200,000 - LBI	£176,046 - LBI	£152,667 - LBI	£90,895 - LBI
Enhanced Service, Islington Children's Social Care Innovation Project	Led by Safeguarding and Family Support	£249,490 – LBI	£278,902 - LBI	£155,064 - LBI	£205,851 - LBI	£264,745 - LBI

Parental Mental Health Service to Islington Targeted and Specialist Children and Family's Service	Camden and Islington NHS Trust	£150,000 – CCG	£150,000 – CCG	£150,000 – CCG	£150,000 - CCG	£150,000 - CCG
Young People counselling and psychotherapy	The Brandon Centre	£35,000 – LBI £29,500 – CCG	£35,000 – LBI £29,500 – CCG £22,188 - TP	£35,000 – LBI £29,500 – CCG £30,000 - TP	£64,500 – CCG £38,650 – TP	£64,500 – CCG £38,614 – TP
Young People counselling and psychotherapy	Mind Connect			£10,000 - TP	£10,000 - TP	£23,724 - TP
Counselling and therapeutic services for refugees	Refugee Therapy Centre	£30,000 - LBI	£30,000 - LBI	£30,000 - LBI	£30,000 - LBI	£30,000 - LBI
Child and family and adolescent clinic	Tavistock and Portman NHS Trust	£214,603 – CCG	£203,118 - CCG	£140,705 – CCG	£159,137 - CCG	£161.842 - CCG
Paediatric Liaison Service	Whittington Health	£96,000 - CCG	£96,000 - CCG	£96,000 - CCG	£96,000 - CCG	£96,000 - CCG
Perinatal mental health service	Whittington Health	£152,053 - CCG	£149,666 - CCG	£153,890 - CCG	£1,060,568 (NCL)	£1,556,189 (NCL)
Royal Free Hospital Eating Disorder Service	Royal Free NHS Foundation Trust	£187,000 - CCG	£187,000 – CCG £67,587 - TP	£187,000 – CCG £67,587 - TP	£187,000 – CCG £67,587 - TP	£187,000 – CCG £67,587 - TP

Public Health – Youth Mental Health First Aid and Direct Action Project	Rethink and Peel Centre	£140,000 - LBI	£140,000 - LBI	£130,000 - LBI	£130,000 - LBI	£130,000 - LBI
Mental health promotion building resilience in schools	Islington Council			£25,000 - TP	£25,000 - TP	£25,000 - TP
New ways of working to support children and young people at risk of or with experience of CSE	Islington Council		£8,000 - TP			
Increase capacity to support complex C&YP IEDS and complex cases				£121,000 - TP		
VCFS Small Grants Programme	Centre 404, Islington Play Association, Key Changes, Family Action			£27,377 - TP	£13,688 - TP	
Child House funding – picked up from NHSE	Camden CCG				£17,000 – CCG	£17,000 – CCG
Psychology input to Transition Team	Camden and Islington Foundation Trust				£16,420 – TP	
Additional Transformation Plan spend					£155,000 - TP	£150,000 - TP
Totals		**£6,385,775**	**£6,811,330**	**£7,013,633**	**£8,033,297**	**£8,645,456**

Appendix 2 - Islington CAMHS Transformation Plan progress against priorities for Phase 1, 2 and 3

Progress to date - Phase 1 2015/16 priorities

Local Priority Scheme 2015/16		**Phase 1**		
Promoting resilience, prevention and early intervention for the mental wellbeing of children and young people				
		Progress Update	***Funding allocation***	***Status***
LPS-1	Mental health promotion building resilience in schools	This is an ongoing piece of work that has enabled the team to increase the number of schools that they are able to work with directly. **KPI of 80% of schools to have implemented 1 or more of the components of the IMHARS framework**	£25,000	OPEN (ongoing programme of work)
LPS-2	Perinatal mental health	This piece of work was taken forward across North Central London following a successful bid to NHS England. The programme of work supports the development of specialist peri natal services with robust care pathways across all Acute Trusts in NCL to ensure equity of access regardless of where a mother decides to have her baby.		OPEN (moved to NCL priorities)
LPS-3	Review of parental mental health services to coherent pathway	This review of 'Growing Together' Parental Mental Health Service, was undertaken by an external consultant with a final report circulated. The aim of the review was to ensure that the service was appropriately targeting women with mental health needs and was not duplicating services.	Existing CCG funding stream	CLOSED
Improving access to support – a system without tiers				
LPS-4	Urgent Waiting list initiative	This initiative was implemented into 16/17 following the recruitment of 4 fixed term band 7 practitioners and assistant psychologists to increase	308,463	OPEN

		capacity to address an increasing waiting list for core CAMH services. The service were set a challenging target of reduction to a waiting time. **KPI 4 weeks to choice and 4 weeks to treatment – an overall Referral to Treatment of 8 weeks(RTT)**		
LPS-5	Community CAMHS crisis care, extended opening hours, improved response and wait times	Increased capacity in Adolescent Outreach Team by 0.6 wte to support the team to respond quickly and flexibly delivering services in the community targeting vulnerable young people who would find it difficult to access services at the Northern Health Centre. Capacity within Priority 1 team (P1) was also developed 0.6 nursing and 0.4 psychiatry to enable them to respond quickly to priority cases. **KPI 24hr response to an emergency (that does not require attendance at A&E) and urgent cases within 5 working days.** This target has been achieved.	30,652 (183,913) full year costs	OPEN
LPS-6	Implementation of Camden and Islington's crisis care concordat	The key focus of this programme of work was to identify a CAMHS practitioner locally who was able to undertake training to qualify as an Allied Mental Health Practitioner (AMHP) to undertake Mental Health Act assessments. We were unable to identify a professional to undertake the training so this was rolled over to 16/17.	3,000	OPEN
LPS-7	Building sustainability and sufficiency in Voluntary Community Faith Sector (VCSF)	To work with voluntary sector providers to increase counselling and therapeutic interventions delivered in a range of community settings – for 15/16 we increased existing capacity in services being provided from our youth hubs to maximise resources late in the year with further preparation work undertaken with the VCSF in preparation for 16/17 funding	22,188 (67,188 full year allocation)	OPEN
LPS-8	Community eating disorder service	Increased funding provided to our local specialist Eating Disorder Service provided by The Royal Free Hospital to ensure compliance with community service guidelines and to meet waiting times: **KPI: urgent 1 week and routine 4 weeks**. This has now moved to NCL priority as part of our STP programme of work.	67,587	OPEN (Moved to NCL priorities)
LPS-9	ED Self Harm post within AOT	This is a dedicated post to support primary care and schools in early identification of eating disorders and where required timely referral into	11,264 (full year costs 67,587)	OPEN

		services. This post was delayed in recruitment so was not recruited to till 16/17 – slippage was used against waiting list initiative.		
Care for the most vulnerable				
LPS-10	Development of an LD Pathway (including C&YP with Autism)	A newly established pathway to deliver comprehensive assessment of learning disabilities for YP thought to have a significant LD. **KPI: All young people will be screened for LD on entry into CAMHS.**	10,375 (62,254 full year cost)	OPEN
LPS-11	New ways of working to support children and young people at risk of or with experience of CSE	This pilot, delivered by Safer London, ran from January 2016 through to June 2016 and the findings from the pilot were used to inform new service developments focusing on this cohort of vulnerable young men who demonstrate sexually harmful behaviours	8,000	CLOSED
LPS-12	Build on and develop CYP IAPT data collection infrastructure	This supported data infrastructure to support the Trust with compliance on data collection for both CYPIAPT (Children and Young People increasing access to psychological therapies) and then moving into the introduction of the Mental Health Dataset (MHDS)	12,000	CLOSED

Progress to date Phase Two (16/17 refresh)

The table below sets out progress against agreed 16/17 priorities, many of which were carried over from 15/16.

Local Priority Scheme 16/17		**Phase 2**		
Promoting resilience, prevention and early intervention for the mental wellbeing of children and young people				
		Progress	***Funding Allocation***	***Status***
LPS-1	Develop a sub group of young people and an action plan to deliver Islington Young people's Mental Health Charter(Mental Health Charter appendix 3)	This programme of work is tasked with overseeing the delivery of the Mental Health Charter, a piece of work undertaken with local YP identifying what they see as the priorities for transforming local CAMHS. This was delayed due to changes in our participation worker but is now back on track and will be core to our engagement strategy for the 17/18 plan. **KPI: deliver outcomes indicated in Islington CYP CAMHS Charter**	5,000	OPEN
LPS-2	Mental health promotion building resilience in schools	Ongoing contribution to the IMHARS programme of work that supports schools to develop programmes of work to support positive emotional health and well-being. **KPI 80% of Islington schools to have implemented one or more of the components of the IMHARS framework by 2021**	25,000	OPEN and on track
LPS-3	CAMHS in Early Years Transformation	This is an ongoing piece of work that Whittington Health have been engaged with as part of the Bright Starts Transformation which impacts on the way CAMHS services are delivered in local children's centres but without a reduction in the local offer.	Existing funding stream	CLOSE
Improving access to support – a system without tiers				

LPS-4	Urgent Waiting list initiative	This piece of work ran through the most part of 16/17 and was on track to meet the challenging waiting time of RTT 8 weeks. However, recruitment and staff sickness meant that at the end of the financial year we started to see a significant increase in waiting times again, although not to the same level as previously) This coupled with a significant increase in the number of referrals into the CAMH service at the Northern alongside a national target to increase the numbers of CYP accessing CAMH services informs the key piece of work proposed for 17/18 around service transformation. **KPI referral to treatment 8 weeks – as of end 16/17 15 weeks (down from 21 weeks)**		OPEN
LPS-5	Increase Access to services by developing CYPIAPT workforce development and training programme Existing Staff IAPT Training 2 ASD/LD 1 Infant Mental Health 1 Adolescent depression 4 CWP trainees	This target is on track – CAMHs recruited 4 Children's Well Being Practitioners who are recruited to undertake an evidenced based training programme delivered by CYPIAPT programme. In Islington we have located these practitioners in the community with Families First and also linked to our local schools. Once trained CWPs are able to deliver evidenced based short term interventions for low level anxiety and depression as well as support a range of parenting programmes / parenting support. We propose to continue this programme next year where we will need to identify to pick up the salary costs of the CWPs (funded by the CYP IAPT programme this year) We have also continued to support staff development in the principles of CYP IAPT that promote the use of evidenced based interventions. The programme has a strong focus on measuring progress and outcomes in partnership with the parent or young person as well as ensuring services embed the principles of service user participation and engagement. **KPI: recruit 4 CWPs for training programme to increase skill mix**	9,760 (contribution to CYP IAPT Training costs)	OPEN

LPS-6	Health Equity Audit	Public Health have conducted a Health Equity Audit in order to assess and describe how Islington's Children and Adolescent Mental Health services are accessed and used by the local population. In particular, the audit wanted to explore whether some population groups were underrepresented in the service and if so what recommendations we needed to consider in order to redress any underrepresentation.	Within existing resources	CLOSE With recommendations being taken forward.
LPS-7	Increase access by building capacity and sustainability in the Voluntary and Community & Faith Sector	Significant work with our voluntary sector partners has been undertaken. Projects and programmes of work have been commissioned to deliver increased capacity in counselling and therapeutic Interventions delivered in community settings – these are being provided by the Brandon Centre and Mind Connect. The programme has increased capacity for VCSF partners to deliver early intervention and prevention projects to support emotional health and wellbeing of C&YP, delivered within the community. Through this work with the VCSF a provider forum for CAMHS providers has been developed which spans NHS, LA and VCSF providers to develop a network approach to share learning as well as developing capacity and an understanding of the service offered across the network. The network links our local NHS community CAMHS providers. This will continue to support our commitment to the principles of 'Thrive', ensuring YP access the right service at the right time and in the right place by ensuring capacity across the whole system is being utilised efficiently. This is a core element of our proposals for 17/18 moving forward.	67,188	OPEN
LPS-8	Develop community ED post to support schools and primary care to support early identification	The initial post holder resigned, and the service had to go back out to recruitment. This has now been successfully recruited to and provides a specialist approach to ED cases in the community as well as supporting those in T4 beds to support seamless care planning for discharge and support back into the community**. KPI contact to be made with all GP practices by e mail and 50% direct contact by March 2017.**Contact has already been made with 100% of GPs in primary care.	67,587	OPEN

LPS-9	Develop local Crisis care pathways in hours	An in hour's crisis care pathway has been developed clearly setting out pathways for young people who require a crisis response. This was drawn up in consultation with a wide range of providers and has been widely circulated. The increased capacity within P1 and AOT (a 15/16 priority) has supported the implementation of this programme of work**. KPI improved access to emergency appointments within 24hrs and priority apt. within 5 working days. In hour's crisis care pathway developed and published by March 2017. KPI ACHIEVED**	183,913 (AOT and P1 posts)	CLOSE (Out of hours crisis care pathways are being developed across NCL as part of our STP work stream)
LPS – 10	Delivery of Crisis Care Concordat including CAMHS professional to be AMHP trained	This year we have identified a member of the Adolescent Outreach Team who is currently undertaking the AMHP training which will give us a CAMHs professional who is able to undertake Mental Health Act Assessments – this supports the crisis care concordat programme of work **KPI: CAMHS practitioner trained as AMHP**	21,000 (Training and backfill)	CLOSE
Care for the most vulnerable				
LPS-11	On-going development of LD pathway and local interface with Transforming Care Intensive Outreach Positive Behaviour Support Service for C&YP with challenging behaviour at risk	An ongoing piece of work with increased staffing capacity to specialise in supporting young people with Learning Disabilities who have mental health needs. This pathway needs to be reviewed in the context of the Neuro Developmental Team (NDT) and Autistic Spectrum Disorder (ASD) assessment pathway. **KPI 100% of YP on LD pathway to receive appropriate assessment and follow up intervention. 100% of YP to be screened on entry to CAMHS service for LD. KPI on track** A specification is currently being worked up to commission a Positive Behaviour Support Service. The premise behind the service is to work with young people to support them to stay and home and in the local community for as long as possible avoiding residential provision where possible. This programme of work builds on the successful programme of work undertaken in Ealing, which has seen significant reductions in residential placements.	62,254	OPEN

		KPI: established PBS service	50,000	
LPS-12	Increase capacity into the ASD pathway in the Social and Communication Team (under 5s assessment and diagnostic pathway) and deliver the findings / recommendations of the ASD Review	Increased capacity in the Social and Communication Team (SLT and OT) which supports a business plan to reduce waiting times to 18 weeks by August 2018. This is currently on track and waiting times are reducing. **KPI Assessment and Diagnostic waiting time of 18 weeks by March 2018**	101,000	CLOSED
LPS-13	Review of CAMHS CLA service	This piece of work has had an initial kick off and is underpinned by a commitment for CLA CAMHS service to work in partnership with children's social care and the development of the Innovation Project, rather than take on a separate piece of work.	Within existing resources	OPEN
LPS-14	Vulnerable Children – Mapping of local Youth Justice Health Pathways	The mapping was completed and a pilot project looking at how we support schools and PRU and local community partners to work with young people who have experienced trauma has been established. The programme of work will be fully evaluated and the findings will be widely shared.	NHSE Health and Youth Justice funding	CLOSED
LPS-15	Establish a working group to consider current CAMHS / AMHS Transition project and potential for development	Transition is a key area of focus and whilst we have started this piece of work its early stages. We are looking to replicate some aspects of the Camden Minding the Gap model, continuing our local Transition model with our shared transition team across children and adults services, as well as looking to hold a workshop to consider how we deliver services for 0 – 25 years olds in relation to mental health.	Within existing resources 14,000 extension of existing within Islington Transition Team	OPEN
LPS-16	Increased capacity with Intensive Eating Disorder Service	Completed now additional capacity within community service.		CLOSED

Progress to date Phase Three (17/18 refresh)

The table below sets out progress against agreed 17/18 priorities, many of which were carried over from 16/17.

Local Priority Scheme		Narrative	KPI
LPS-1	Develop a sub group of young people and an action plan to deliver Islington Young People's Mental Health Charter	Islington young people have set out their vision of what CAMHS would look like by 2020/21 following transformation. This LPS is to ensure CYP continue to be involved in the delivery of YPs local mental health charter A summary of the CAMHS Transformation Plan will also be developed and made available on line and disseminated via local partnerships. **Local CYP formed the CYP CAMHS Service Re Design Sub Group which helped to inform the proposed SEMH service re design model.**	*80% of the Charter Statement delivered across Islington services and Young People reporting satisfaction*. *Summary of CAMHS Transformation Plan refresh in place by 31st December*
	By 2021 • *Islington Emotional Health and Well Being Services will be delivered and accessed across the borough in the way that young people have told us.* • *Children and Young People will be routinely involved in both the commissioning and redesign of local CAMHS services* • *Access to services will increase by a minimum of 35% of the prevalent population*		
LPS-2	Mental health promotion building resilience in schools	To ensure the delivery of IMHARS across Islington schools, this priority scheme contributes to staffing to deliver the programme of work. Schools will be supported to identify when there are emotional well-being concerns and utilise local partnerships and pathways to ensure the young person receives the intervention required. Islington has recently submitted an expression of interest to the Anna Freud Centre for wave 2 of the	*80% of Islington schools to have implemented one or more of the components of the MHARS framework by 2021.* *80% of schools to report staff are appropriately trained and supported to identify and make appropriate onwards referrals where required.*

		Mental Health Services and Schools Link Programme. **Work has begun with BIG Alliance to plot IMARS in partnership with business volunteers with City & Islington College.** **Time To Talk day workshops were held in 17 schools - delivered in partnership with Council/CCG staff and BIG Alliance business volunteers.** **Two youth Mental Health First Aid training days were held in January for primary schools with 41 primary school staff booked on.** **KPI 80% of Islington schools to have implemented one or more of the components of the IMHARS framework by 2021**	*100% of schools to be involved in the schools link programme (if the EOI is successful.)*
	By 2021 • ***Teachers and support staff will report feeling supported in the early identification of emotional health and wellbeing issues***		
LPS-3	CAMHS in Early Years Transformation	To ensure that CAMH services are integrated into the Bright Start Programme – transformation of early years services including provision of integrated health offer. **The Parent and Baby Psychology Service (PBPS) and input into Bright Start Islington was embedded and fully staffed at the end of 17/18. Quarterly meetings have been established between CAMHS U5s managers and Bright Start area leads agreeing service development and priorities.**	KPIs agreed for 18/19
	By 2021 • **Parents/Carers and their young children will have access to timely evidenced based interventions.** • **Parents/Carers with young children with challenging behaviour will report feeling better supported and able to implement changes.**		

LPS - 4	CAMHS Waiting times	Whittington Health Community CAMHS will continue to focus on utilising CAPA and service pathway redesign in order to deliver the agreed waiting times for the emotional health pathway and behavioural pathway. 14 – 18 year olds experiencing first episode of psychosis will receive specialist intervention within 2 weeks. **Waiting as of end 17/18 = 18 weeks**	*Referral to Treatment waiting time 8 weeks (4 weeks choice 4 weeks partnership).* *Establish a process for monitoring EIP referrals ad benchmark - November 2017.* *50% 2017/18* *53% 2018/19* *56% 2019/20* *60% 2020/21*
	By 2021 • *Access to care and support will be timely, offer evidence-based interventions and approaches providing choice and control.* • *No young person will wait longer than 8 weeks to access a CAMH service.* • *By 2021 60% of young people experiencing first episode of Psychosis will be seen within 2 weeks.*		
LPS-5	Increase Access to services by developing CYPIAPT workforce development and training programme	As part of the local workforce strategy to ensure that the CYP IAPT training programme is rolled out across CAMH services including VCSF providers and wider partners to ensure services are offering evidenced based interventions. Children's Wellbeing Practitioner posts will be embedded within Early Help services Islington now has 2 waves of CWPs – 8 roles in total. **At the end of 17/18 there were 6 CWPs in post, three who qualified in May 2018 and three who are currently attending the CWP evidenced based training programme delivered by CYPIAPT programme. The practitioners have been offering early, evidenced based short-term interventions in the form of low intensity support and guided self-help to children and young people who demonstrate**	ICCG will deliver its % contribution towards the national clinical workforce target and the increase in IAPT trainees ➢ *6 new CAMHS professionals* ➢ *12 IAPT trainees* 8 CWPs will be embedded into Islington's Early Help Services

		mild/moderate anxiety, low mood and behavioural difficulties. They have been offering workshops and groups as well as 1:1 interventions and have been delivering these across a range of settings in Islington. In the first year of the programme the CWPs were placed one day a week in Families First however it was found the complex issues that the service users of Families First presented with were beyond the CWP programme threshold. In the second year of the programme there has therefore been an increased focus on linking with schools, voluntary agencies (e.g. Lift / Platform) and other community services. We propose to continue this programme for 18/19 although the placement of the CWPs in the wider CAMHS structure is being reviewed due to a service re design. **We have continued to support staff development in the principles of CYP IAPT that promote the use of evidenced based interventions supporting three trainees for 1-year full time in 17/18.**	
	By 2021: • ***Young People will have increased access to CAMH services, minimum of 35% of YP with diagnosable mental health issue will treatment by 2020/21.*** • ***Young people will report improved mental health as a result of access to evidenced based interventions*** • ***Islington CCG will have increased its clinical workforce in line with national target and will have embedded evidence based practice across clinicians and wider partners***		
LPS 6	Undertake a health equity audit	This 17/18 priority is now closed as this has been undertaken and published.	Achieved and Closed
LPS-7	Increase access by building capacity and sustainability in the Voluntary and Community & Faith Sector	Increase capacity across VCFS to deliver increased access to services for CYP. Delivery of CAMHS emotional health and well-being network led by VCFS partner, to develop capacity and sustainability across the whole system.	***Increase access to VCFS services to support young people's emotional health and well-being by 20% 2020/21.*** ***Emotional Health and Well Being Network convened termly and delivers***

		VCSF will be key partners in developing THRIVE model providing a greater level of access for YP in a wider range of settings. **The VCSF provider forum for CAMHS providers has been successfully running since November 2017 with regular attendance from providers across the NHS, LA and VCSF. The Network has provided a platform for shared learning as well as developing capacity and an understanding of the wide service offer across the network. This Network will continue to support our commitment to the principles of 'Thrive', ensuring YP access the right service at the right time and in the right place by ensuring capacity across the whole system is being utilised efficiently and is a core element of our proposals for 18/19 moving forward as part of our service re design.**	***agreed project as set out in specification.***
	By 2021: • *Young people will have access to a broad range of services across a range of levels and interventions* • *Access to care and support will be timely, offer evidenced based interventions and approaches providing choice and control.*		
LPS-8	Develop community ED post to support schools and primary care to support early identification	This post holder, who is now in post, has a dedicated function to lead on ED cases within community CAMHS providing: Link to RFH and T4 cases Link with primary care and schools to support early identification and onward referral. **At the end of 17/18 the eating disorder specialist had made contact with 100% of General Practices to raise awareness of the service. Training for school staff to recognise signs of eating disorders has been booked for 18/19.**	*100% T4 CPAs to be attended* *Liaison with 100% primary care practices and 90% schools on an annual basis*

	By 2021: • *More children and young people with mental health problems will recover* • *Schools and GPs will report feeling confident in identification and onward referral of ED cases.*		
LPS-9	Develop local crisis are pathways (including ongoing work across P1 and AOT services)	Ongoing delivery of in hours' crisis care pathway (developed in phase 2) across AOT and P1. **At the end of 17/18 the service continued to meet the KPI of 100%.**	*100% of YP known to AOT / P1 to have a crisis care plan in place* *100% of YP who require an emergency appointment seen within 24 hrs and an urgent appointment within 5 working days.*
	By 2021 • *Access to care and support at time of crisis will be timely, offer evidenced based interventions and approaches providing choice and control*		
LPS-10	Delivery of Crisis Care Concordat including CAMHS professional to be AMHP trained	**CAMHS professional has completed AMHP training so that locally there is some AMHP capacity that has a CAMHS background.**	*AMHP training completed by CAMHS professional.* ***Closed.***
	By 2021: • ***Where possible young people requiring a mental health act assessment will be seen by an AMHP with a CAMHS background***		
LPS-11	On-going development of LD pathway and local interface with Transforming Care Intensive Outreach Positive Behaviour Support Service for C&YP with challenging behaviour at risk	The LD pathway established in Phase 2 needs to ensure its working alongside NDT and is integrated in CAMHS pathways – CAMHS will lead this piece of work internally. Establish a positive behaviour support service to provide intensive outreach support for parents / carers where a young person may be experiencing challenging behaviours that may result in breakdown of the family home and need for residential placement. **A Positive Behaviour Support (PBS) Service Protocol has been produced and a PBS Project Group established with education, health and social care**	*Integrated cohesive pathway for YP with Learning Disabilities within community CAMHS.* *Established PBS service across education, health and social care partners March 2018.*

		partners, to implement a Positive Behaviour Support Service from Sept 2018.	
	By 2021: • ***All young people with a learning disability accessing community CAMH services will have access to timely specialist care and support offering evidenced based interventions and approaches providing choice and control.*** • ***Parents with CYP with challenging behaviour will report feeling better supported particularly at times of crisis***		
LPS 12	Increase capacity into the ASD pathway in the SCT and deliver the findings / recommendations of the ASD Review	Robust plan in place to address waiting times for ASD assessment in under 5s and the ongoing sustainability. Robust plan to be developed for NDT pathway which will utilize 17/18 underspend on NCL crisis care pathway to reduce waiting times to 18 weeks by March 2019.	***SCT waiting time reduced to 18 weeks by August 2018.*** ***NDT waiting time reduced to 18 weeks by March 2019.***
	By 2021: • ***All young people with Autistic Spectrum Disorder will have access to timely specialist diagnosis and ongoing care and support offering evidenced based interventions and approaches providing choice and control.***		
LPS-13	Review of CAMHS CLA service	This project will now be picked up as part of children's social care innovation project and proposed LPS 17.	
LPS-14	Vulnerable Children – Mapping of local Youth Justice Health Pathways	Delivery of Trauma pilot (ARC framework) in 5 primary schools and the PRU with local community input and fully evaluated. Findings to be shared with CAMHS advisory Board and Youth Justice Management Board for further consideration. Continue to monitor and review access and impact of integrated health offer provided into Targeted Youth Support and YOS. **During 17/18 we supported five primary schools and the PRU in their work with children who have experience complex trauma. This work will be**	***100% of pilot schools to have completed trauma training and accessed follow up support.*** ***Findings of pilot circulated for consideration by September 2018.*** ***Health data to be reported to Youth Justice Management Board routinely.***

		extended to a further 5 primary schools and two secondary schools in 18/19. The findings to date indicate potentially positive impact of the work, especially in relation to: • **Staff being better equipped to support children who may be dealing with underlying trauma.** • **Children and young people seeing their school as being a sensitive and caring environment and one in which there is an adult who they feel comfortable talking to.** • **Schools having increased capability in supporting vulnerable children.** • **Schools experiencing improvements in school behaviour and attendance.**	
	By 2021: • ***Young people to receive timely and evidenced based interventions delivered by the integrated health team.***		
LPS-15	Establish a working group to consider current CAMHS / AMHS Transition project and potential for development	Establish mulit-agency steering group to develop a clear plan to enhance current Transition team offer for YP moving between CAMHS and AMHS. Increase capacity of AP in existing team and development of fortnightly transition meeting in line with Camden Model. **This was increased from 0.5 wte to 1.0 wte in December 2017.** Implement National Transition CQUIN. **To meet CQUIN requirements the Islington Transition Team have updated their service protocol and developed service user questionnaires for feedback on YP experience both before and after transition. Consent for Islington YP to be sent a questionnaire post transition, in line with CQUIN guidance, has**	***Established Steering Group by November 2017*** ***Increased capacity of AP in existing team September 2017*** ***Completion of National Transition CQUIN in line set targets***

		been included in Community CAMHS protocol. Initial feedback from YP has been collated to help inform development of the transitions pathway.	
	By 2021: • ***Young people in Transition will report feeling supported to access adult services in a timely way, accessing evidenced based interventions and approaches providing choice and control.***		
LPS-17	Service Transformation Redesign – Whole System Pathway	Work across the Islington Partnership to develop a proposal for an integrated CAMHS model based on Thrive with a single point of access to a broad range of services / interventions. Phase 1 development of model based on further data analysis, including a review of our local access target and a revised trajectory to meet the needs of ALL children and young people.	***Project board established by December 2017.*** ***Data collection and analysis to support programme of work completed by March 2018.*** ***Proposed model outline for consultation June 2018.***
	By 2021: • ***Access to care and support will be timely, offer evidenced based interventions and approaches providing choice and control.*** • ***More children will have a positive experience of care and support provided by services*** • ***More children and young people with mental health problems will recover***		
LPS-18	Development of a local workforce programme building on the NCL wide workforce mapping currently underway	Building on the NCL wide workforce mapping to develop a local workforce plan that will support the delivery of national workforce targets as well as support the development of local service transformation.	***Local Workforce plan published March 2018.*** ***Contribute to the delivery of national access target of meeting 35% of need by 2020/21*** ***Contribute to national workforce targets of 1,700 new CAMHS professionals and 3,400 IAPT Trainees.***

	By 2021: • ***Islington will have a workforce across universal, targeted and specialist services that is able to provide care and support that is timely, evidenced based and gives the young person choice and control.***		
LPS-19	Consideration to be given to the findings of the Digital Participation Project for CYP	Implementing recommendations informed by the Digital Participation pilot project which explored how to utilise technology in order to support CYP with low level emotional health and wellbeing needs. Findings will inform the service transformation as well as local workforce strategy. **Completion of a 6-month Digital Participation Pilot which made recommendations to include Digital Solutions as part of the new SEMH offer in order to ensure that Islington young people are supported to manage their care and have early access to goal and outcomes focused intervention (where appropriate). Digital channels are intended to provide choice and control for CYP and minimise the stigma often associated with mental health services. As a result of these recommendations Digital Solutions have been included as a key part of the SEMH service redesign.**	***Implementation of the following recommendations from the final digital participation pilot project report on the findings of the project with clear recommendations for the use and integration of digital technology to support emotional health and well-being to be completed by February 2018.***
	By 2021: • ***Digital access to care and support will be timely, offer evidenced based interventions and approaches providing choice and control.***		
LPS-20	CAMHS outcomes measures (PROMS and PREMs to demonstrate impact and effectiveness)	Outcomes measures should be used routinely across all CAMH services in order to be able to demonstrate impact and effectiveness of intervention. To date Whittington Health CAMHS have been good at collecting the initial measure but follow up with the second. measure has been very poor. This has been raised with the service and an agreed KPI has been set. **An increase in recorded outcomes measures for the CAMHS Community Service Emotional & Behaviour pathways from 33% on Q2 17/18 to 83% Q1 18/19.**	***80% of community CAMHS cases to have at least 2 points of outcome measures by March 2018.***

<table>
<tr><td></td><td colspan="3">By 2021:
More children and young people with mental health problems will recover</td></tr>
<tr><td rowspan="2">LPS-21</td><td>Develop Integrated Personal Commissioning (IPC) to support young people with mental health needs; building on the current pilot with looked after children.</td><td>Learning from the current IPC pilot which is currently focusing on the mental health of Children Looked After to consider the findings of the project to think about how IPC can be embedded into CAMHS further – this will have a particular focus on:
Care Leavers
CLA placed out of borough
Transition
Transforming Care Cohort with significant mental health needs.
A personalised budget project (PBP) for YP, known locally as the Choice & Control Project, has been developed with currently 36 PHBs in place across the Independent Futures and Children Looked After (CLA) Teams.</td><td>40 looked after children / young people will be in receipt of an IPC by March 2019

.</td></tr>
<tr><td colspan="3">By 2021:
Young people will report feeling involved in their care and in the development of services providing that care.
Access to care will be timely, offer evidenced based intervention and approaches providing choice and control.</td></tr>
</table>

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

May 2017

Rebecca Perrin

Public Health Registrar

Acknowledgements

Sheron Hosking (Head of Children's Health Commissioning), Tanya Parr (Commissioning Officer), Clive Blackwood (Borough Lead CAMHs, Universal Services & Family Nurse Partnership), Kieran Martin (Data Analyst), Anup Pandya (Business and Performance Manager), Jason Strelitz (Consultant in Public Health), Gabrielle Emanuel (Assistant Public Health Information Officer), Dalina Vekinis (Principal Public Health Intelligence Specialist), Katherine Logan (PH Intelligence & Information Officer)

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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].

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[2] 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[3]. Alongside this focus on mental health, the 2012 Annual Report of the Chief Medical Officer[4] 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[1].

In 2014 the House of Commons Health Committee published a report into Child and Adolescent Mental Health and CAMHS[5], 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[6] 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[7]. 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[8] 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[9]. For all ages, the largest ethnicity group in Islington is White British

(48%), followed by White-other, Black, Asian, mixed and finally other[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[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[12] and 2017–2020[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[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[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[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.

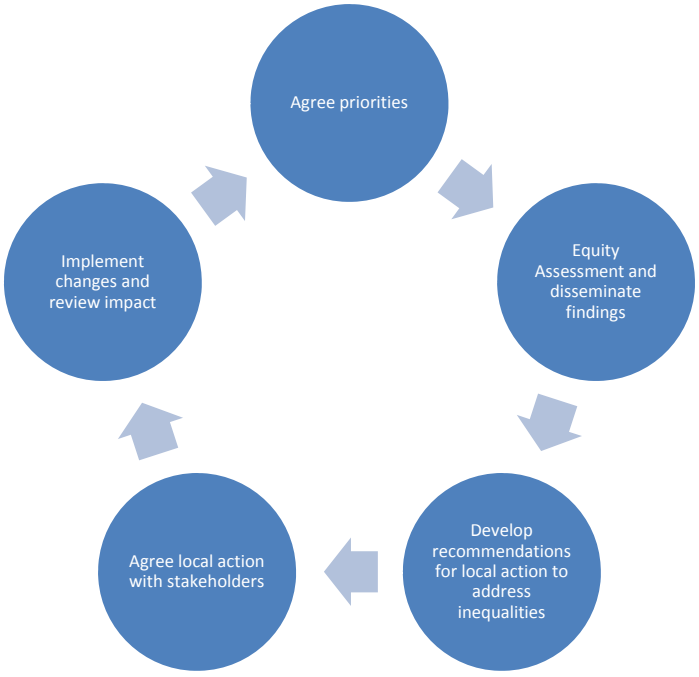
As well as these contracted providers, there are a number of voluntary organisations across Islington which offer support for this age group in a variety of ways.

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[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[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[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 then 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 Agnold[22] 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:

Overall	14%
Gender	14%
Age **5-10** **11-16** **17-18**	 14% 14% 18.9%
Ethnicity	14%

2.3 Datasets

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

Organisation	**Data**	**N=**
Whittington Health	CAMHS tier 2 and 3 data 2015/16	n=2228
Whittington Health	CAMHS tier 4 data 2015/16	n=9
The Tavistock and Portman NHS Foundation Trust – via LBI Children's Services	Aggregate data with no demographics for 2015/16	
The Brandon Centre	Aggregate data for 2015/16	N=80 59 female, 21 male, 10 aged 16 yrs, 45 ages 17-18 yrs, 48 white, 14 mixed, 10 Black/Black British, 5 not

		recorded, other ethnicities disclosive numbers
Refugee Therapy Centre	Oct 15 – March 16, data for Apr – Sep 15 not available at time of analysis) Numbers disclosive	n=8
Camden & Islington PH Team	GP PH Dataset 2015, Islington GP registered population aged 0-18	n=38,881

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

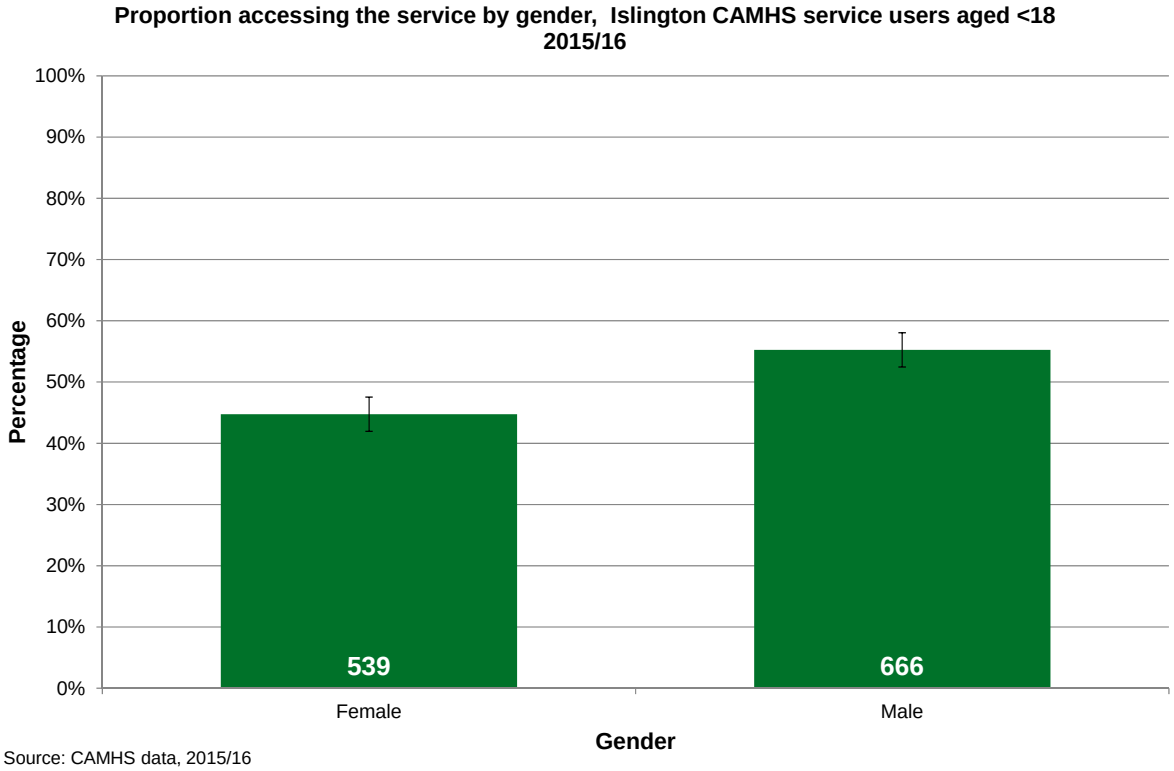
3.1 Profile of those accessing and attending CAMHS

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.

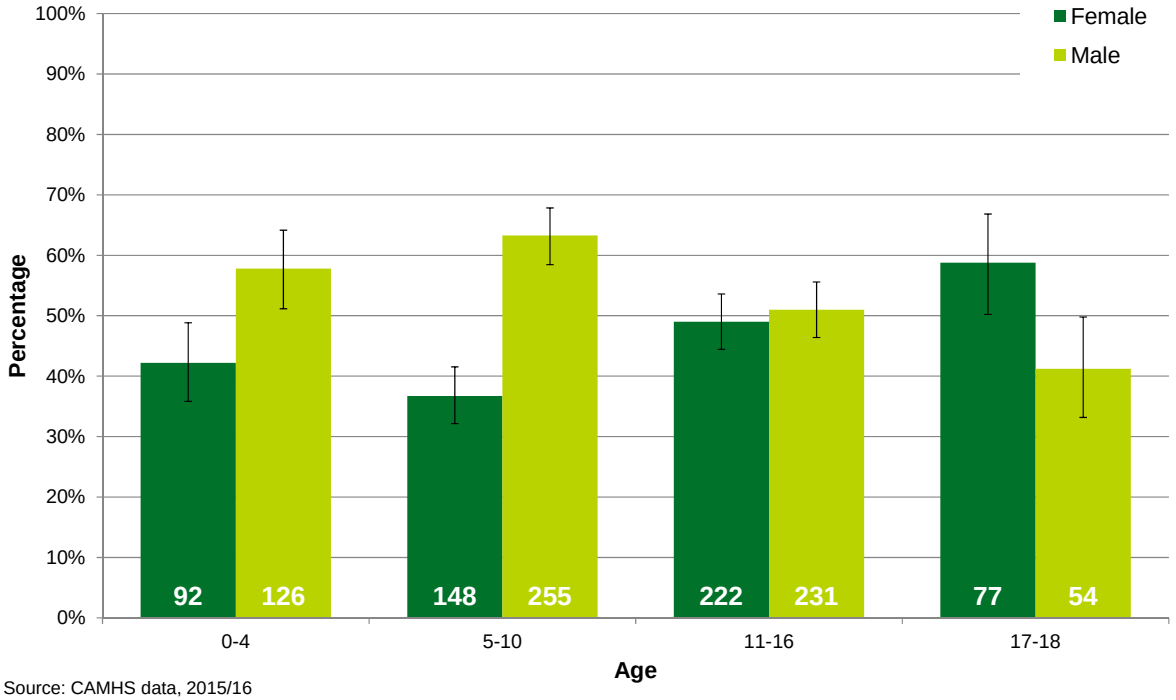


Source: CAMHS data, 2015/16

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.

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



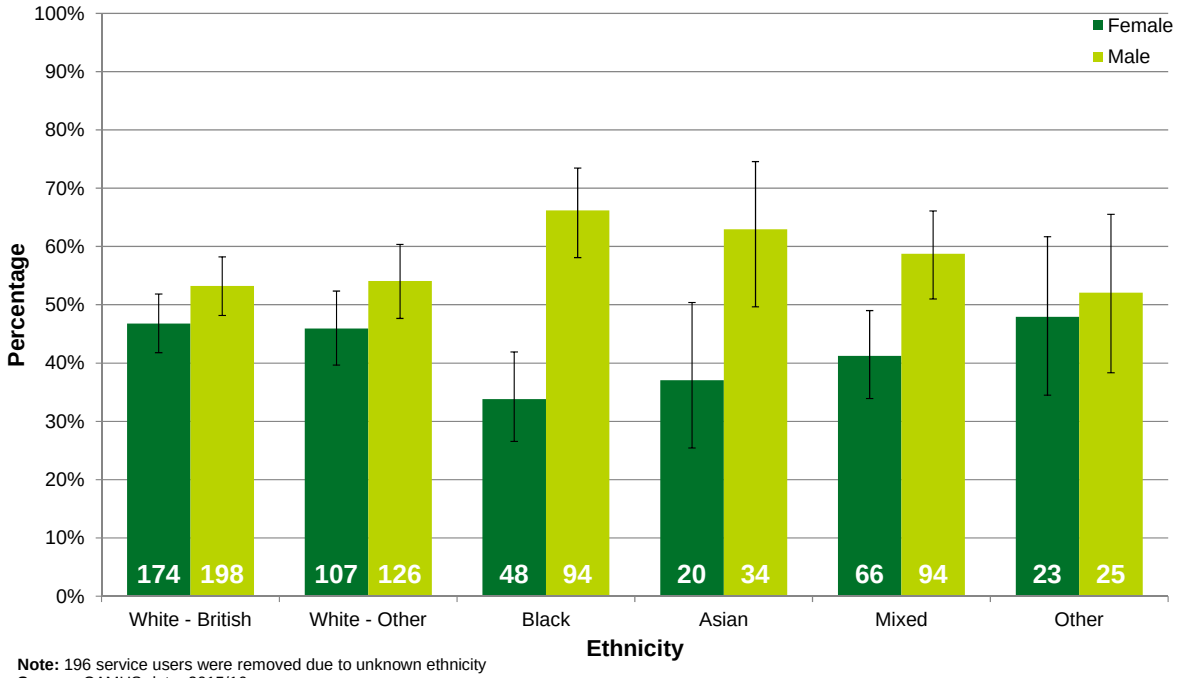
Source: CAMHS data, 2015/16

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.

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

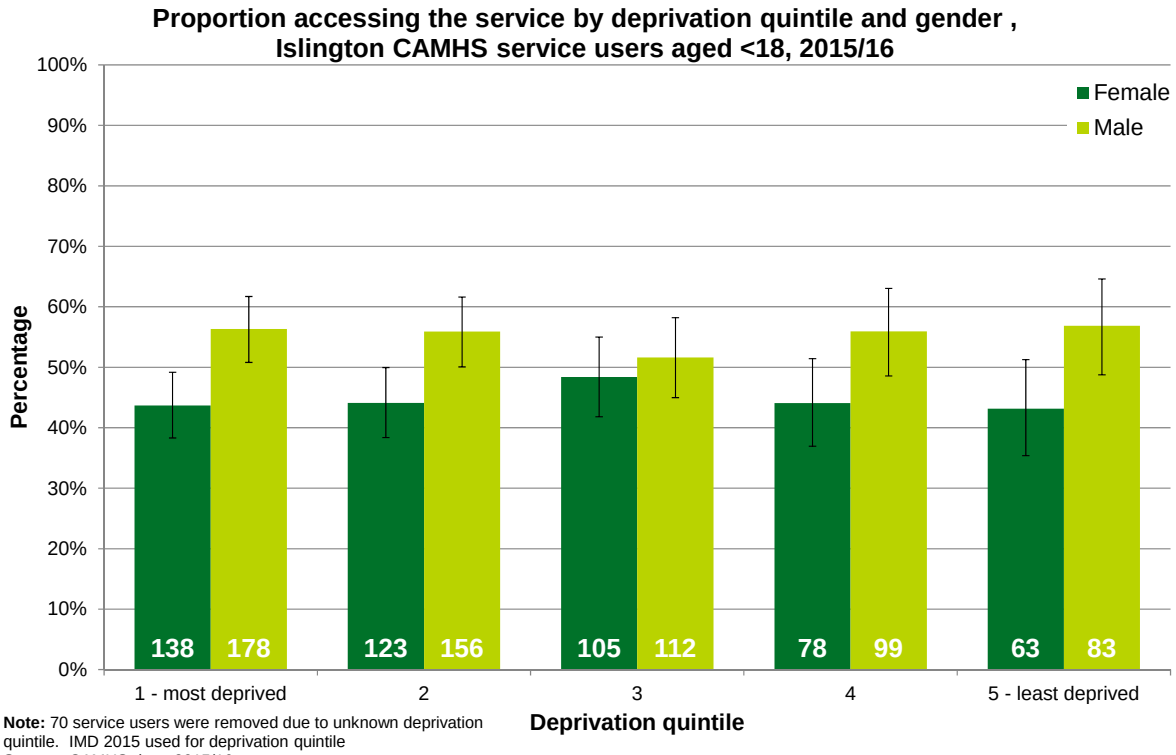


Note: 196 service users were removed due to unknown ethnicity
Source: CAMHS data, 2015/16

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).

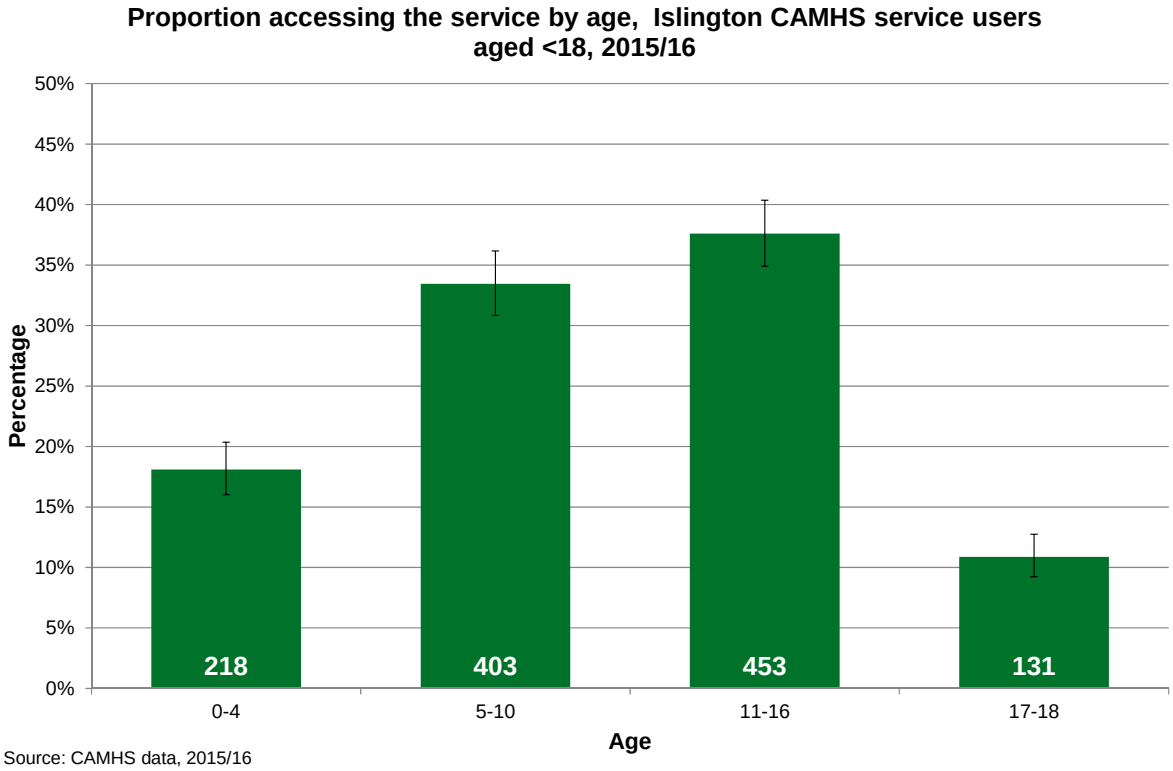


Note: 70 service users were removed due to unknown deprivation quintile. IMD 2015 used for deprivation quintile
Source: CAMHS data, 2015/16

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.

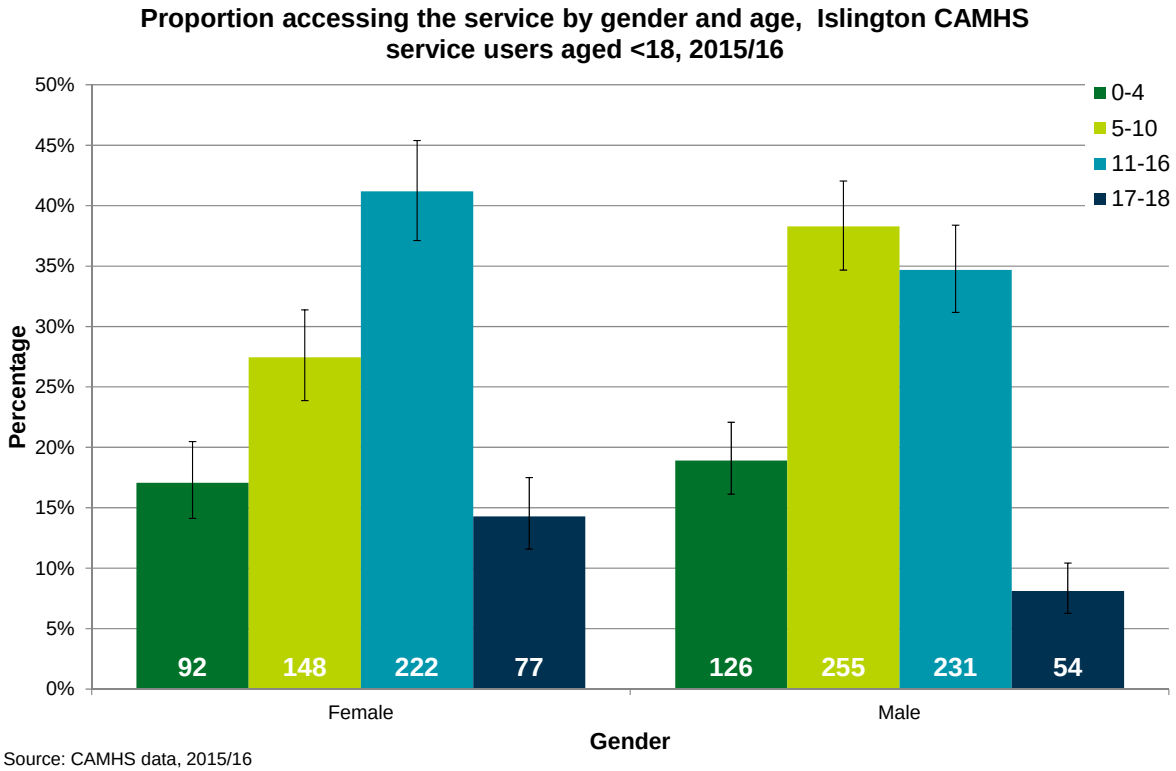
There is evidence to support the observed difference in proportions of children accessing the service between these two groups and the 0-4 (18%, 16-29%, n=218) and 17-18 (11%, 9-13%, n=131) age groups.



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.

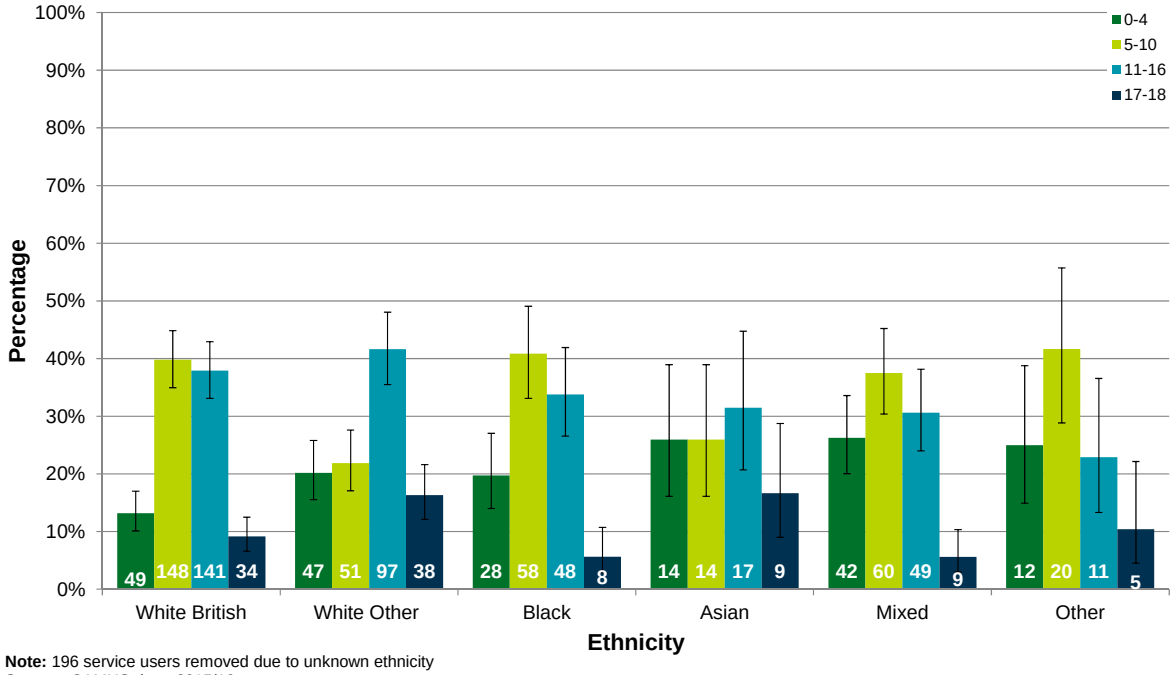


Source: CAMHS data, 2015/16

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



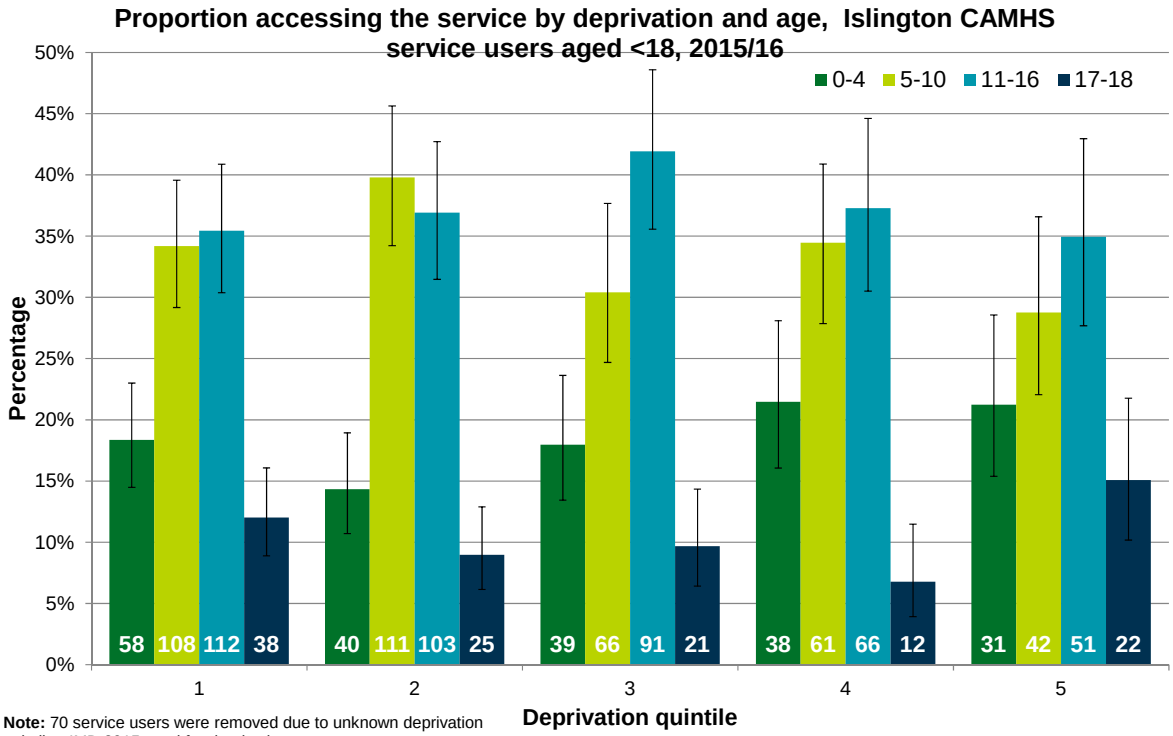
Note: 196 service users removed due to unknown ethnicity
Source: CAMHS data, 2015/16

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.

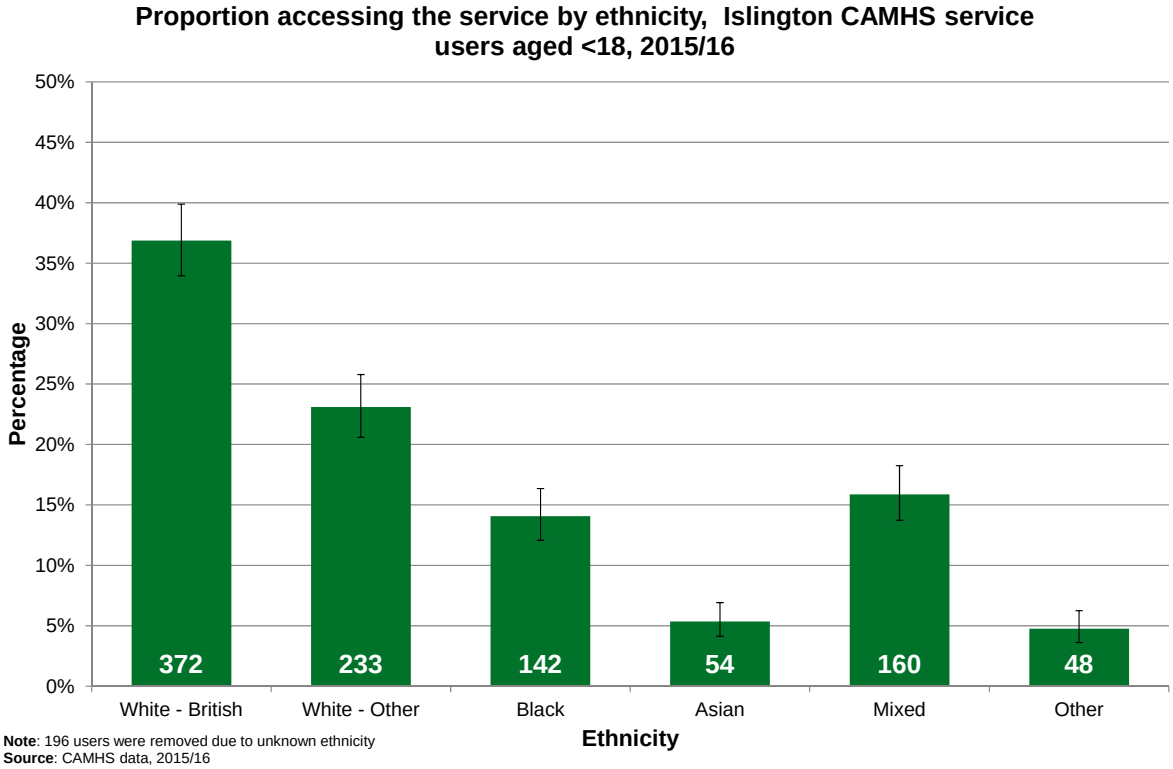
Although without evidence to support the finding, a slightly higher proportion of 0-4 year olds were seen in the 4th and 5th (least) deprived quintiles.



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.



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

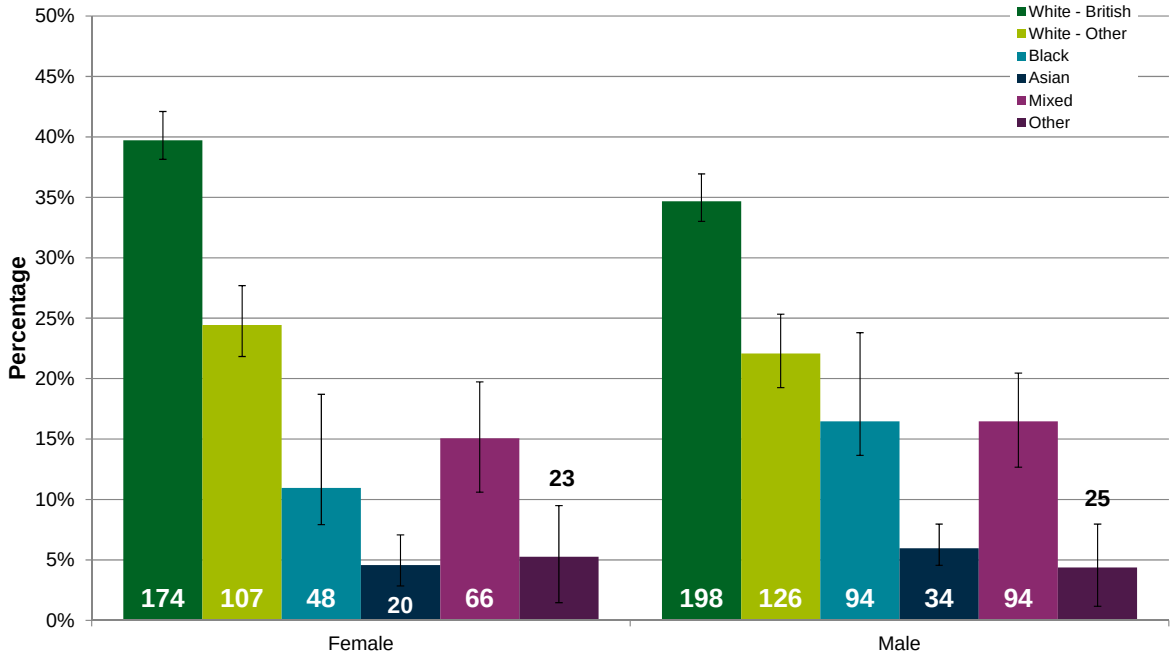
Strong evidence for a higher proportion of those of White British ethnicity being in contact with the service than any other group (37%, 34-40%, n=372) was demonstrated. In comparison to the overall Islington population proportions, within which the proportions rank in descending order White-British, 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

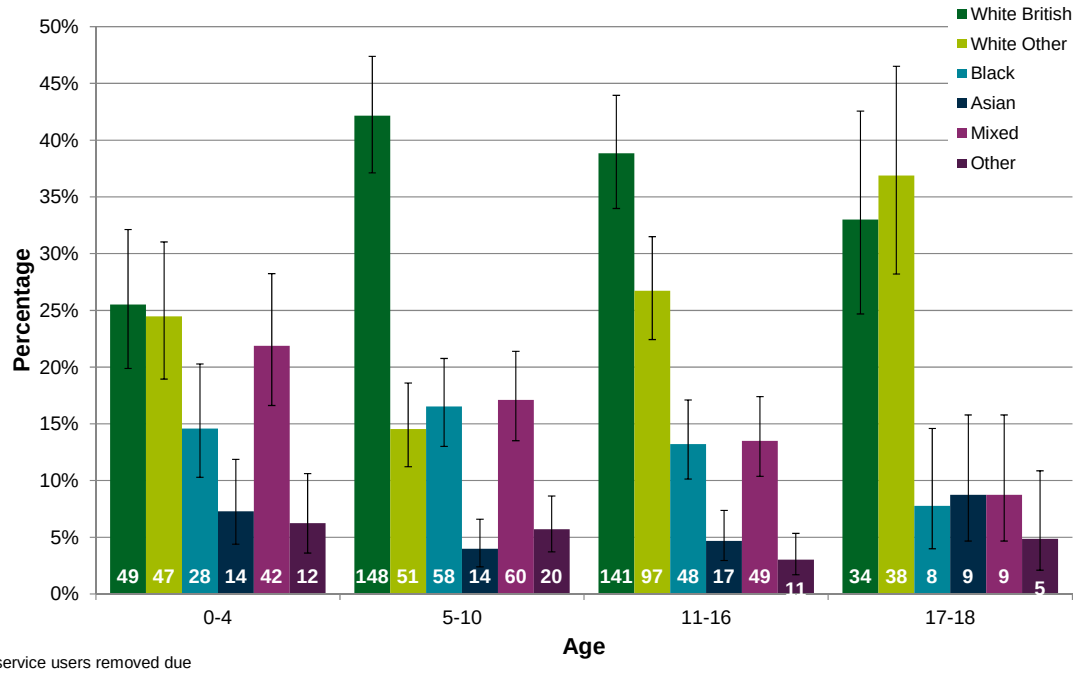


Note: 196 service users were removed due to unknown ethnicity
Source: CAMHS data, 2015/16

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.

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

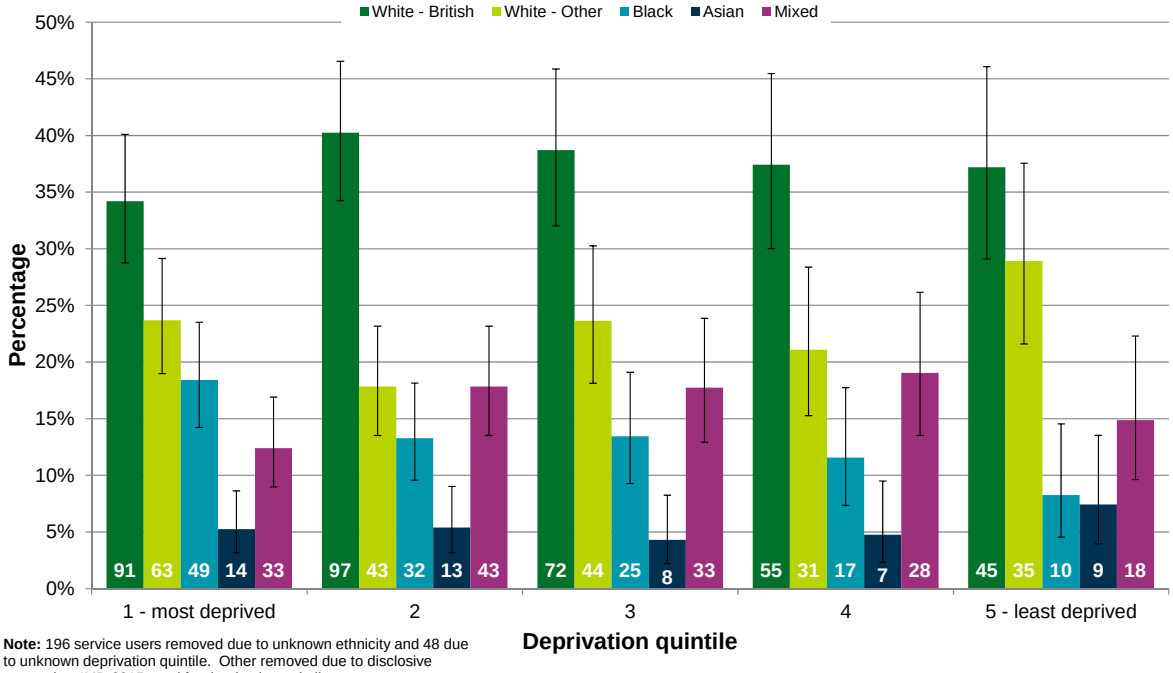
In the analysis of deprivation and ethnicity 48 contacts had to be removed due to unknown deprivation quintile and 196 as a result of unknown ethnicity, leaving only 961 contacts. This resulted in disclosive numbers within the ethnicity group other, which has been removed from the charts.

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

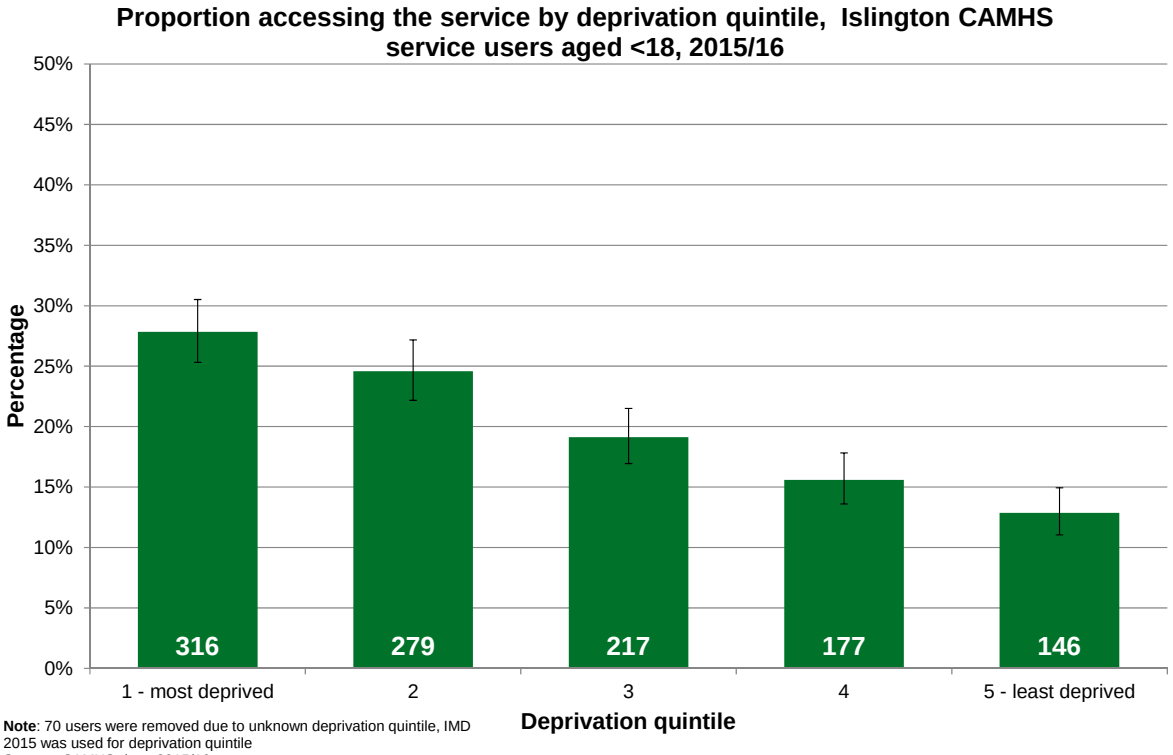


Note: 196 service users removed due to unknown ethnicity and 48 due to unknown deprivation quintile. Other removed due to disclosive categories. IMD 2015 used for deprivation quintile
Source: CAMHS data, 2015/16

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.

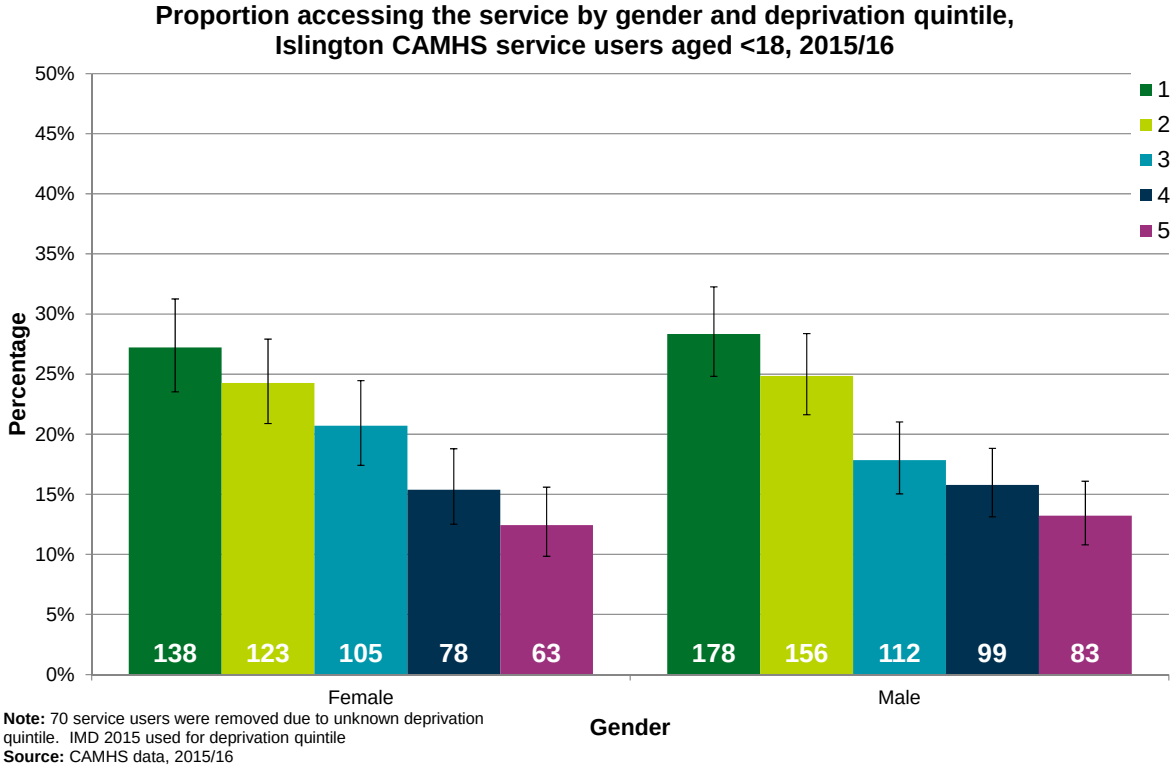
A higher proportion of children in the most deprived quintile (28%, 25-31%, n=316), accessed the service than those in the least deprived quintile (13%, 11-15%, n=146), for which there was strong evidence.



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.

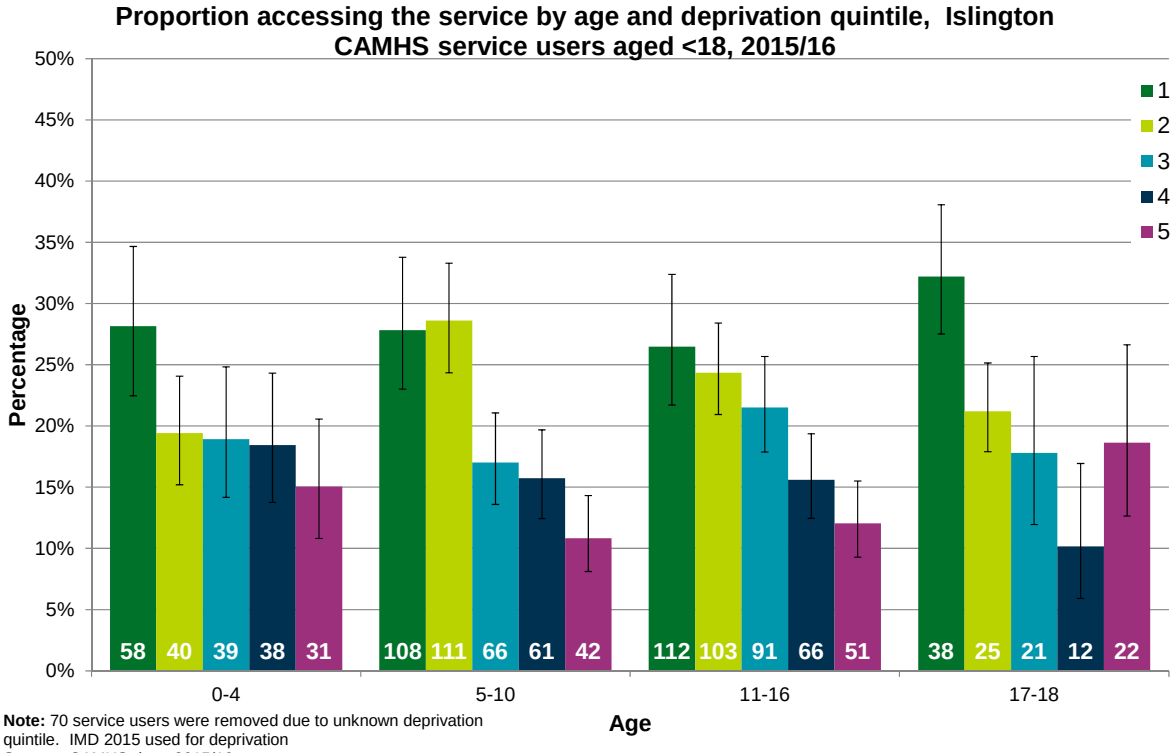


Note: 70 service users were removed due to unknown deprivation quintile. IMD 2015 used for deprivation quintile
Source: CAMHS data, 2015/16

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

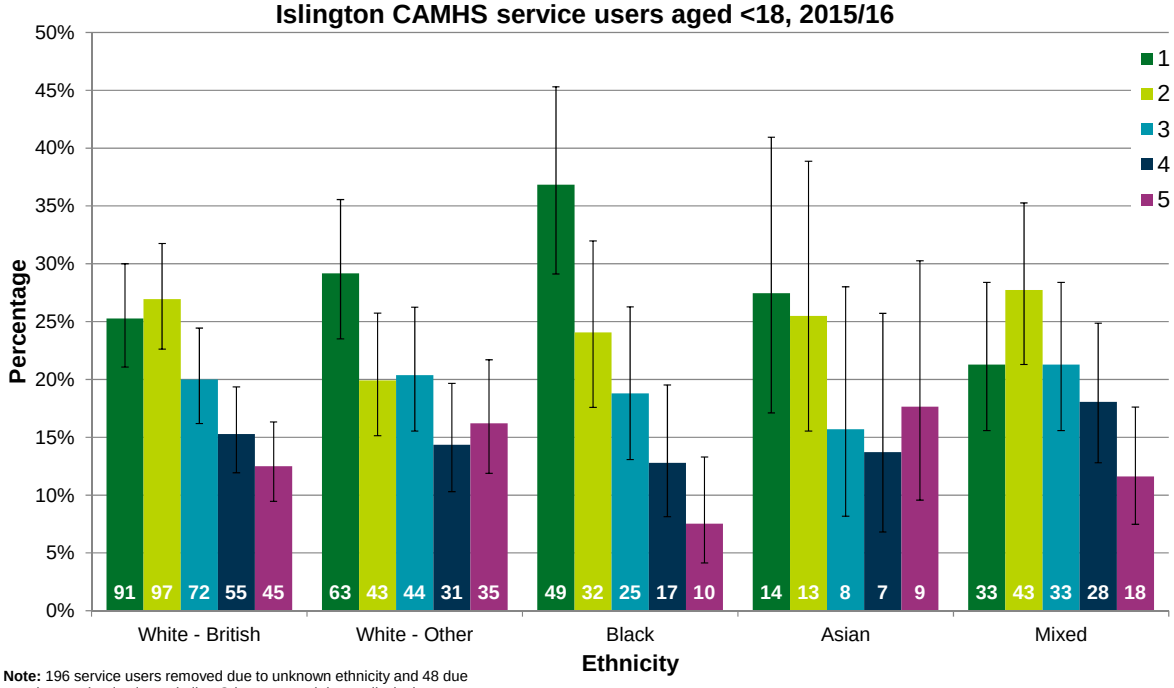
Deprivation within ethnicity

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.

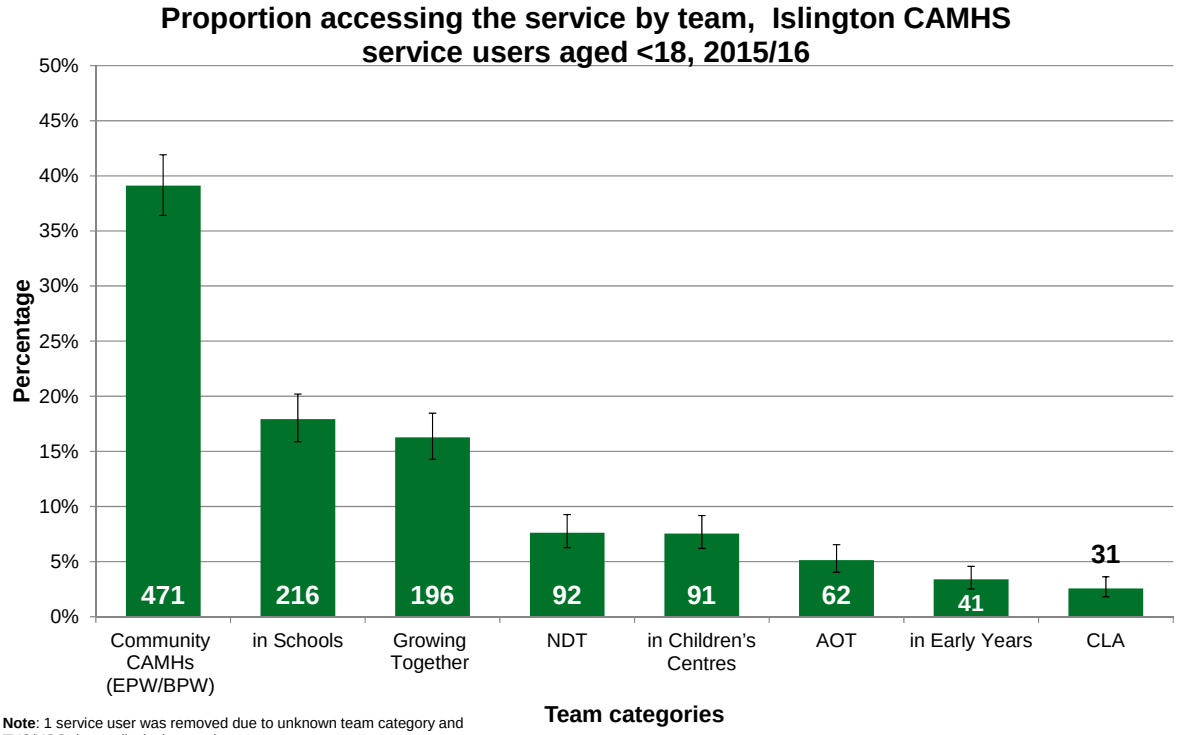
Proportion accessing the service by ethnicity and deprivation quintile, Islington CAMHS service users aged <18, 2015/16



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.



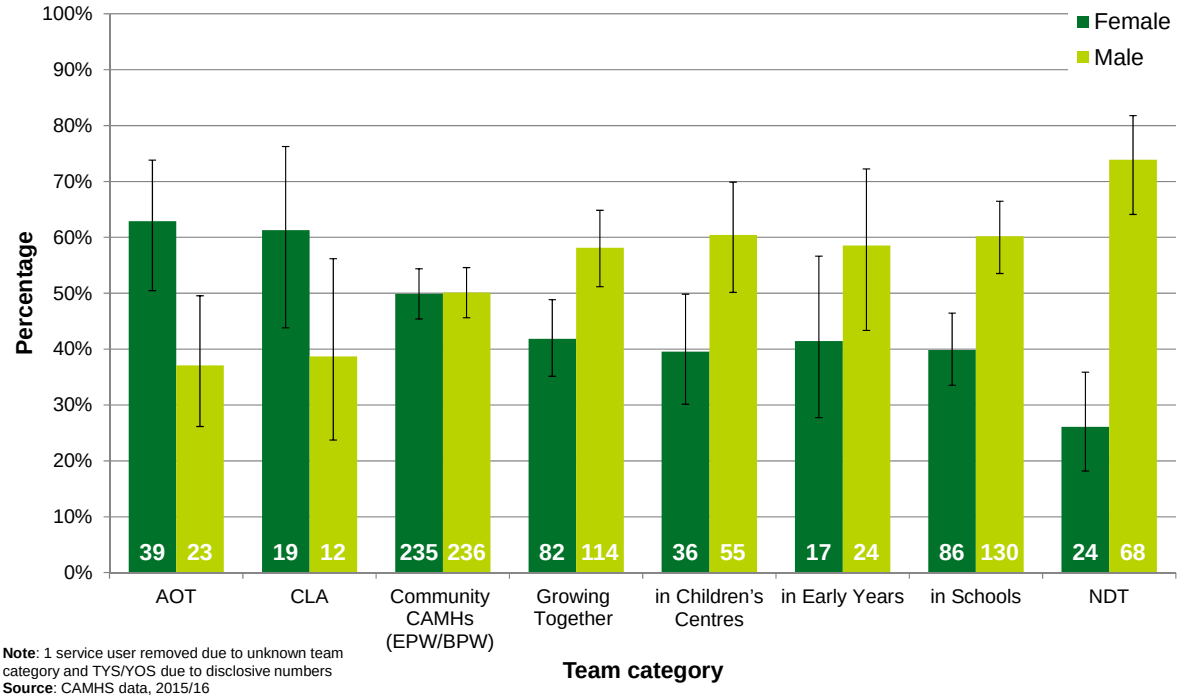
Note: 1 service user was removed due to unknown team category and TYS/YOS due to disclosive numbers
Source: CAMHS data, 2015/16

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



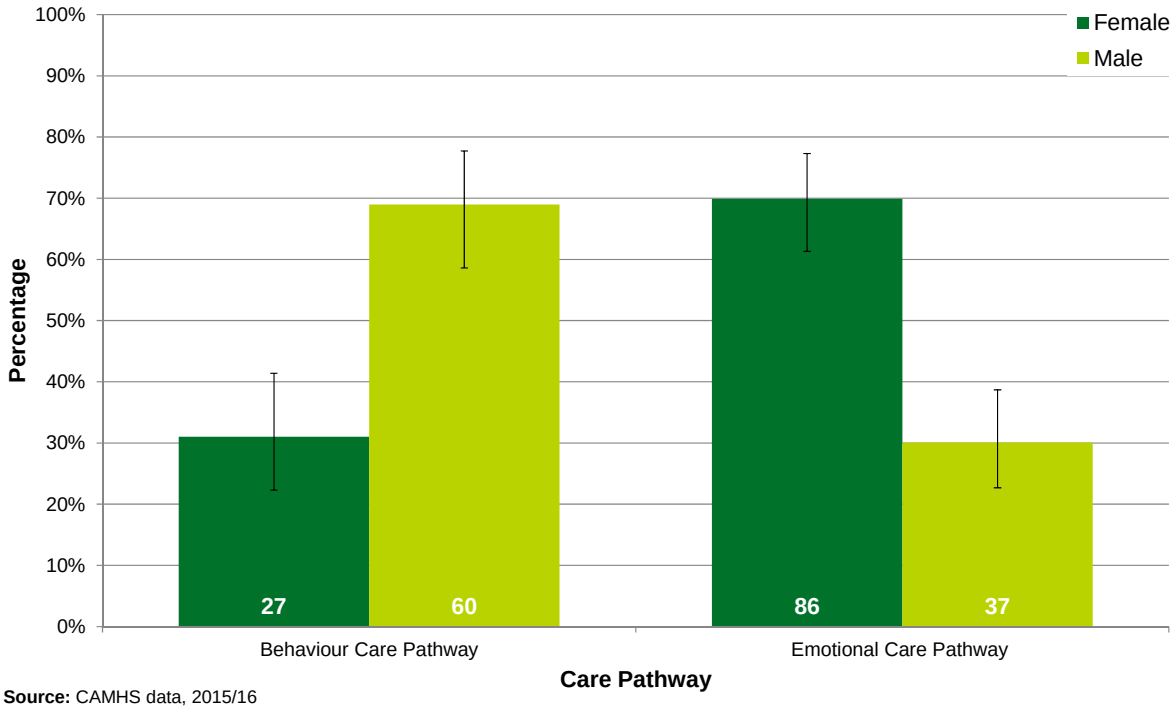
Note: 1 service user removed due to unknown team category and TYS/YOS due to disclosive numbers
Source: CAMHS data, 2015/16

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.

Proportion accessing the Behaviour and Emotional Care Pathways by gender, Islington CAMHS service users aged <18 2015/16



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

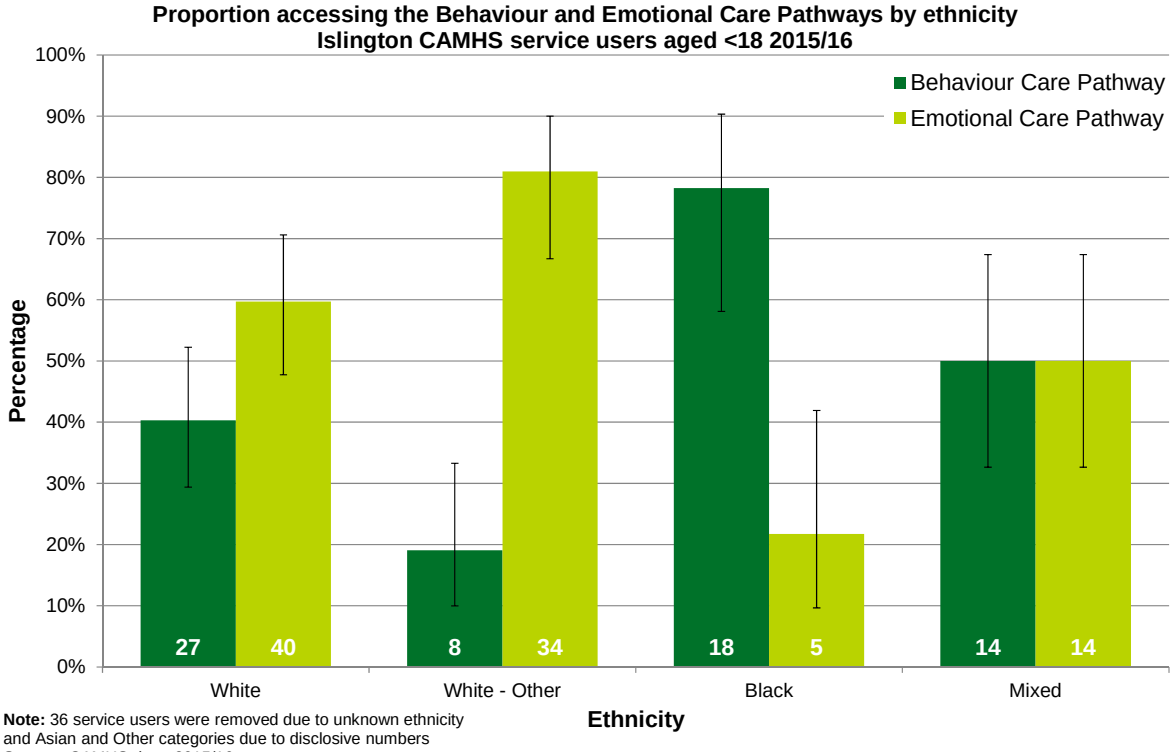
- Due to the number of team categories there were disclosive numbers in some strata, therefore the charts cannot be presented here.
- The highest proportions seen within all teams except AOT were those of white British ethnicity, with evidence for this in Community CAMHS (42%, 37-47%, n=154) and CAMHS 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

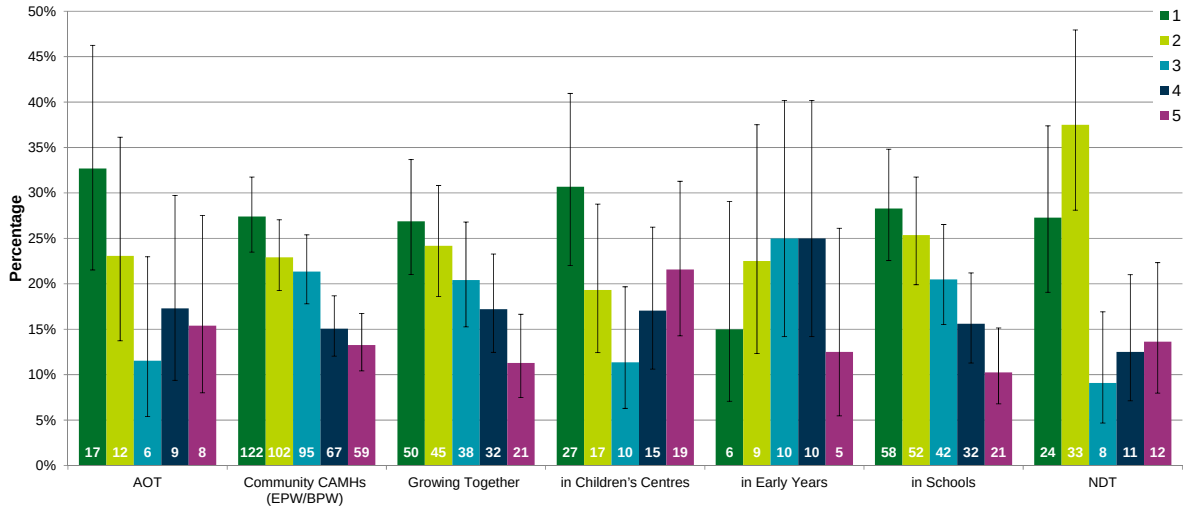
Deprivation quintile was unknown for 70 contacts and team category for 1, which were removed from the analysis. This left disclosive numbers in Children Looked After and TYS/YOS which will not be presented here.

- 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.

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



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

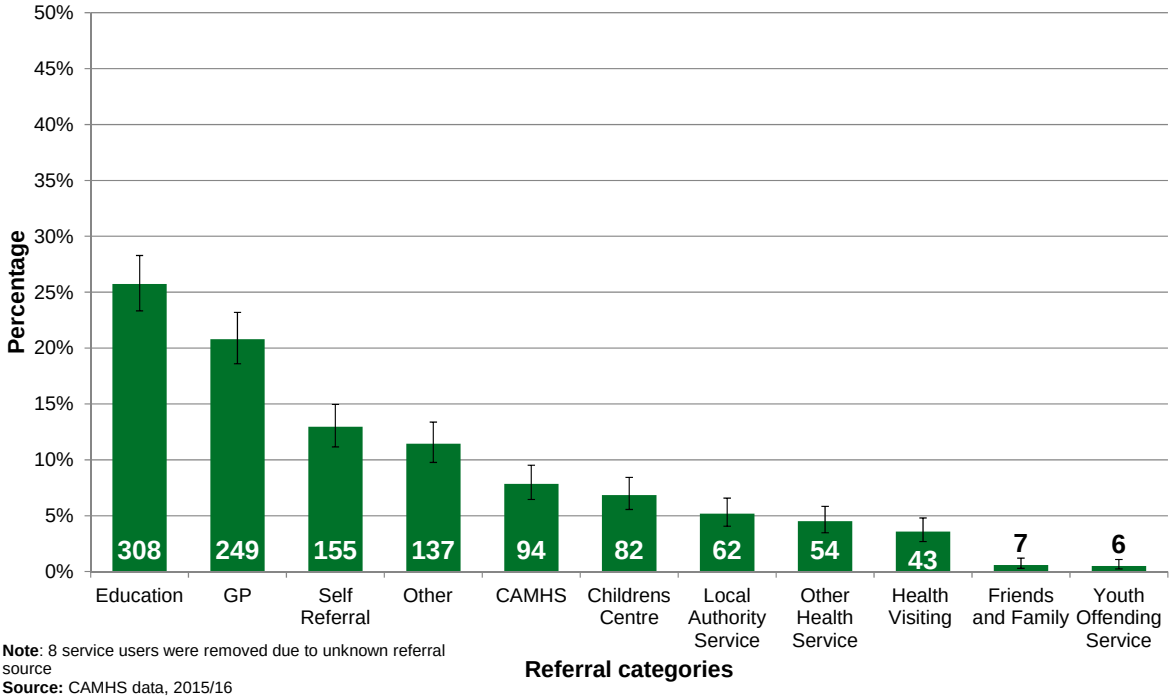
Referral category was unknown for 8 contacts, which were removed from the analysis.

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.

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

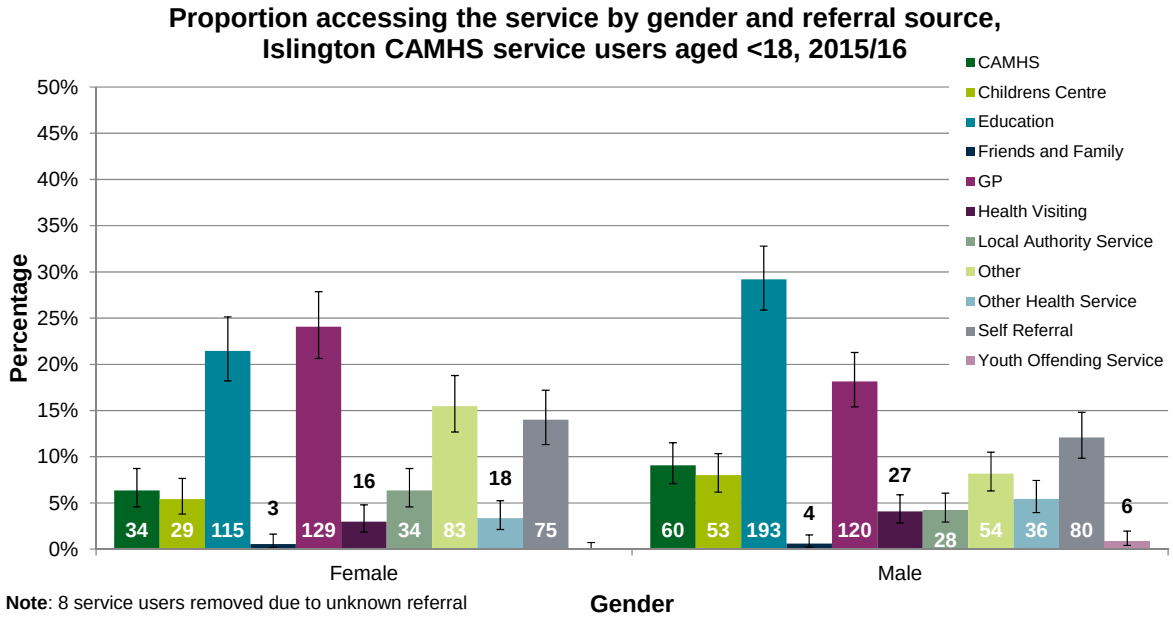


Note: 8 service users were removed due to unknown referral source
Source: CAMHS data, 2015/16

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).

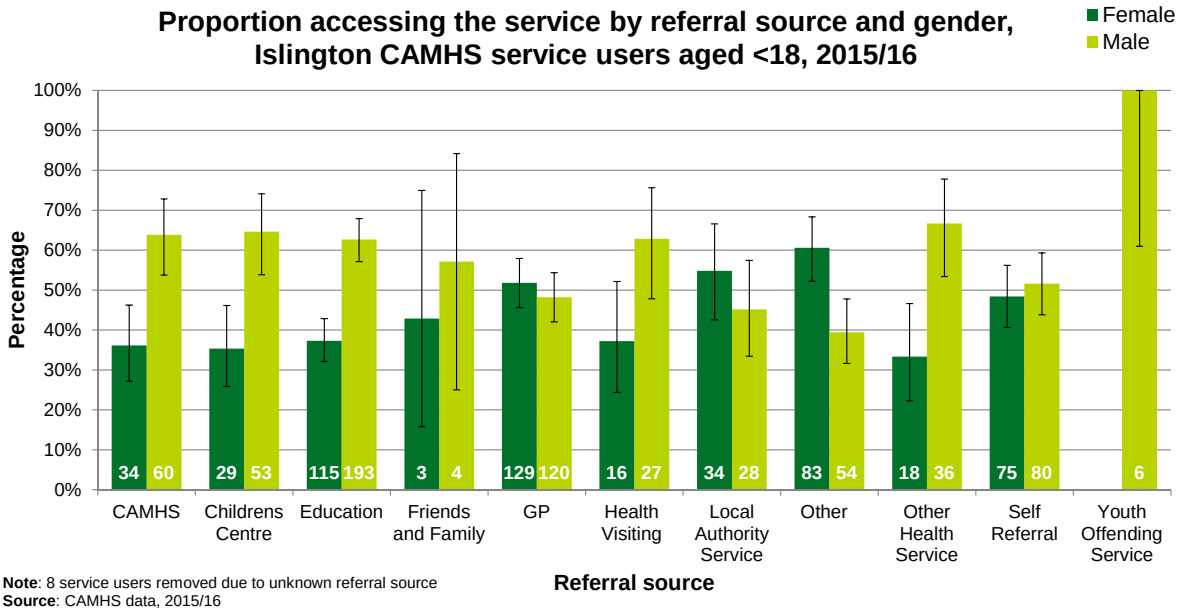


Note: 8 service users removed due to unknown referral source
Source: CAMHS data, 2015/16

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),



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

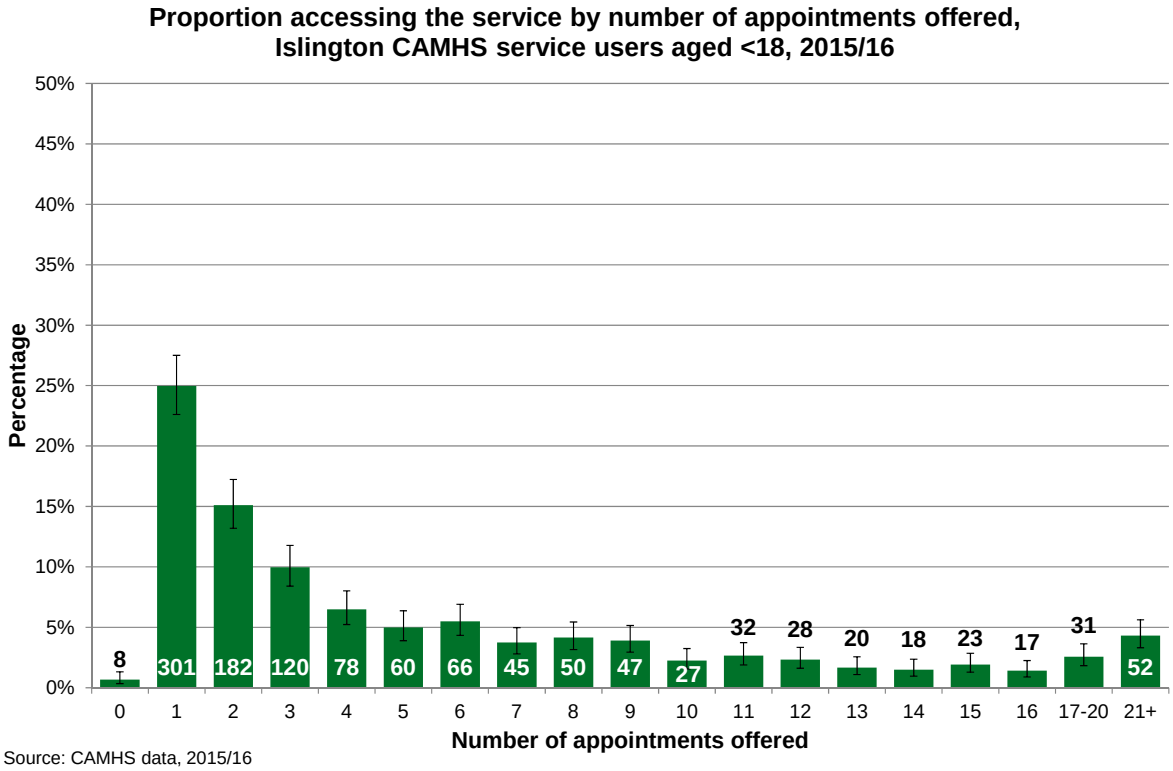
- Once those with unknown ethnicity – 196 – and referral category – 8 - were removed from this analysis, it left disclosive numbers in all ethnicity groups and all but four referral source. This aspect of the health equity audit cannot therefore be explored in detail here.
- The highest proportion of 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.

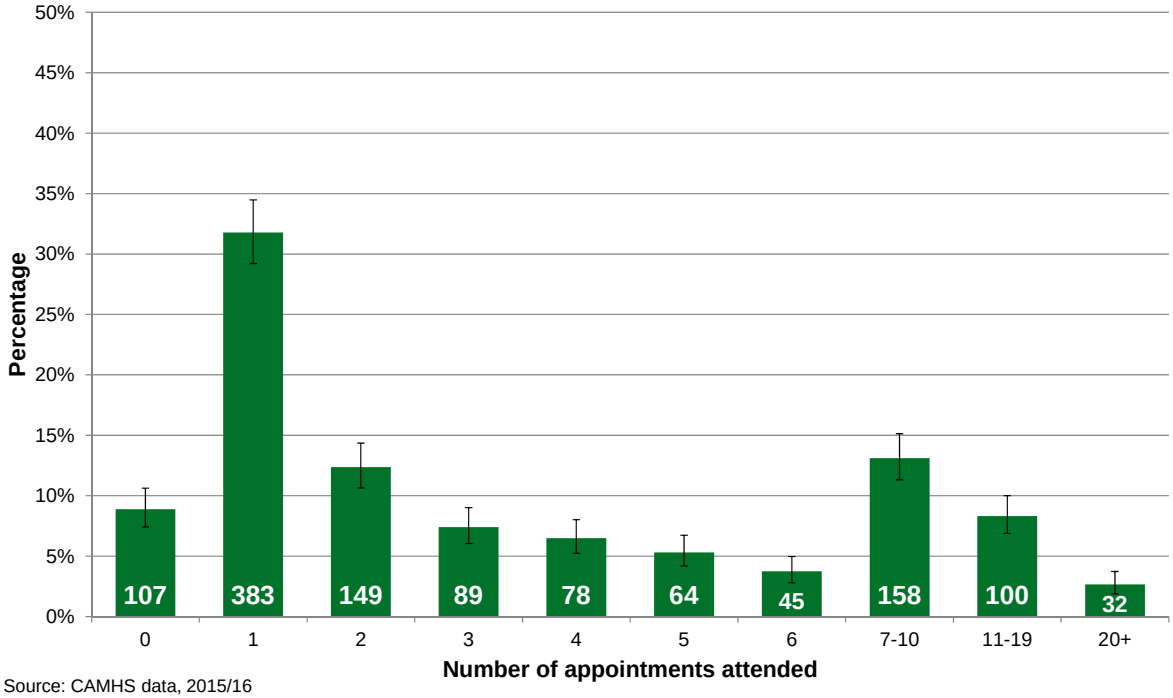


Source: CAMHS data, 2015/16

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.

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



Source: CAMHS data, 2015/16

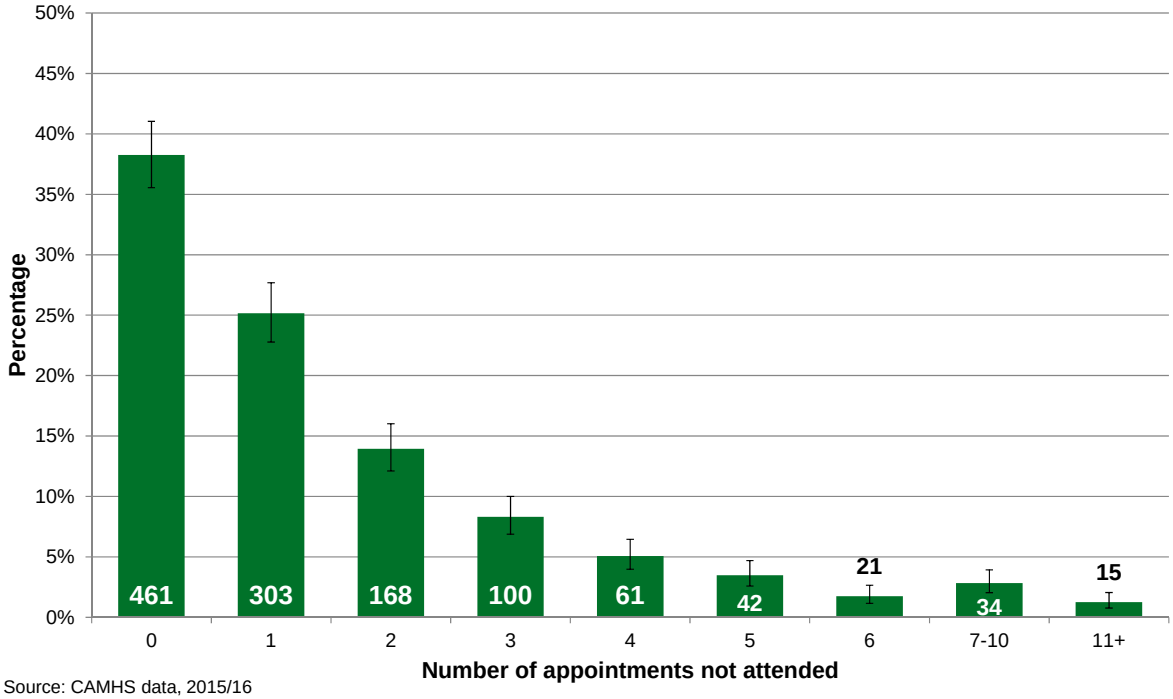
Age and appointments attended

- 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.

Proportion accessing the service by number of appointments not attended, Islington CAMHS service users aged <18, 2015/16



Source: CAMHS data, 2015/16

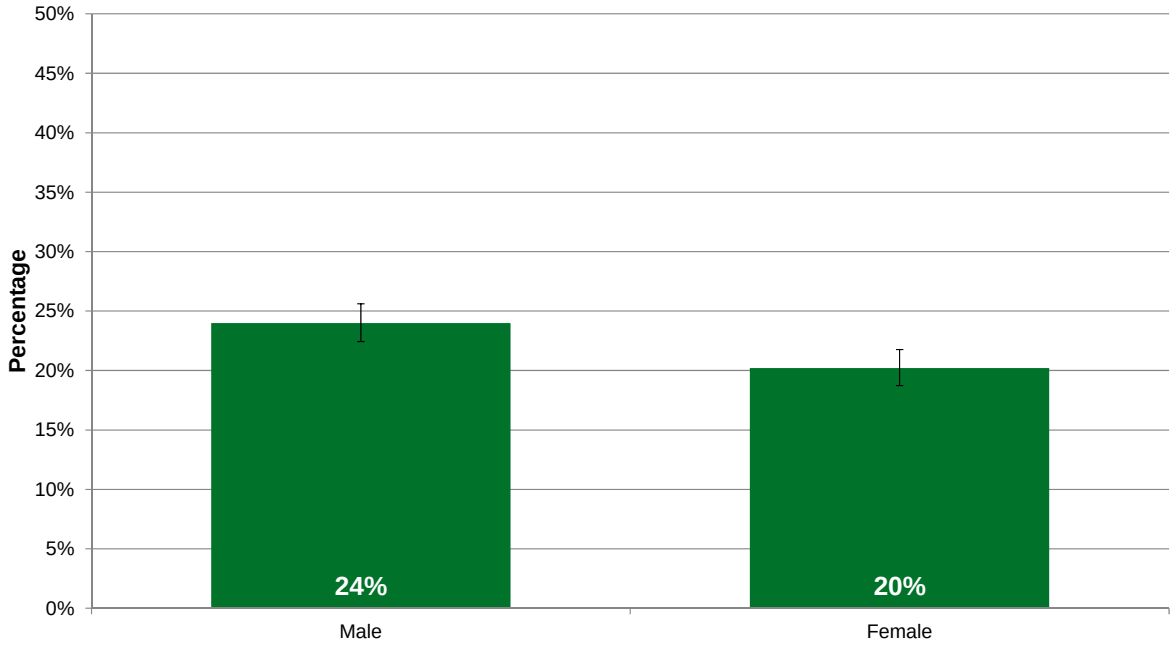
3.2 Assessment of Equity - Service Utilisation According to Need

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.

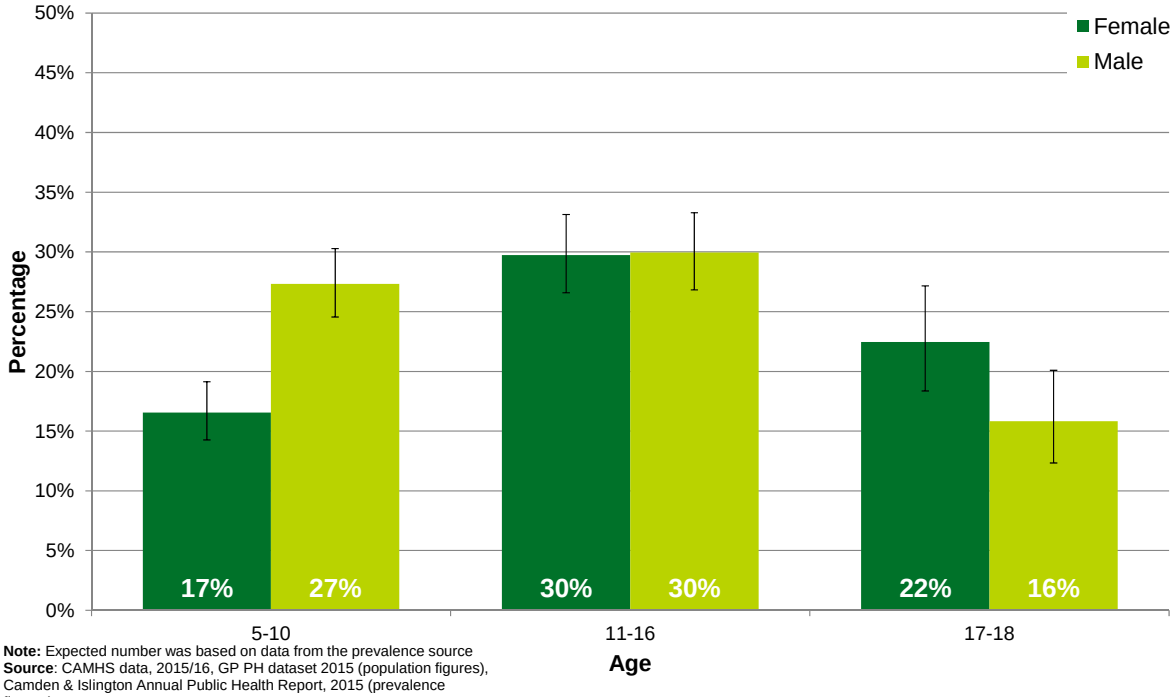
Proportion of those expected to have a mental health condition accessing CAMHS, by gender, Islington registered population aged <18, 2015-16



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)

- 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.

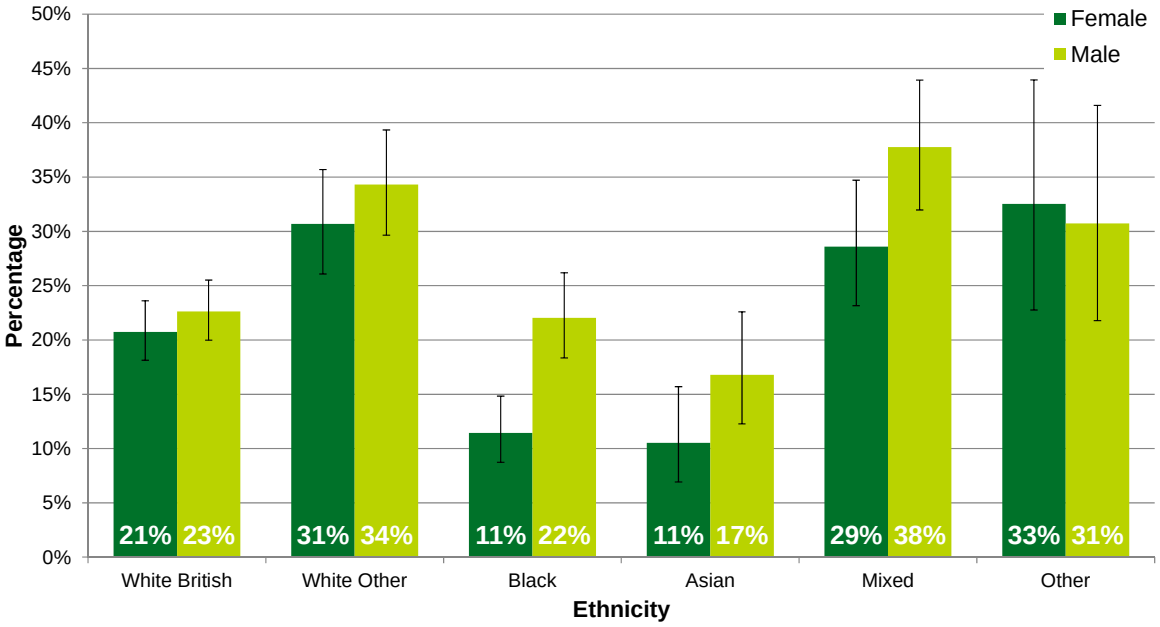
Proportion of those expected to have a mental health condition accessing CAMHS, by age and gender, Islington registered population aged <18, 2015-16



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 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%).

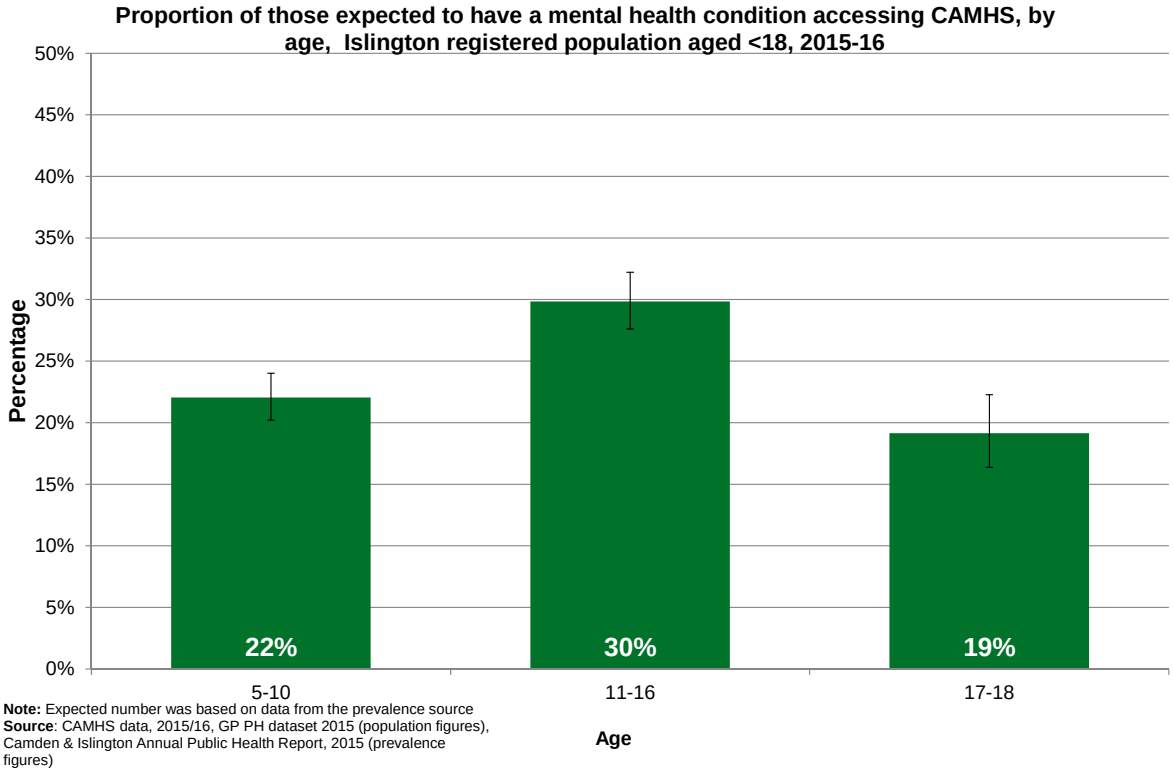
Proportion of those expected to have a mental health condition accessing CAMHS, by ethnicity and gender, Islington registered population aged <18, 2015-16



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.

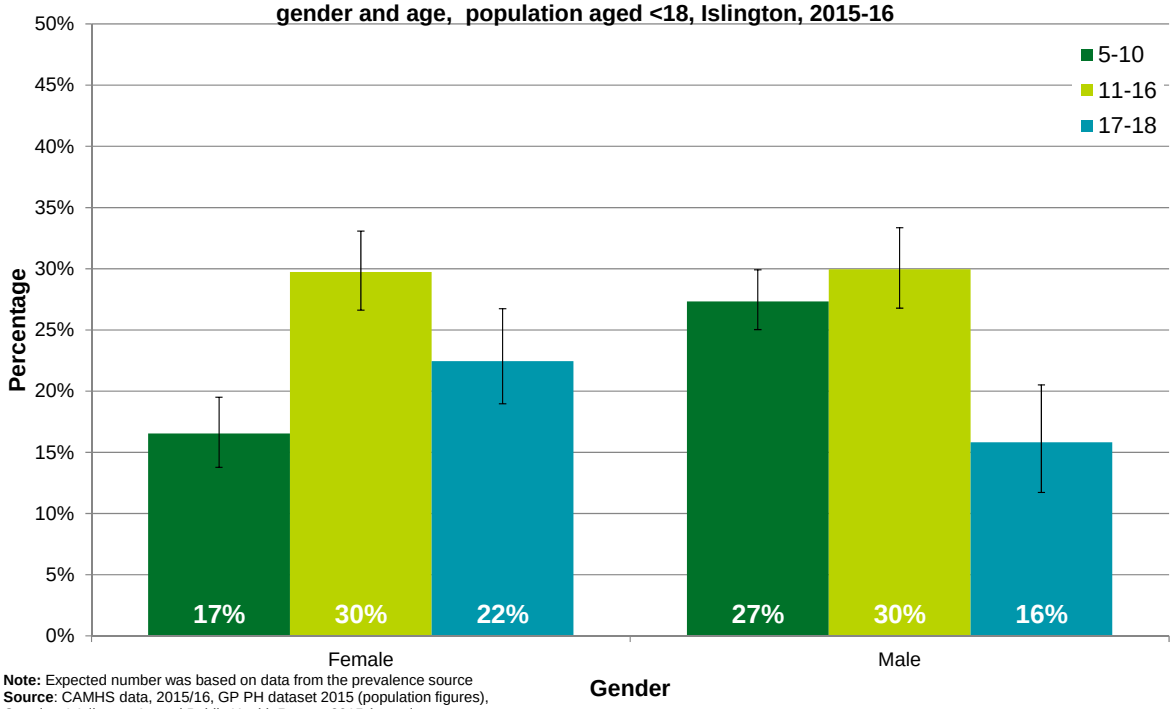


Note: Expected number was based on data from the prevalence source
Source: CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)

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.

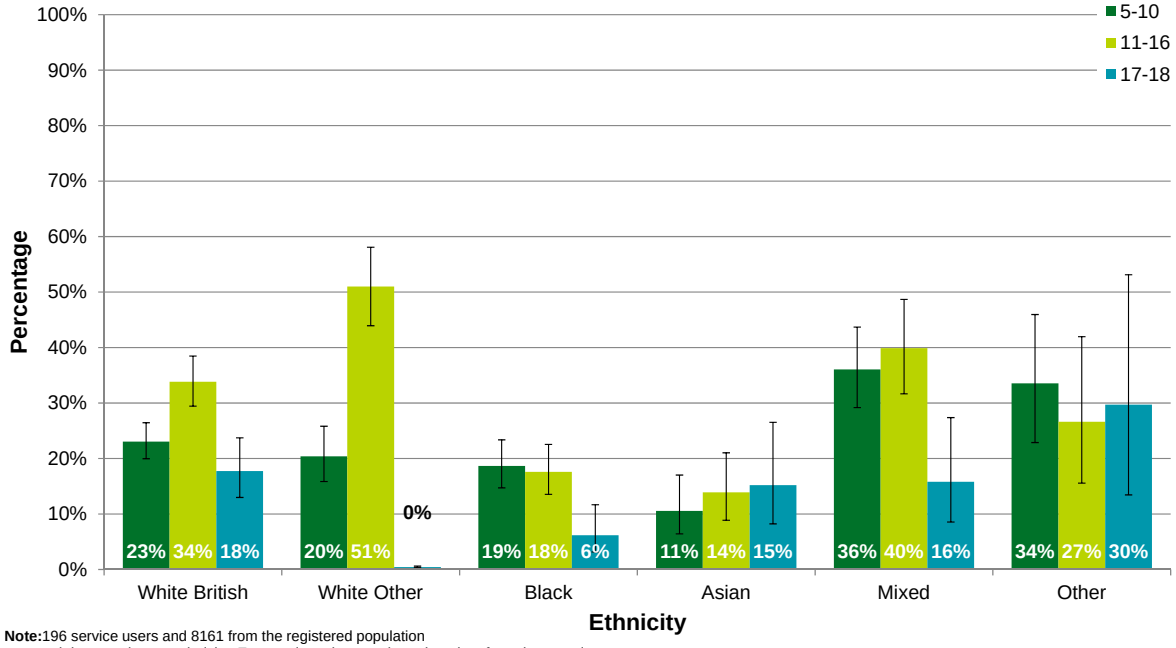
Proportion of those expected to have a mental health condition accessing CAMHS, by gender and age, population aged <18, Islington, 2015-16



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

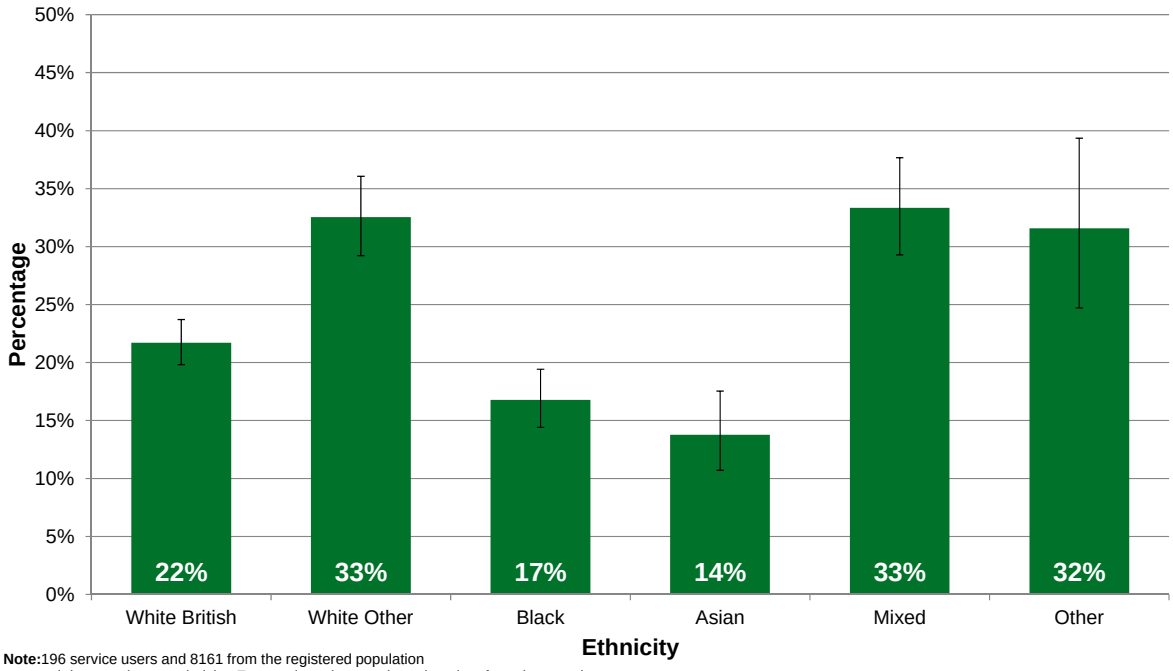
In line with the exclusions applied to the service data, all those with unknown ethnicity were removed from the population data (n=8,161).

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.

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

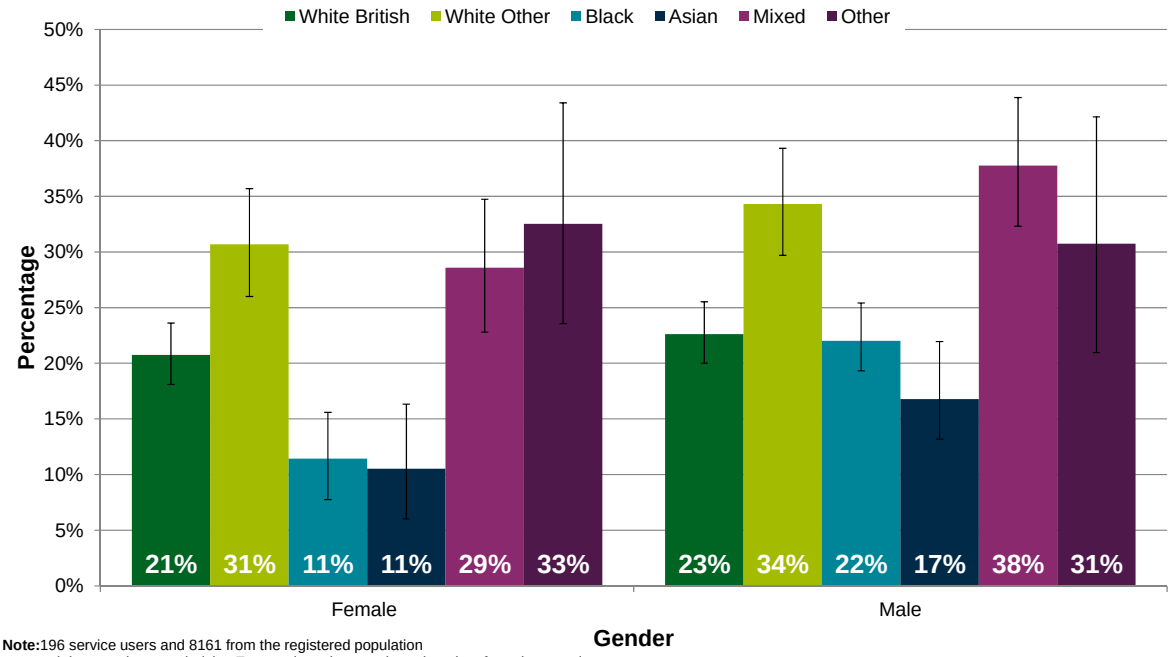


Note:196 service users and 8161 from the registered population removed due to unknown ethnicity. Expected number was based on data from the prevalence source
Source: CAMHS data, 2015/16, GP PH dataset 2015 (population figures), Camden & Islington Annual Public Health Report, 2015 (prevalence figures)

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.

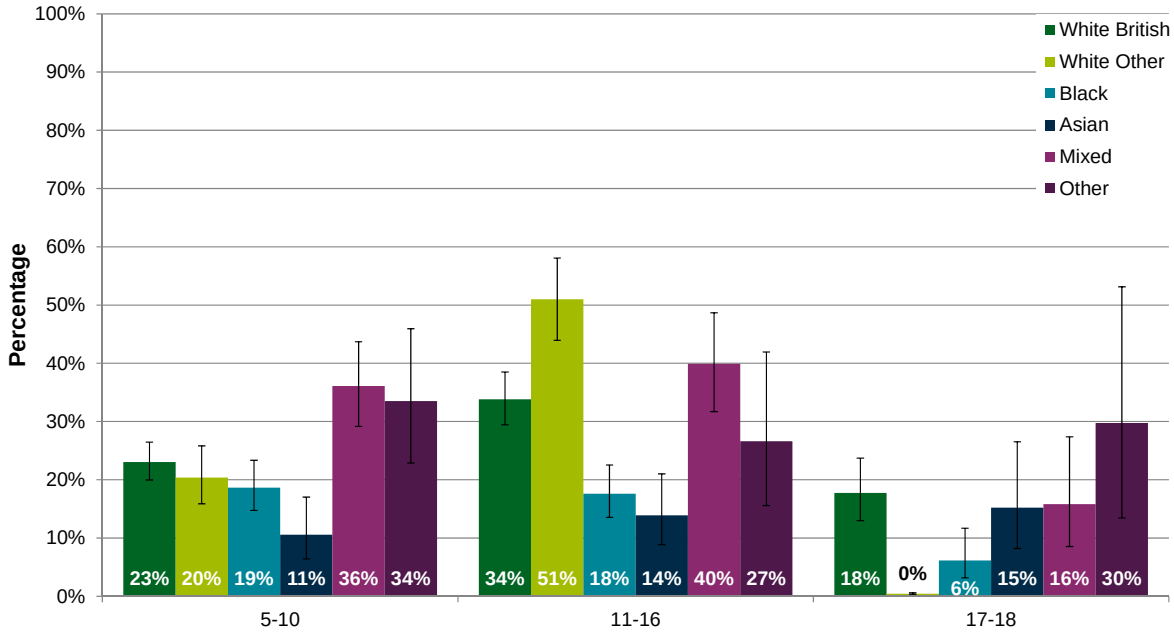
Proportion of those expected to have a mental health condition accessing CAMHS, by gender and ethnicity, population aged <18, Islington, 2015-16



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)

- 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[18]. 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[18] 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[21] 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 survey[18]. 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 wth 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 counterparts[23]. 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 particlaur 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

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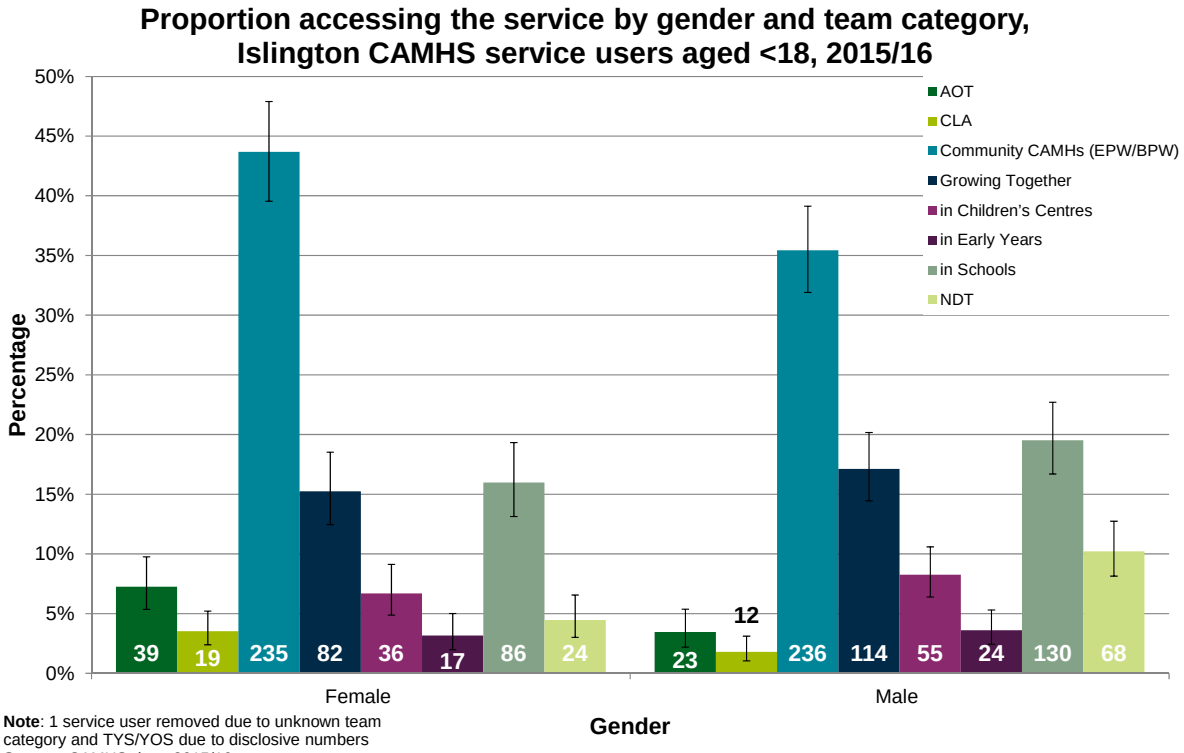
Appendix 1 – extra charts not included within main results

Team categories within gender

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

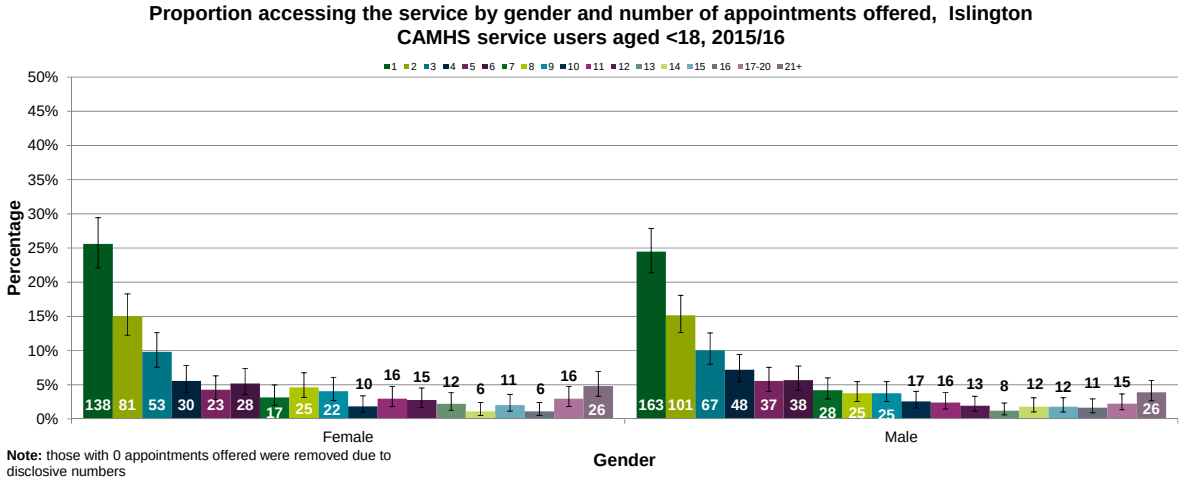
For males and females, the highest proportions were within Community CAMHS (35%, 32-39%, n=236 and 44%, 40-48%, n=235), in comparison to all other services, as was the case overall.



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

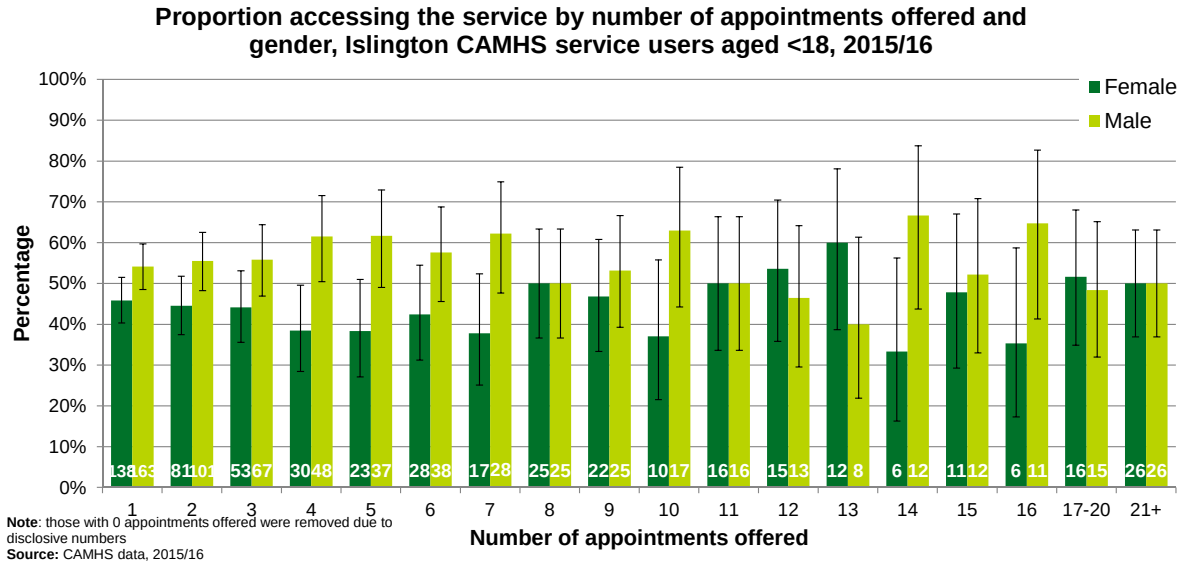
The numbers within the 0 category (i.e. no appointments offered) were disclosive and therefore this category has been removed from the charts.



Note: those with 0 appointments offered were removed due to disclosive numbers
Source: CAMHS data, 2015/16

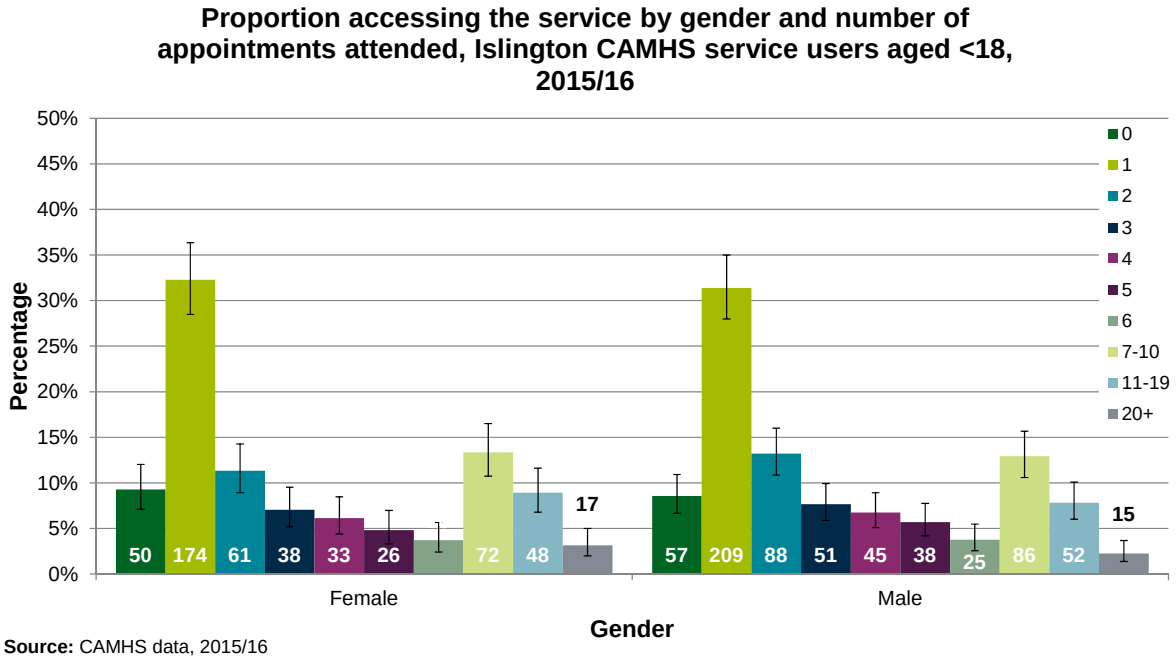
Gender within appointments offered

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.



Note: those with 0 appointments offered were removed due to disclosive numbers
Source: CAMHS data, 2015/16

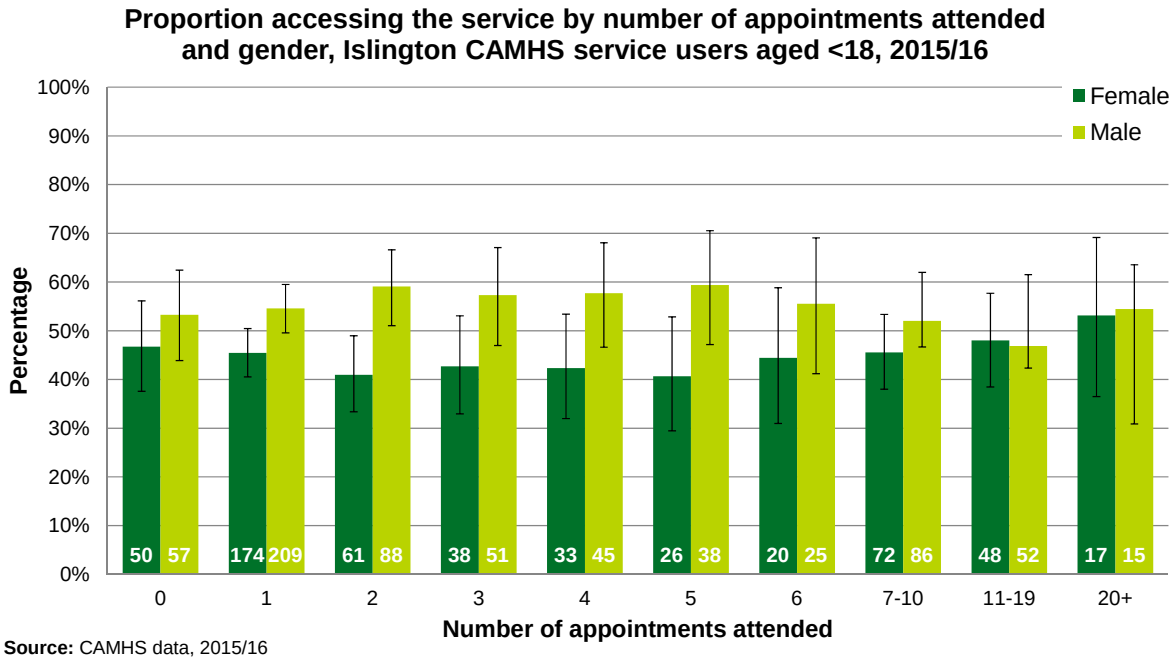
Appointments attended within gender



Source: CAMHS data, 2015/16

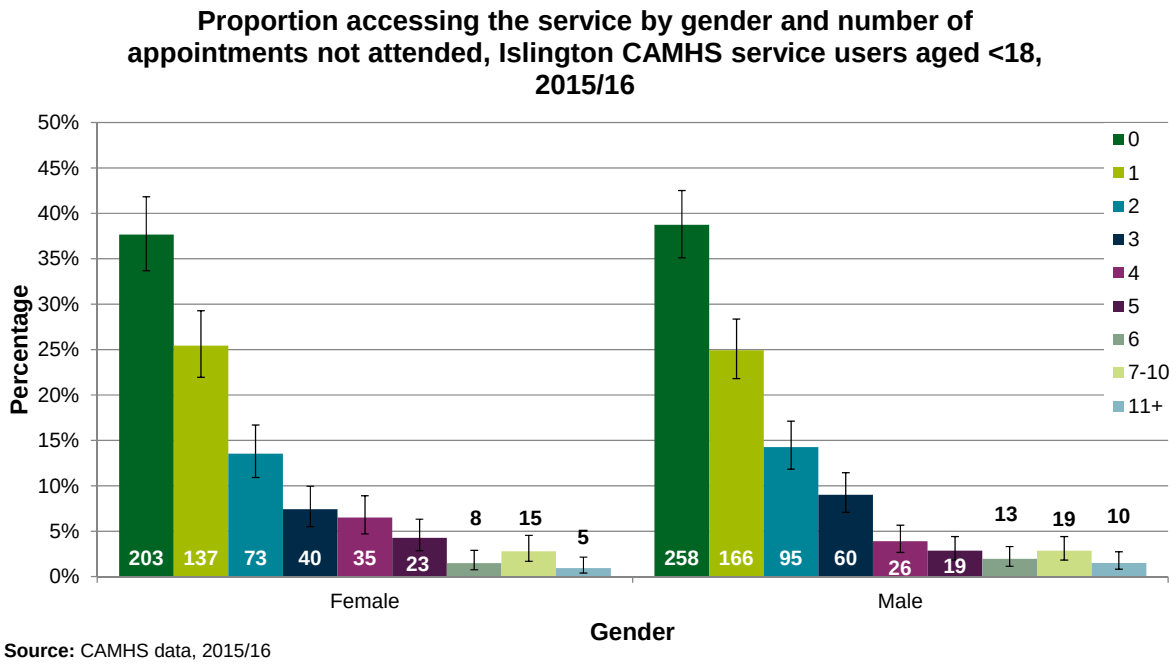
Gender within number of appointments attended

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

Number of appointments not attended within gender

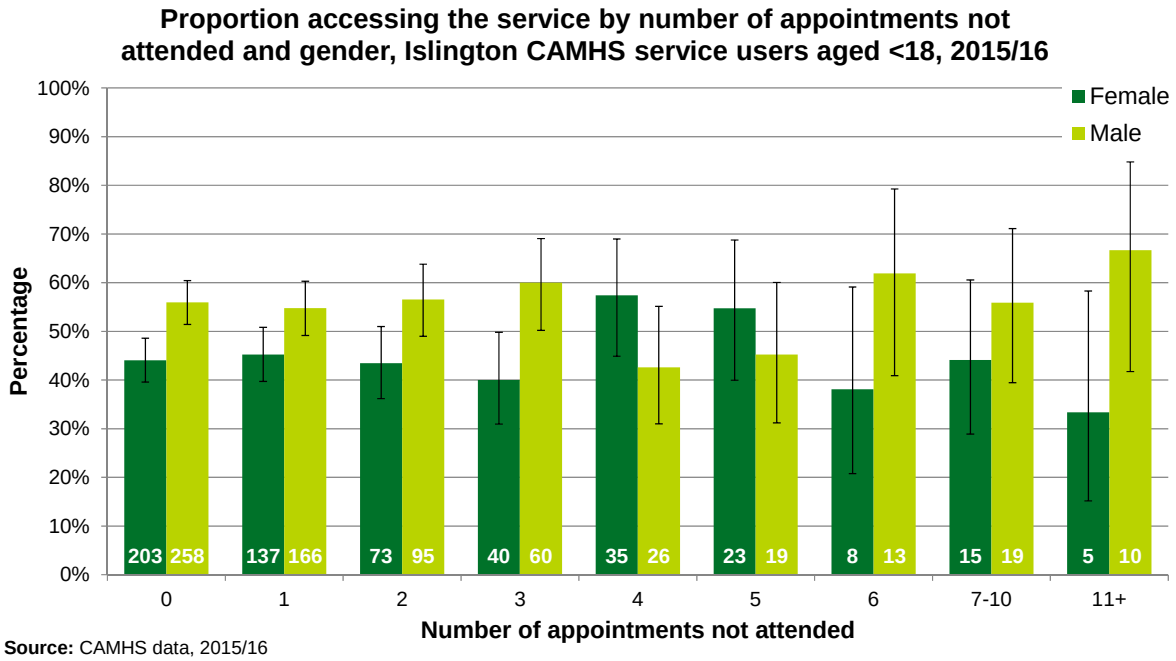


Source: CAMHS data, 2015/16

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

Appendix 4 – Staffing Breakdown in Whittington Health Community CAMHS Services

Service	Staffing numbers (WTE)					
	2016-17		2017-18		2018-19 projected	
	Clinical WTE	Non-clinical WTE	Clinical WTE	Non-clinical WTE	Clinical WTE	Non-clinical WTE
Islington Community CAMHS	25.6	6.95	22.96	6.95	22.96	6.95
CAMHS in Early Years	2.4	0.1	7.9	0.3	7.9	0.3
CAMHS in Children's Centres	2.2	0.1				
CAMHS in Schools	5.4	0.8	7.175	0.3	7.175	
CAMHS in TYS/YOS	1.2	-	1.2	0.2	1.2	
Neuro-Developmental Team	5.6	0.5	6.55	0.5	6.55	
CAMHS in Children Looked After Health Team	3.8	0.4	3.825	0.4	3.825	0.4
Adolescent Outreach Team	5.5	0.4	5.21	0.2	5.21	0.2
Growing Together	6.6	0.6	6.35	0.6	6.35	0.6
CWPs	-	-	3.8	0.2	6.8	0.2