Promoting Mental Health 4 Life
Building Thriving Communities

Slough CAMHS Strategy 2015-2019

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FOREWORD

[To be completed once draft is finalised]

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Councillor Pavitar Mann, Chair of the Slough Children and Young Peoples Partnership

Introduction

This strategy provides the strategic overview and priorities for tackling the drivers of poor emotional resilience and addresses the needs identified by local families and children in the 2014 Thames Valley CAMHS survey[29] and supports the Child and Parental Mental Wellbeing priority in the Slough Children and Young Peoples Plan 2015-16.

It is based on a public mental health approach and on the evidence base for mental health promotion which is cost effective.

The basis for the Mental Health 4 Life approach is set out in the following principles.

Table 1. Core principles for supporting mental health – source Mental Health 4 Life[44]

Know	Believe	Act
Know the nature of mental illness	Understand your own mental health, what influences it, its impact on others and how you can improve it	Communicate effectively with children, young people and adults about mental health
Know the determinants at a structural, community and individual level	Appreciate that there is no health without mental health and the mind and body work as one system	Integrate mental health into your own area of work and address mental and physical health holistically
Know how mental health is a positive asset and resource to society	Commitment to a life course approach and investment in healthy early environments	Consider social inequalities in your work and act to reduce them and empower others to do so
Know what works to improve mental health and prevent mental illness within own area of work	Recognise and act to reduce discrimination against people experiencing mental illness	Support people who disclose lived experience of mental illness

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The strategy that follows is built not only on national best evidence but is grounded in powerful local tests of whether the interventions work, from feedback from training offered through the voluntary sector, for schools and young people, for general practices and from co-creation of the wellbeing website with young people.

DEFINITIONS

Early intervention – implementing evidence based programmes and interventions for children and young people which can have a lasting effect on their life long mental wellbeing

Mental health - is a state of wellbeing by which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.

Prevention – preventing the development of mental illness, preventing suicide and also doing something for people without a mental illness, for examples preventing stigma or discrimination

Promotion – promoting a healthy lifestyle for body and mind, helping people choose activities that are enhancing their wellbeing

Public health - is the art and science of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society

Public mental health - is the art and science of improving mental health and wellbeing and preventing mental illness through the organised efforts and informed choices of society, organisations, public and private, communities and individuals. Includes promotion, prevention and early intervention. See details in the key themes.

WHY DO WE NEED THE STRATEGY

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National figures [2, 3, 4] show that

- Between 10 and 20% of women develop a mental illness during pregnancy or within the first year after having a baby[4]. Examples of illnesses include antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder and postpartum psychosis. These conditions often develop suddenly and range from mild to extremely severe, requiring different kinds of care or treatment.

- The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child. Perinatal anxiety (when it exists alone and not with depression) costs about £35,000 per child, of which £21,000 relates to the mother and £14,000 to the child. Perinatal psychosis costs around £53,000 per child, but this is a substantial under-estimate because of lack of evidence about the impact on the child; costs relating to the mother are about £47,000 per case, roughly double the equivalent costs for depression and anxiety

- Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three quarters before their mid 20's

- Nationwide, 4% (4,028) of callers to ChildLine[5] report a problem relating to parental mental health. Of these, 35% stated that physical abuse was the main problem they were concerned about. This was followed by family relationship problems (20%) and sexual abuse (10%). The ACE study[11] estimated that preventing four or more adverse childhood events such as; abuse, neglect and witnessing of domestic violence could reduce heroin/crack use by 59%, violence by 51%, incarceration by 53%, and unplanned teenage pregnancies by 38%.

- WHO[34] estimates child maltreatment is responsible for almost a quarter of the burden of mental disorders. The All Parliamentary report on the first 1001 days of a child's life[2] noted that 80% of maltreated children could be classified as having disorganised attachment which can have lifelong effects on the infant, including high levels of physical and mental illness, high levels of entry into care, disruptive behaviour in preschool and school, low educational and employment

achievement, poor relationship skills, high levels of violence, imprisonment, worklessness and homelessness. Over 25 years the CMO report[1] estimated the total return from parenting programmes, for children with conduct disorder, is between 2.8 and 6.1 times the intervention cost, much of this through reduced crime.

- One in ten young people between 5 and 16 years has a mental health problem[4] young people are estimated to have a mental health condition of which 25% will need to access professional help. (This figure increases to 72% of young people in care and 95% of young people in custody). The majority of mental health conditions include anxiety and depression and conduct disorders and these occur in direct response to what is happening in their lives (Source Mentalhealth4life[4]; Promoting Mental Health in Schools).
- The Chief Medical Officers report[1] identified that in 2000, the service costs associated with childhood psychiatric disorders were 12 times greater for frontline education services than for specialist mental health services. Early intervention services that provide intensive support for young people experiencing a first psychotic episode can help avoid substantial health and social care costs: over 10 years for every £1 invested £15 in costs can be avoided.
- Public Health England[23] have noted that in an average class of 30 15-year-old pupils: three could have a mental disorder, ten are likely to have witnessed their parents separate, one could have experienced the death of a parent, seven are likely to have been bullied, six may be self-harming
- Early intervention is cost effective (for every £1 spent £85 pounds is saved on costs of care)[4]

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DRIVERS FOR CHANGE

National

- All Parliamentary report into child and adolescent mental health (2015)
- APHO 2015. The Chief Medical Officer's annual report 2012
- NHS England 2015. Five Year Forward View
- NHS England 2014. Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)
- PHE (2014) Improving Young Peoples Health and Wellbeing -
- Tavistock and Portman 2014. THRIVE model for CAMHS services
- CYP IAPT principles in Child & Adolescent Mental Health services values and standards 2014. Delivering with and delivering well (National standards for operating CAMH services)
- NHS England guidance (awaited) on CAMHS transformation plans

Local

- Thames Valley CAMHS Engagement Programme (2014)
- Slough Joint Strategic Needs Assessment (2013-14 and 2015)
- Slough Five Year Plan 2015-2019
- Slough Children's and Young Peoples Plan (2015-16)
- Slough Alcohol and Domestic Abuse Strategies
- Results of evaluation of the Mindfulness programme
- Results of the Slough public mental health service redesign

LOCAL CONTEXT

The Slough JSNA 2015[27] is based on the same life course sections (Starting well, Developing well, Working well, Aging well) as used in the Mental Health 4 Life materials.

The JSNA has identified that further work is needed to commission an effective parental mental health service which supports parents in pregnancy and immediately after birth continuing through childhood throughout adult life and in older age. The latter two life stages are out of scope for this strategy but will be integrated into the adult mental health framework.

In 2013-2014 Slough was the lowest referrer into specialist CAMHS services and various explanations were proposed i.e;

- that our BME communities were not using services due to the stigma associated with a mental health diagnosis
- there was greater or equivalent need which was being met through schools and other support mechanisms in the community.

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In 2014 public health and the CAMHS primary mental health team agreed to lead on the development of a national website and app which required a full review of; pathway improvements, existing tier 1-3 services and resources for schools and GPs. This opportunity has resulted in changes to;

- eight pathways which set out what can be done by the person themselves from taking a self care approach right the way through to accessing local services which can be found in the family services guide under health and wellbeing
- resources for schools which can be found in the Family Services Guide under health and wellbeing /resources and professional guides
- an updated list of local services that fit into the original tier 1-4 model of CAMHS services which can be found in the Family Services Guide under health and wellbeing/resources and professional guides
- professional guides to responding to emotional health and wellbeing issues (GP, social care, school staff etc) can be found in the Family Services Guide under health and wellbeing/resources and guides
- A schools training programme was developed and various hubs established to test the effectiveness of national programmes locally. There are now support hubs running in local schools, within social care (the CAMHS and wellbeing hub for our most vulnerable young people) and for coordination and quality assurance of all our services (the Five Ways to Wellbeing hub). A parental mental health programme has been tested and is providing clients with facilitated self help but as yet the only commissioned parental mental health service is through the CCG IAPT service. Further work is planned through the CAMHS transformation fund[17] to adopt a range of approaches to supporting women prior to and post pregnancy.
- Work undertaken by the Five Ways to Wellbeing hub during the pilot phase has identified new ways of delivering evidence based programmes at a community level. Results show reduced anxiety and depression and increased self awareness and a reduction in self harm in targeted

groups. Those who were unable to benefit (in the minority) required more support due to their additional support needs on a complex care pathway

- Waiting times to discuss childrens and young peoples issues and improve access a range of support to address mental health and wellbeing needs (for anxiety, depression and self harm) in the pilot schools was no longer than two weeks. In addition, since the launch of the pathway changes. the profile of cases managed by the primary mental health and specialist CAMHS teams has changed.

- During the pilot phase the specialist CAMHS team received additional funding to reduce waiting times for diagnosis of Autism Spectrum Disorder and Attention Deficit Disorder and to operate a response for complex trauma cases arriving at hospital. In addition the teams are developing an on line case management programme for young people called Young ShaRon which fits well with young peoples preferences shown in Figure 2.

- The model for a future integrated public mental health service has now been clarified for commissioning through the CAMHS transformation fund.

- The baseline demands on existing services has been determined. The primary mental health team manages over 900 calls for information and face to face consultations per annum and a caseload of which around 65 are open at any one time. Specialist CAMHS manages c 750 referrals into their service which is expected to rise to 850 for 2016-17; of these around 140 are stepped down per year to the primary mental health team (of which half are known to social care) and as a result of the changes to pathways less than 5 have been stepped up to specialist CAMHS. The additional coordinated support from a range of services such as early help advisors, SEBDOS, educational psychology, school nursing and youth services has also informed the pilot and future models of service.

- During the pilot in two secondary schools over 50 young people who were self harming or struggling with low mood/anxiety have all have received an intervention and a proportion have taken part in evidence based Mindfulness programmes. Results show a measurable reduction in anxiety and depression in the majority

- The co-created Slough wellbeing website can be found at www.puffell.com which contains sections for young people and adults

Figure 2. Work with young people identified their desired content for the on line offer

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Their must have priorites are shown below and embedded in the website. The ‘should have’ and ‘could have’ sections will be incorprated in later releases.

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Table 2. Young peoples views on ‘Must have’, ‘Should have’ and ‘Could have’ topics on the website

Must have topics	**Should have**	**Could have**
Self harm	Relationships	Eating problems/disorders
Anxiety/Depression	Domestic Violence	School Life
Anger Management	Drugs	Coping with Parents
Bullying	Parents Section	
How to Help Others		

Key points that the young people noted would help them use this resource are shown below

- Confidentiality is key – must be secure
- Needs to be useful and not just information
- They should be able to personalise it and make it their own
- Has to work across all devices
- Should be a mix of content styles e.g video, text etc
- Should have an interactive place where they can chat with others and with health professionals
- Needs to connect to a service if they need it
- Should have tools that help people manage and improve

- Make it feel like it is ok for young people to struggle with mental wellness – 'it's nothing to be ashamed of'

OUR VISION

That children and young people are able to achieve supportive relationships, a sense of belonging in their families, schools and communities and gain the skills needed to be resilient for life. And for our most vulnerable young people that their needs are identified early and that evidence based support is available as soon as possible.

STRATEGIC AIMS

- Promoting attachment and positive mental health across the life course
- Building resilience and early intervention in early years and school settings
- Empowering people to make informed decisions about their mental wellbeing
- Working with schools and communities to reduce harm at a population level
- Enabling young people and families to obtain access to evidence based support when needed
- Improving the physical health of those who struggle with mental health problems
- Ensuring the standards of commissioned services meet those agreed nationally and locally

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Outcomes and expected benefits for health and social care in Slough

- Informed and resourced parents, professionals, children and young people who can support others in their community
- School and community based interventions are effective and support both parental, children's and young people's wellbeing
- Fewer children and young people require specialist CAMHS support
- For those children and young people who do need a diagnosis, shorter waiting times and effective exit pathways reduce the length of stay with specialist CAMHS
- High quality, accessible and cost effective local services reduce demands on education and children's social care

Thematic priorities

THEME 1: Promoting Mental Health 4 Life with parents

- All professionals working with women during the antenatal period need to be aware of the signs of distress and know how to offer help that avoids stigma or fear
- High quality training is offered in infant mental health (e.g. www.1001criticaldays.co.uk and www.chimat.org.uk/pimh)

- All professionals working with families and young children need to know how to respond to a request for help and refer to effective interventions e.g. www.centreformentalhealth.org.uk/parenting, http://bit.ly/FPHgoodstart, http://www.education.gov.uk/commissioning-toolkit,

- The LSCB coordinates and ensures the effectiveness of action to promote the welfare of children e.g. for domestic abuse at www.nice.org.uk/guidance/ph50, for social and emotional wellbeing guidance at www.nice.org.uk/guidance/ph40 and safeguarding at http://bit.ly/LGAsafeguarding

THEME 2: Promoting Mental Health 4 Life with children and young people

- All professionals working with families and young children need to know how to respond to a request for help and refer to effective interventions e.g. www.centreformentalhealth.org.uk/parenting, http://bit.ly/FPHgoodstart http://www.education.gov.uk/commissioning-toolkit, www.triplep.net, www.incredibleyears.com

- Children are enabled to fulfil their potential and are less likely to develop mental health conditions and other problems e.g. in primary schools www.nice.org.uk/guidance/ph12, in secondary schools www.nice.org.uk/guidance/ph20 (for every £1 spent £84 is saved)

- Whole school antibullying approaches save the taxpayer £14 for every £1 invested e.g. on domestic abuse www.nice.org.uk/guidance/ph50

- The LSCB coordinates and ensures the effectiveness of action to promote the welfare of children e.g. for domestic abuse at www.nice.org.uk/guidance/ph50, for social and emotional wellbeing guidance at www.nice.org.uk/guidance/ph40 and safeguarding at http://bit.ly/LGAsafeguarding

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THEME 3: Promoting Mental Health 4 Life with schools

- School staff need to know how to respond to a request for help and where to refer to effective interventions e.g. www.centreformentalhealth.org.uk/parenting, http://bit.ly/FPHgoodstart, http://www.education.gov.uk/commissioning-toolkit, www.triplep.net, www.incredibleyears.com

- School based training is compliant with NICE guidance for promoting social and emotional wellbeing; in primary schools www.nice.org.uk/guidance/ph12 or in secondary schools www.nice.org.uk/guidance/ph20

- Whole school, whole community action is taken to tackle bullying e.g. www.nice.org.uk/guidance/ph40

- Schools should work closely in partnership with local authority children's services, the NHS and other services to develop and agree local protocols covering the assessment, referral and definition of the role of schools and other agencies in different interventions e.g. the eight care pathways (insert link here)

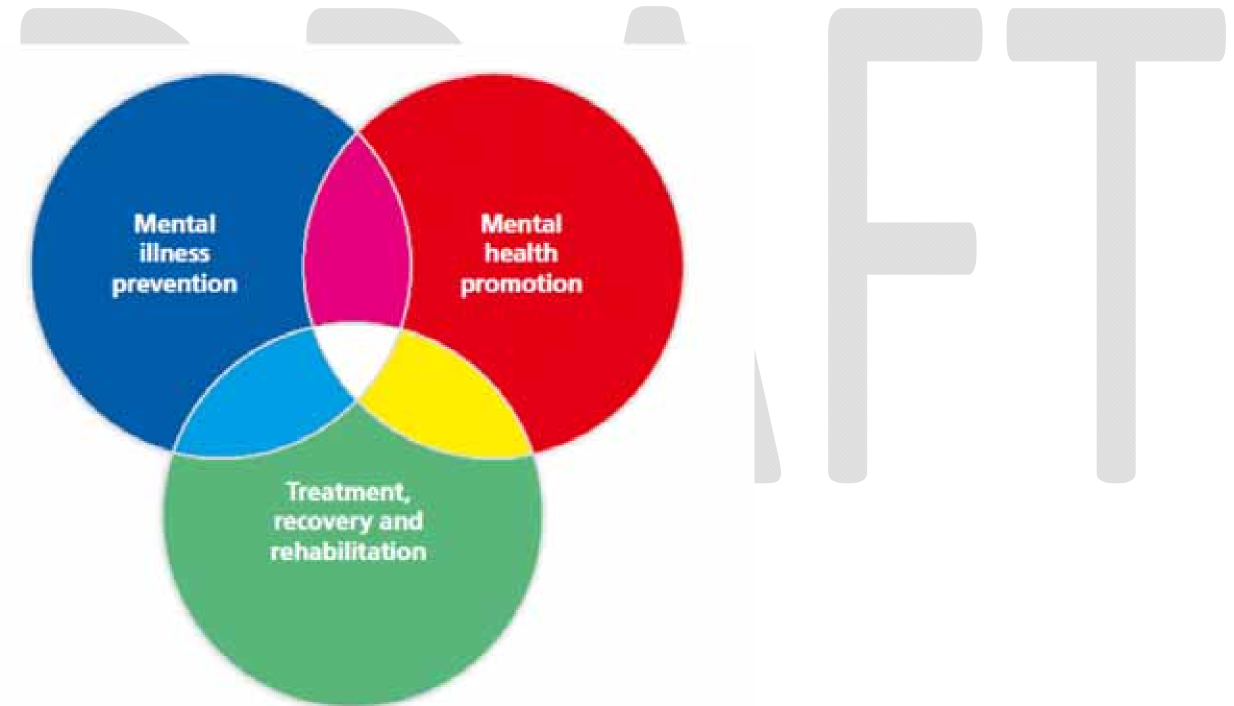
The timescales for achieving the themes are as follows;

- In one year, the goal is for the integrated service to be operating in as many secondary schools that are able to engage in the programme,
- In three years, all primary and secondary schools to have a rolling programme of training and integrated support
- In five years, theme 1 (which is the most challenging to implement in our diverse communities) would be supported through professional development programmes nationally and locally and measurable changes would be available showing long term reduction in harm at a community level.

National context and THRIVE model of CAMHS

The Chief Medical Officers independent report[1] noted that there were three distinct areas of public mental health for which there is a strong evidence base as shown overleaf

Figure 1: The World Health Organisation conceptual model of public mental health



The CMO report made a strong recommendation that the NHS and Public Health England should not commission services under the description of ‘supporting well-being’, but should focus on commissioning services for which there is evidence according to the WHO model. This is because people with self reported high levels of wellbeing may in fact have mental illness. Until valid measures can be put in place the Chief Medical Officer’s (CMO) report recommended a focus on the evidence base for public mental health within the known domains of; mental illness prevention, mental health promotion, treatment, recovery and rehabilitation.

The report therefore recommended that until there was measurable evidence of the psychometric relationships between measures of mental wellbeing and measures of mental disorder/illness councils should not support wellbeing programmes. Further the report recommended that ‘well-being’ social

marketing campaigns for public mental health should not be rolled out, unless and until there is robust evidence for their effectiveness.

This has led to the generation of new evidence based resources (under the Mentalhealth4life logo)[4] which include the development of public mental health competencies across the life course. Slough Borough Council has made a commitment to incorporate this programme into its work with early year's services, schools, through its services for adults and older adults and through support to roll this out through the voluntary sector. The free resources can be downloaded from our Slough Service Guide *(link to CAREIF national resources[4]).*

Other national and regional reports emerged in the course of 2014 such as; the House of Common CAMHS review (2014), the local Thames Valley Child and Adolescent Engagement survey (2014) the Thames Valley Child and Maternity network report into perinatal mental health service provision (2014) and latterly the development of the THRIVE model of CAMHS provision (Wolpert et al 2014, 2015). All of these pointed towards a review of local services based on a life course and public mental health approach.

The House of Commons report[2] identified that GPs did not feel confident to identify and refer to CAMHS services and requested training to support them in their role

Young peoples and families views were gathered regionally in a very comprehensive engagement exercise, as reported in the Thames Valley Child and Adolescent Mental Health survey (2014). This report[29]29 provided the mandate for redesigning Child and Adolescent Mental Health services (CAMHS) locally, as families and children reported three areas of concern; the timeliness of services, the efficiency and effectiveness of services. The report showed that the language of the tiered model of CAMHS is not well understood by; parents, teachers, social care workers or GPs who; as primary referrers to specialist CAMHS, were seeing rising rates of referrals for autism spectrum disorder, for attention deficit disorder and for self harm in addition to the core work on anxiety and depression and a range of other diagnosable conditions.

Much of the confusion about CAMHS came from the lack of understanding about what services were available and how they worked together to deliver a comprehensive Child and Adolescent Health service. Up to 2014 CAMH services were defined in terms of tiers i.e;

Tier 1: consists of universal, non-specialist services who support children and young people these include; special educational needs coordinators, educational psychologists, behavioural support teams, health visitors working with, for example, common emotional and behavioural problems of childhood such as, sleeping difficulties or feeding problems and school nurses who can provide signposting and support for self management and early emotional needs.

Tier 2: consists of specialised Primary Mental Health Workers (PMHW's) offering support to other professionals around child development; assessment and treatment in problems in primary care, such as family work, bereavement, parenting groups etc. This also includes Substance Misuse & Counselling Services. Counselling services such as Cognitive Behaviour therapy, Mindfulness and nurture groups can be offered on an individual basis or in groups by primary mental health workers and educational psychologists. DfE guidance sets out the quality standards required when schools commission counselling services as up to 80% of schools use the pupil premium to do so.

Tier 3: consist of specialist multidisciplinary teams such as Child & Adolescent Mental Health Teams based in a local clinic. Problems dealt with here would be problems that are too complicated to be dealt

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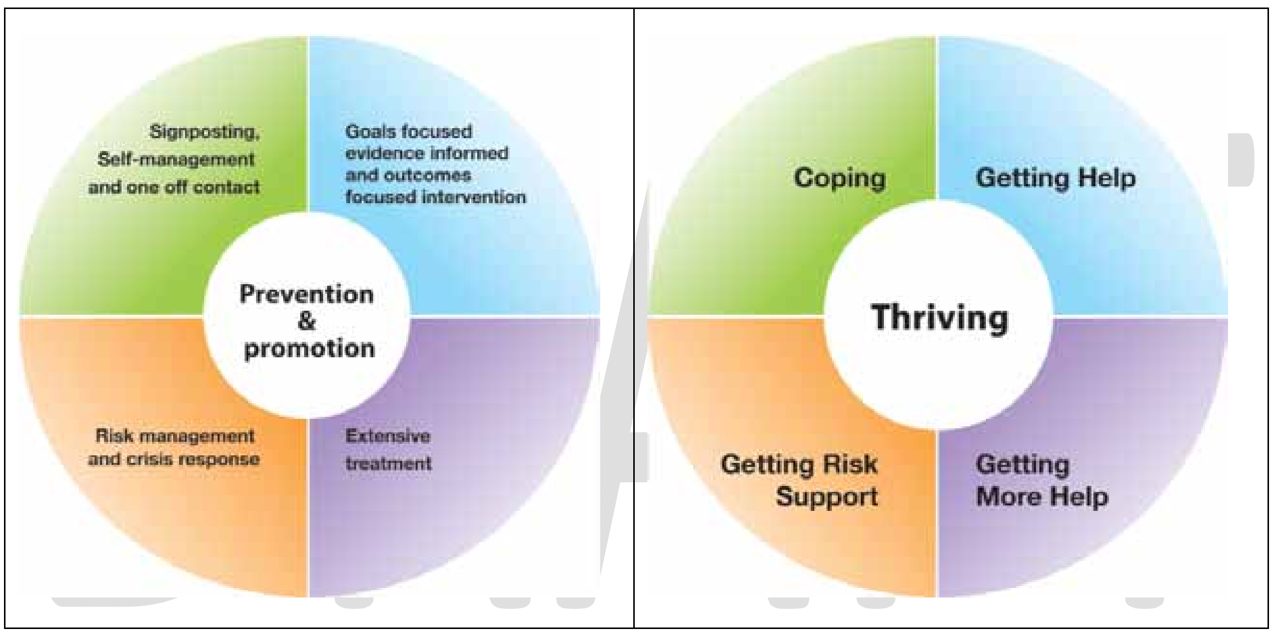
with at tier 2 e.g. assessment of development problems, autism, hyperactivity, depression, early onset psychosis.

Tier 4: consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated.

CAMHS tier 2 and 3 service staff have worked nationally to design a much more understandable and comprehensive model for CAMHS (THRIVE, Wolpert et al, 2014, 2015). The model shown in Figure 2 encourages staff at any stage to reflect on; whether they are offering evidence based interventions to help young people and to consider what they are doing under the four categories of; coping, getting help, getting more help or getting risk support. It is underpinned by a strong evidence base.

Figure 2; The THRIVE model of CAMHS (Wolpert et al 2015)



The THRIVE model above sets out four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community. It is in essence a discussion tool for practitioners to use in shared decision making with young people and their families and moves away from a diagnosis based grouping,

Wolpert et al 2015 note that currencies are classifications that aim to group together episodes of health care (or advice/help) with broadly similar resource use, in a manner that is compatible with need. In the national guidance produced by the NHS pricing team these should

- be clinically meaningful,
- identify health care provision of broadly similar resource usage, reflecting patient need and
- group units of care consistently (i.e. be reliable).

Wolpert et al noted was that the national costing model did not find any measurable relationship between the need for resources and the complexity of cases which is a common misperception. The categories examined included whether young people were in employment, education or training and other contextual factors such

as; looked after children, serious health issues, autism, Aspergers, neurological problems (Tics and Tourettes), on a child protection plan, children in need, refugee or asylum seeker, previous experience of war, torture or trafficking, abuse or neglect, parental ill health, contact with youth justice system, living in poverty.

The national payment system will undergo further revisions to inform future commissioning for tier 2 and 3 services and the national tariff will apply to specialist CAMHS when reporting goes direct to the Health and Social Care Information Centre through the Mental Health Services dataset. The latter is a combination of the Children and Young Peoples Introducing Access to Psychological therapies and the adult mental health datasets.

Specialist CAMHS in Berkshire are accessed by the common point of entry and they are contracted to lead on the following pathways; autism spectrum disorder (for a diagnosis), attention deficit disorder (for a diagnosis and treatment), anxiety and depression, eating disorders, crisis response for early psychosis and trauma or self harm.

By contrast the work of the primary mental health services covers the sections of the model that relate to coping and getting help with some group treatment programmes that can be offered in school or community settings and last for less than 12 weeks. National agreed tariffs are being launched as part of the CAMHS transformation plans which will allow the work of the integrated support services that collectively deliver the Five Ways to Wellbeing service to be commissioned. This public mental health and CAMHS service is coordinated by the primary mental health team and lead on; promoting information and support direct to schools through; the Slough Services Guide, training for school staff and GPs, evidence based interventions for self harm, anxiety and depression for secondary school pupils. This service supports young people who have been 'stepped down' from the common point of entry at specialist CAMHS. See the full service guide in the Slough Services Guide.

Slough's emotional, behavioural difficulties outreach service (SEBDOS) supports children in early years and primary school settings after a diagnosis has been made and supports specialist schools and resource centres. The service also offers support to schools to challenge sexting and cyber bullying as young people have reported these as continuing issues.

Interviews with young people reflect other factors that help them to cope; the importance of good relationships is at the centre of the model for young people's health and wellbeing shown in Figure 3.

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Figure 3 Model for promoting young people's health and wellbeing (PHE, 2015)

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Evidence on what works in enabling young people to build strong relationships to enable them to cope[21] starts from birth by enhancing the bond between the mother and child (based on Attachment Theory[12]) examples of programmes that incorporate attachment based interventions include the Family Nurse Partnership, baby massage[17,21] nurture programmes[26],[28] as well as a range of DfE approved parenting support and parenting programmes cited in the conduct disorders and attachment pathways.

NICE guidance and PHE guidance for schools on emotional health and wellbeing cites examples of what works in building social and emotional and life skills for school aged children and young people[19,20,23]

There is a clear message that life skills can be learned and enable young people to cope and become resilient to both internal and external stressors. Ungar (2014)[26] noted that *"In the context of exposure to significant adversity, resilience is both the capacity of individuals to **navigate** their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to **negotiate** for these resources to be provided in culturally meaningful ways."*

In terms of interventions in school settings;

- Mindfulness training is a well evaluated intervention for symptoms of depression and anxiety disorders in in young people as well as adults as reported in a metanalysis published by Zoogman et al 2014[35]. Further evaluations of Mindfulness are planned nationally. The learning from local pilots has also been captured and is awaiting publication

- CBT based approaches for youth and adult counselling are evidence based as cited in NICE guidance and form the basis of the CYPIAPT offer nationally which all specialist CAMHS services should report to the Health and Social Care Information Centre in future.

- Systemic Family Practice is evidence based and cost effective[28]
- Nurture groups can be effective in supporting those with behavioural difficulties at key transition stages, with supervision and peer support[322.]

In summary therefore the THRIVE categories provide a useful bridge between the language of 'wellbeing' and 'building resilience' used by staff and pupils in schools, and that used by professionals who work in specialist treatment services.

JOINT ACTION PLAN

The joint action plan shown in Appendix 3 is owned by the Children and Young Peoples Partnership subgroup for health.

The objectives are based on the four categories of the THRIVE model (Wolpert M. et al 2014) which fit with the emergent themes from young people obtained during the design and testing of the web based service, from engagement with young people and school staff during the service redesign phase and with engagement with specialist CAMHS services and the national team leading on the development of the Mentalhealth4 life resources.

- signposting and information
- getting help and early intervention
- timely access to evidence based care
- risk management for vulnerable young people
- service quality standards.

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COMMUNICATIONS

Effective communication is vital to the successful implementation of this strategy and the joint action plan. There is a duty for all statutory bodies to consult and include the people they serve in the development of their services. This is known as the 'Duty to Involve' and influences all the councils and NHS engagement and communication activities. It is therefore important that all stakeholders are aware of this strategy and what it is intended to achieve. The joint communication plan with the youth council will set out how this strategy is to be communicated. This will be done using a variety of methods and media to encourage participation and ownership of the strategy by all stakeholders.

IMPLEMENTATION AND GOVERNANCE

Responsibility for the implementation of this strategy rests with the Slough Children's and Young Peoples board and the health subgroup. Decision making in relation to the commitment of statutory funding rests with Slough Borough Council's Cabinet and Slough CC Governing body

REVIEW

This strategy and its joint action plan will be in place from 2015-19 and will be reviewed annually to;

- Review the effectiveness of the actions and programmes

- Respond to local, regional and national changes
- Identify new priorities that have emerged since the implementation of the strategy
- Reassess priorities, actions and initiatives
- Plan for future development and or/amendment

The detailed action plans shown in Appendix 4 are already aligned to the THRIVE headings which support a payment schedule for the interface between primary and specialist CAMHS services. The detailed planning templates of the CAMHS transformation funding will be announced in the summer of 2015 during the consultation period. The final plans are required to cover five priority areas; all of which are mentioned in the action plans attached i.e; building capacity and capability across the system, rolling out the CYPIAPT programme, developing evidence based eating disorder services, improving perinatal care, bringing schools and local children and young peoples services together around the needs of the individual child.

Further local testing within further schools in the Autumn term will also inform the plans for the eating disorder service.

The continuing funding of the delivery organisations will be dependent on effective delivery of the targets and outcomes. Consistent monitoring arrangements will be in place across all agencies to assess performance against these outcomes.

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Equality impact assessment

The full EIA can be found at Appendix 1. We aim to promote and deliver healthcare services that are equitable and are appropriate to each service user's needs regardless of age, disability, race, ethnic or national origin, gender, religion, belief, sexual orientation or domestic circumstances. Some groups are more likely to be affected by mental health disorders as shown below;

- Conduct disorders disproportionately affect males compared to females
- Self harm disproportionately affects females compared to males. There are multiple causes of self harm with rates of self harm reported as between 6-20% generally and more common in young people who are; lesbian, gay, bisexual transgender or questioning
- Eating disorders affect females disproportionately to males
- The PHE wellbeing report identified those who are most vulnerable i.e.; living in poverty, with special educational needs, Not in Education, Employment of Training, providing targeted support for those in care, those in youth custody (up to 40% having emotional and mental health needs where rates of mental illness are higher), asylum seekers, those excluded from school, teenage parents and young people in the Troubled Families programme.

CONTACT INFORMATION

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Appendix 1: Equality impact assessment

	Positive impact (Y or N)	**Negative Impact** (Y or N)	**Reasoning / evidence**

Age			
Older people(60 +)		✓	Separate services exist for adults with mental health problems. Families will however be encouraged to engage with this new service.
Younger people(17-25)	✓		Higher risks of suicide are reported among children in care or leaving care 4-5 fold increased risk of attempted suicide 7.5 fold increased risk if in long term foster care Young offenders are at increased risk of self harm and suicide with increased risk of severe mental health problems in later life and in association with solitary confinement. Alcohol misuse can lead to: psychosis . Self harm and suicide are more common in people who misuse alcohol. (RCP 2014). Alcohol affects the chemistry of the brain, increasing the risk of depression. Peer victimization has been associated with lower levels of personal wellbeing (Wolke and Skew 2011). 86% of children and young people report that they are members of social networking sites (ONS 2014) Although positive connections can form it has also been associated with increased rates of depression. Social media increases the risk of cyber bullying, sexting and exposure to risky situation but as yet there is no quantitative survey data on the impact of cyberbullying.
Gender			
Men	✓		More than half of all adults with mental health problems were diagnosed in childhood. (Young Minds 2015) Males members of social class V are at greater risk of committing suicide than females (National Institute of Mental Health 2003)
Women	✓		Between 10 and 20% of women develop a mental illness during pregnancy or within the first year after having a baby. Examples of these illnesses include antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis. Symptoms range from mild to severe. Anxiety is more common in women than men (RCP 2014)

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Ethnicity			
Asian or Asian British people	✓		The Mental Health Foundation notes that In general, people from black and minority ethnic groups living in the UK are: • more likely to be diagnosed with mental health problems • more likely to be diagnosed and admitted to hospital • more likely to experience a poor outcome from treatment • more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health Bhui and McKenzie 2008 noted that South Asian females aged 25–39 are at increased risk of suicide and self harm (OR 2.8)
Black or Black British people	✓		The Mental Health Foundation noted that African Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. Bhui and Mckenzie 2008 noted that rates of suicide and self harm were higher in black males i.e Black African (OR 2.5) and Black Caribbean (OR 2.9) aged 13–24 And among females the rates were increased in Black African (OR 3.2) and Black Caribbean (OR 2.7) groups

Ethnicity continued			
Chinese people	✓		The Mental Health Foundation notes there is very little information about the incidence of mental health problems in this category
Gypsy, Roma and Traveller People	✓		Evidence from a number of studies (Parry et al, 2004; Goward et al, 2006; MIND Bristol, 2008) shows that Gypsies and Travellers have greatly raised rates of depression and anxiety, the two factors most highly associated with suicide, with relative risks 20 and 8.5 times higher than in the general population (Harris & Barraclough, 1997).
Irish People	✓		Irish people living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups. In particular they have higher rates of depression and alcohol problems and are at greater risk of suicide. Mind 2015.

People of Mixed Heritage	✓		See other categories
White People	✓		The Mental Health Foundation report that one in four people will experience a mental health problem in their lifetime. Mixed anxiety & depression is the most common mental disorder in Britain, with almost 9% of people meeting criteria for diagnosis. (The Office for National Statistics Psychiatric Morbidity report, 2001) Between 8-12% of the population experience depression in any year. (The Office for National Statistics Psychiatric Morbidity report, 2001) Rates among children are reported in the various pathways
People of other ethnic backgrounds	✓		See other categories
Asylum Seekers and Refugees	✓		Robjant et al 2009 noted that among those in detention centres. Anxiety, depression and post-traumatic stress disorder were commonly reported, as were self-harm and suicidal ideation. Time in detention was positively associated with severity of distress. There is evidence for an initial improvement in mental health occurring subsequent to release, although longitudinal results have shown that the negative impact of detention persists. Homeless people have an increased risk of suicide 61% reported suicidal ideation 34% attempted suicide
Disability			
People with physical or sensory difficulties	✓		Physical health and life expectancy are severely compromised in individuals who self-harm compared with the general population (Bergen et al 2012)
Deaf People who use British Sign Language.	✓		Children with early onset, severe to profound deafness are more vulnerable to mental health problems than their hearing peers. The key risk factors are developmental delays associated with early communication deprivation, CNS disorders associated with specific causes of deafness and abuse. Early psychological support to families and a wide range of communication options are crucial components in preventing mental health problems. Clinicians working with deaf children need to be sensitive to their communication needs and if necessary use British Sign Language (BSL) interpreters. Deaf children can benefit from a wide range of mental health interventions provided by generic and specialist services. (Hindley 2006)
People with mental health issues	✓		Suicide and self harm rates are reportedly 7% among 11-16 year olds (Green et al, 2005). Among those with existing mental health problems increased rates are suggested according to the condition.

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People with learning disabilities	✓		The National Autistic Society note that people with autism or Asperger syndrome are particularly vulnerable to mental health problems such as anxiety and depression, especially in late adolescence and early adult life (Tantam & Prestwood, 1999). Young people with other learning disabilities in this age group will not be excluded and pathways for autism have been developed and included

Appendix 2 Needs and estimated demand for CAMHS in Slough

Automated CAMHS needs assessments are produced nationally on the Child and Maternal Health Intelligence Network (CHIMAT) website and these are being updated. The latest was reproduced in the JSNA CAMHS section available at http://www.slough.gov.uk/council/strategies-plans-and-policies/child-and-adolescent-mental-health.aspx

The extract that follows is for Slough CCG which is coterminous to Slough UA and is awaiting update by CHIMAT which has produced a series of prevalence estimates for mental health disorders in children. These combine the findings from different national and international studies to provide modelled estimates at a local level. Slough Clinical Commissioning Group's (CCG's) CAMHS Needs Assessment has been summarised below and is based on the 2012 registered population information. The full report can be found on the Slough JSNA website[27].

Pre School children

1,900 children aged 2-5 have the potential to develop a mental health disorder (based on a modelled prevalence of 19.6%)

School-age children

The prevalence of mental health disorders in school-age children vary by age and sex, with boys more likely (11.4%) to have experienced or be experiencing mental health problems than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems.

In 2012, 2,170 children aged 5-16 were estimated to have a mental health disorder in the CCG.

Table 3. Estimated number of children with mental health disorders in Slough CCG by age group and sex

All mental health disorders	6 to 10 year olds	11 to 16 year olds	Total number
Boys	655	680	1335
Girls	305	530	835
Total	960	1210	2170

Table 4 Estimated number of children with specific mental health disorders in Slough CCG by age group and sex

Conduct disorders	6 to 10 year olds	11 to 16 year olds	Total number	Emotional disorders	6 to 10 year olds	11 to 16 year olds	Total number
Boys	445	440	885	Boys	145	220	365
Girls	170	265	435	Girls	150	315	465
Total	615	705	1,320	Total	295	535	830

Table 5 Hyperkinetic and less common disorders

Hyperkinetic disorders	6 to 10 year olds	11 to 16 year olds	Total number	Less common disorders	6 to 10 year olds	11 to 16 year olds	Total number
Boys	175	130	305	**Boys**	145	90	235
Girls	25	25	50	**Girls**	25	60	85
Total	200	155	355	**Total**	170	150	320

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Young people aged 16-19

The prevalence of neurotic disorders in young people aged 16-19 is shown below

Table 6: Estimated number of young people aged 16-19 with neurotic disorders in Slough CCG

	Mixed anxiety and depressive disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder
Males (aged 16-19)	185	60	35	25	35	20	310
Females (aged 16-19)	420	40	95	75	115	25	650
Total	605	100	130	100	150	45	960

Local child health and wellbeing profiles are produced by Public Health England[24] and the 2015 report shows that in comparison with the 2008/09-2010/11 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm was below the England average in the 2011/12-2013/14 period.

Although the admission rate in the 2011/12-2013/14 period is lower than the England average, nationally and locally our work shows that, levels of self-harm are higher among young women than young men.

Estimated need for CAMHS services

CAMHS Tier 1: 5,580 children and young people. Service provided by professionals whose main role and training is not in mental health. These include GPs, health visitors, school nurses, social services, voluntary agencies, teachers, residential social workers and juvenile justice workers.

CAMHS Tier 2: 2,605 children and young people. Provided by specialist trained mental health professionals. They work primarily on their own but may provide specialist input to multiagency teams. Roles include clinical child psychologists, paediatricians, educational psychologists, child psychiatrists and community child psychiatric nurses. **I think this describes teir three? Teir two are the ed psyches, school nurse,PMHW's,specialist TA's, youth service,YOT ect**

CAMHS Tier 3: 690 children and young people. Aimed at young people with more complex mental health problems than those seen in Tier 2. This service is provided by a multidisciplinary team, including child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists and art, drama and music therapists)

CAMHS Tier 4: 30 children and young people. Aimed at children and adolescents with severe and/or complex problems. These specialised services may be offered in residential, day patient or out-patient settings. These services include in-patient units, secure forensic adolescent units, eating disorder units, specialised teams for sexual abuse and specialist teams for neuropsychiatric problems

Children with a learning disability

Approximately 555 children aged 5 to 19 are estimated to have a learning disability in Slough CCG. This figure increases by age group:

- 5 to 9 year olds: 125
- 10 to 14 year olds: 200
- 15 to 19 year olds: 235

Approximately 225 children aged 5 to 19 are estimated have a learning disability with mental health problems in Slough CCG. This figure also increases by age group:

- 5 to 9 year olds: 50
- 10 to 14 year olds: 80
- 15 to 19 year olds: 95

The JSNA[27]26 provides estimates of the numbers of young people with learning disability and within other protected groups.

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Appendix 3 Joint action plans

Theme	Objective Number	Objective	Measure	Owner
Signposting, information, peer support and training	1	Ensure young people are aware of what they can do to help others, can promote a range of self help resources, can tackle stigma and ensure confidentiality is maintained	Use of Puffell wellbeing deck Nos of young people trained in Youth MHFA and in anxiety and depression and self harm Feedback from courses	Youth Parliament, app champions, young peoples services. The Five Ways to Wellbeing team
Signposting, information, peer support and training	1	Ensure school staff are competent to understand their own response to promoting wellbeing and can assess and detect health problems early	No's of staff accessing MHFA, self harm training or training in using the pathways or resources Feedback from courses	Head teachers, SENCOS and pastoral staff supported by the Five Ways to Wellbeing hub partnership (including PMHWs, SEBDOS, SN, EHAs, Family support and educational psychologists)
Signposting, information, peer support and training	1	Ensure that early years and schools settings have information to promote Mentalhealth4life and pathway related resources, know their responsibilities and can get support to improve their practice in engaging the help of others	Information to be distributed to all new and existing schools on a termly basis	Slough Services Guide, Five Ways to Wellbeing hub partnership. and Gateway school distribution team
Signposting, information, peer support and training	1	Ensure that voluntary and community services have introductory training around Mental Health First Aid	No's of courses and feedback	Slough Council for Voluntary Services and SBC young peoples services
Signposting, information, peer support and training	1	Encourage GPS and other primary care professionals to promote Mentalhealth4life resources	No's accessing from the Slough Services guide	Practice managers and patient navigators
Signposting, information, peer support and training	1	Promote and support awareness of the SBC website and Puffell website	No's accessing per quarter	Slough services guide and public health

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Theme	Objective Number	Objective	Measure	Owner
Signposting, information, peer support and training	1	Ensure that family courts and magistrates are trained to recognise mental health conditions and self help options	No's trained per quarter	BHFT specialist CAMHS

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Theme	Objective Number	Objective	Measure	Owner
Getting early help and building resilience	2	Schools and services in other educational settings, ensure that effective social and emotional education is available for children, young people and parents.	Use of evidence based PSHE programmes Use of Mindfulness or THRIVE interventions Use of pupil premium to fund CBT and behaviour support interventions	Five Ways to Wellbeing Hub, schools and Young Peoples Services
Getting early help and building resilience	2	Develop parents' understanding of the impact of their own mental health on themselves and on their children. Develop professionals understanding of postnatal depression Provide Mentalhealth4life resources to enable schools to help parents understand the role of mental ill health plays in their and their family's lives so they can develop the skills to change behaviours	No's accessing supported parental self help groups through the voluntary sector No's accessing Institute of Health Visiting resources for fathers and mothers No's using e-learning for post natal depression No's of CCs offering in reach services for post natal depression	Perinatal support groups, CAMHS and Wellbeing hub, schools
Getting early help and building resilience	2	Encourage GPs to signpost to CPE where necessary and based on the pathways	% of appropriate referrals from GP surgeries to CPE No's stepped down from CPE to Five Ways to Wellbeing hub	Specialist CAMHS and Five Ways to Wellbeing hub
Getting early help and building resilience	2	More young people get access to help early	Nos of early help assessments completed	All agencies and settings
Getting early help and building resilience	2	Ensure that interventions are available at all stages of the criminal justice system, enabling young offenders to address their mental health or developmental delays and to understand how this is tied to their offending behaviour.	Significant decrease in the number of referrals to CAMHS coming from within the justice system	Young peoples services, TVP, YOS, specialist CAMHS, social care

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Theme	Objective Number	Objective	Measure	Owner
Timely access to evidence based interventions	3	Improve the provision of evidence based mental wellbeing education in antenatal settings to promote maternal health and attachment	No's of referrals to Introducing Access to Psychological Therapies, baseline 89 in 2014-15	Slough GPs and CCG, BHFT perinatal mental health services, midwives and health visitors
Timely access to evidence based interventions	3	Improve the provision of evidence based mental wellbeing education in early years settings to promote attachment	No's of mothers attending peer led support programmes to reduce post natal depression	Health visitors, voluntary sector providers
Timely access to evidence based interventions	3	Ensure that young people are supported to access early interventions within all school settings	No's of referrals and cases held in school settings No's of Mindfulness and nurture group sessions No's of CBT sessions	School hubs, Five Ways to Wellbeing hub and CAMHS and wellbeing hub, and educational psychology services
Timely access to evidence based interventions	3	Promote and support awareness of the Young Sharon website and app	No's of specialist CAMHS users supported on line quarterly figures	Specialist CAMHS
Timely access to evidence based interventions	3	Ensure staff and peer leaders have access to a rolling programme of training to ensure high quality implementation of agreed programmes	No's of staff taking part in training	Learning and development team, Slough Council for Voluntary Services, specialist CAMHS and MHFA providers
Timely access to evidence based interventions	3	Ensure consistent quality standards are met across all agencies providing specialist counselling or family services	No's of schools that have had training in accessing key resources and guidance provided via the Five Ways hub	Training offered through the Five Ways to Wellbeing hub supported by specialist CAMHS
Timely access to evidence based interventions	3	Improve data collection and sharing for the Troubled Families programme and reduce anxiety and depression using a range of techniques in areas disproportionately affected by domestic abuse and related crime and disorder in the borough	Hub metrics and routine GIS based reporting of domestic abuse issues, driven by data sharing between stakeholders.	Troubled Families coordinator

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Theme	Objective Number	Objective	Measure	Owner
Risk management of complex and vulnerable cases	4	Ensure that mental health services engage as early as possible with the families of complex cases. Improve capacity and capability for the identification, assessment and referral of children and young people affected by parental mental health problems.	Training of CSC staff in FST. Waiting times to access FST. Changes to CYP global scores Changes in parental and carers ability to cope	Integrated support service, CAMHS Wellbeing service, Troubled Families support partners
Risk management of complex and vulnerable cases	4	Assertive outreach is provided by BHFT working with local accident and emergency/hospital services	Crisis response rates for early psychosis and self harm	Frimley Park Hospital and Slough CCG, specialist CAMHS
Risk management of complex and vulnerable cases	4	Provide effective family based therapeutic services for children placed in care	LAC and foster carer reports. SDQ changes at reviews. Corporate parenting panel reviews	Children's Trust CSC, family services and Specialist CAMHS
Risk management of complex and vulnerable cases	4	Integrate motivational interviewing and mental health interventions into CSE action plans	No's of young people and families supported No's of plans with a mental health action	CSE coordinator and CAMHS wellbeing hub
Risk management of complex and vulnerable cases	4	Provide effective interventions to address attachment and understanding of behaviour for foster carers (NICE guidance)	No's of families accessing training	Children's Trust
Risk management of complex and vulnerable cases	4	Coordination of post ASD and ADHD diagnosis support is reviewed annually	No's of cases supported per quarter	SEBDOS, educational psychology and specialist CAMHS

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Theme	Objective Number	Objective	Measure	Owner
Risk management of complex and vulnerable cases	4	Mainstream OOH and crisis support services into core services	No's of cases supported per quarter	Specialist CAMHS
Risk management of complex and vulnerable cases	4	Enhance the early intervention in psychosis service and 24/7 inpatient services	No's of cases supported per quarter	Specialist CAMHS
Risk management of complex and vulnerable cases	4	Drugs and alcohol services for young people are integrated with mental health services	No's of cases supported per quarter	DAAT commissioned services Specialist CAMHS

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Theme	Objective Number	Objective	Measure	Owner
Service quality standards	5	Waiting times for consultation and action plans in the school based hubs are no longer than 2 weeks (for those screened and where a need has been identified or if there is a programme in school running) or 24 hrs in a crisis (a CPE role for the crisis response team) for the CAMHS and wellbeing hub.	Waiting times for those stepped up to and down from specialist CAMHS and for direct referrals. Bank Holiday and OOH reports from A and E	Five Ways to Wellbeing and specialist CAMHS metrics
Service quality standards	5	Young people are included in annual reviews of the service	Engagement reports through the youth parliament	Youth Parliament, app champions, youth engagement services
Service quality standards	5	Information on what each service does is freely available and updated regularly	Service guide and dates of updates	Slough Services Guide, Five Ways to Wellbeing hub partnership
Service quality standards	5	Children and young people friendly environments are available at specialist services e.g. magazines, websites, leaflets, apps, stress balls in waiting areas, posters which focus on positive mental health	*Mystery shopper reports from Youth Parliament*	Berkshire Healthcare Foundation Trust specialist CAMHS
Service quality standards	5	Electronic apps, tablets and Smartphone accessible services are monitored	Service metrics	Young SHARON and Slough CAMHS website
Service quality standards	5	Service letters and referrals are clear and enable improved case management		GPs, SENCOS and pastoral staff supported by the Five Ways to Wellbeing hub partnership
Service quality standards	5	Care plans include physical and emotional health measures	All statutory care plans for YOS, LAC, CP, CIN, and on the edge of care include measures such as SDQ, BAI, BDI and self harm metrics and health assessments for LAC	CAMHS and wellbeing hub, Five Ways to Wellbeing partnership, specialist CAMHS and LAC school nurse
Service quality standards	5	Staff are trained to national competencies appropriate to their role	No's trained per quarter by category; GPs, school staff social workers, PMHWS, family workers, other hub staff	CAMHS and wellbeing hub, Five Ways to wellbeing partnership and specialist CAMHS
Service quality standards	5	Trauma and specialist DAAT support can be accessed when needed	No's of cases requiring family support	DAAT family services reports

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Theme	Objective Number	Objective	Measure	Owner
Service quality standards	5	Learning disability services are trained to provide appropriate mental health support	No's of outreach sessions by location and type of LD	Specialist CAMHS

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APPENDIX 4 STATUTORY DUTIES IN RELATION TO ASSESSING AND IMPROVING CHILD AND ADOLESCENT MENTAL HEALTH

Legislation of particular relevance (identified in the statutory guidance) includes:

- The Crime and Disorder Act 1998
- The Children Act 1989 and associated regulations
- The Children Act 2004
- The Health and Social Care Act 2012
- The Care Act 2014
- The Children and Families Act 2014.

The Crime and Disorder Act 1998 requires the council and its partners to set up a youth offending service. The YOS duties include for the assessment of the health needs (including emotional and mental health) needs of young people. The initial screening is accomplished with a number of nationally determined tools. Of particular relevance here are "SQIFA" (the mental health screening questionnaire for adolescents) and "SIFA" (the mental health screening interview for adolescents). These are only completed if a more general assessment (Asset) shows a need for this more detailed assessment

Under **Section 10 of the Children Act 2004**, the Children's Services authority is required to promote co-operation with its partners and others with a view to improving the physical, mental health and emotional well-being of children in its area.

The Children Act 1989: Section 1(3) establishes a set of principles which must guide any decision made in relation to a child. The overriding principle is the welfare of the child and further considerations include (at sub-section 1(3)(b)) the child's physical, emotional and educational needs).

Section 17 deals with Children in Need and establishes the LA's duty to provide a "range and level of services appropriate to those children's needs".

Section 11 establishes that disabled children (who are established to be "Children in Need" in section 10) includes children with poor mental health

Section 23 (3) (a) of the Children Act 1989 establishes the key duty for a local authority to be "to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption". Health Care Assessments include the requirement for the completion of a "Strength and Difficulties Questionnaire" (initially and as part of the normal review process). This is an important tool for identifying those individuals in need of specialist (Tier 3) support and is (in aggregate) a measure of the performance of the emotional health and wellbeing arrangements across a local authority area.

The Health and Social Care Act 2012 established local health and wellbeing boards, charged with "preparing the joint strategic needs assessment, the joint health and wellbeing strategy and in promoting integrated working between NHS, public health and social care commissioners (Chapter 2)."

Other acts establish specific duties for Local Authorities. In particular there are specific duties relating to emotional health and wellbeing for Children in Care Children and Young People involved with the Youth Justice System (under the Youth Offending Team) and Children in Need.

The Care Act 2014 requires A local authority must establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers (including young carers)

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The Children and Families Act 2014 requires the integration of educational provision and training provision with health care provision and social care provision and the preparation and maintenance of an education, health and care plan to promote the well-being of children or young people in its area who have special educational needs or a disability

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ACRONYMS

BAI	Becks anxiety inventory
BDI	Becks Depression Inventory
BHFT	Berkshire Healthcare Foundation Trust
BP	Boxall profile
CAMHS	Child and adolescent health services
CBT	Cognitive behaviour therapy
CCG	Clinical commissioning group
CGAS	Child global assessment score
CORC	Child outcomes research consortium
CSE	Child sexual exploitation
CYPIAPT	Children and young peoples improving access to psychological therapies
EPDS	Edinburgh Postnatal Depression Score
GP	General Practitioner
HV	Health visitor
IAPT	Improving access to psychological therapies
MH	Mental health
MMQ5	Mindfulness Questionnaire
PIMH	Parental and infant mental health
PND	Post natal depression
SEBDOS	Slough Emotional and Behavioural Outreach Service
SDQ	Strengths and difficulties questionnaire
SN	School nurse

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