Equality Analysis

PURPOSE
Equality Analysis is a best practice method to demonstrate due regard to the general duty under the Equality Act 2010 to eliminate discrimination, advance equality of opportunity and foster good relations between people from different groups.

The purpose of an Equality Analysis (EA) is to examine the extent to which a proposed service change/policy/strategy may impact differently on different members of the community and, where appropriate, prompt the consideration of alternative measures to ensure an equal standard of service is accessible to all

RESPONSIBILITY
Responsibility for compliance with the CCGs public sector equality duty rests with the author’s lead Director. Specialist guidance and support is, however, available from the Policy & Engagement Manager and the Director of Governance & Compliance.

Assessments must be carried out for all policies, strategies and service change proposals. New analysis should start early in the development process and must be carried out in the following circumstances:

• Where a new policy or function is planned
• Where an existing policy or function is to be altered significantly
• Where a function has not been assessed for three years

CONSULTATION & ENGAGEMENT
Please note that early engagement is recommended and in many cases is necessary to develop policies, procedures, strategies or service changes. Completing the EA early in the project cycle i.e. at Project Charter stage will identify the groups that you need to engage with. Please ask the Communications & Engagement Team if you would like some help with finding and meeting particular groups.

INSTRUCTIONS: Insert the following pages once completed into Committee and Governing Body Papers between Front Cover and Main Report to inform decision making. Insert the Summary at the front of all Policies with the Equality Analysis appended.

1 Note: Different impact does not necessarily mean adverse (or negative) impact
2 Meeting the Equality Duty in Policy and Decision-Making England (and non-devolved public authorities in Scotland and Wales) 2014
## SUMMARY OF EQUALITY ANALYSIS for Child & Adolescent Mental Health Services (CAMHS) PROCUREMENT

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Negative Impact YES / NO</th>
<th>Level of Negative Impact HIGH / MEDIUM / LOW</th>
<th>Positive Impact YES / NO</th>
<th>Level of Positive Impact HIGH / MEDIUM / LOW</th>
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<tr>
<td>NAME OF THE STRATEGY / POLICY / GUIDANCE/ SERVICE CHANGE PROPOSAL / PLAN (‘ACTIVITY’)</td>
<td>RE-PROCUREMENT OF CAMHS SERVICES</td>
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<tr>
<td>Who is this ‘activity’ aimed at? Please delete and explain further if relevant.</td>
<td>Patients/Public</td>
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**What are the main aims and objectives of the ‘activity’?**

NHS Guildford & Waverley Clinical Commissioning Group commission child and adolescent mental health services (CAMHS) in Surrey, on behalf of the six CCG collaborative in Surrey. In May 2014 the CCG Collaborative approved project costs and tasked G&W CCG with re-procurement of CAMHS for completion by September 2015.

Through review of national evidence and the local engagement, four additional themes were identified and felt to be valuable additions to the current provision. These are considered by the CAMHS procurement board as priorities to recommend CCGs address but with the awareness that they will require additional investment to achieve the improvements required.

**The key themes from this engagement and for consideration of investment ahead of tendering are:**

1. Raising the age range of CAMHS to 25
2. A county wide pathway for children and young people presenting with emotional and behavioural problems/disorders
3. Counselling: Access to CAMHS for children with mild-moderate mental health issues
4. Children and young people with learning disabilities needing access to CAMHS

**Describe the current situation:**

Surrey has a wide range of services and initiatives seeking to address and promote emotional wellbeing and mental health for children and young people. Many of these are universal services such as health visiting, primary care, schools. The ones under consideration of this procurement relate to specific CAMH services rather than universal services. The majority are commissioned currently from Surrey and Borders Partnership NHS Foundation Trust.

Stakeholders have identified a number of priorities which would be addressed within a new CAMHS service specification that could be cost neutral, assuming bidders remain within the current financial envelope. There are also four thematic areas that could improve outcomes for children and young people but which have significant financial implications: increasing the age of CAMHS from 18 to 25; establishing a
countywide behavioural pathway for children and young people (aged 6-18); improving access to CAMHS for children with mild-moderate anxiety or depression and enhancing services for children with learning disabilities.

Please describe what ENGAGEMENT AND/OR CONSULTATION that has taken place to inform this equality analysis? Consider internal and external routes. If you would like assistance with identifying particular groups to consult with please liaise with the Communications & Engagement team.

NHS Guildford and Waverley CCG led a public engagement between 30\textsuperscript{th} July and 14\textsuperscript{th} October. This provided commissioners with information about current gaps in the service which the recommendations hope to address. The groups involved were from a wide range:

- GP’s, multi-professionals, providers, parents and cares, young people.

Six engagement event workshops were held across Surrey with representatives from the above groups attending. In total, 116 stakeholders attended. 428 stakeholders responded to the online surveys. Stakeholders have a detailed picture on the current needs of children and young people, and how they thought current services were performing to meet that need. They offered ideas that could improve meeting the emotional well-being and mental health needs of children and young people in Surrey.

As a result, an engagement report was written in November 2014 on the findings and this can be accessed on the G&W CCG website:

The following documents were also used to inform this impact assessment:

- A Surrey Emotional Wellbeing and Mental Health Services for Children and Young People Needs Assessment, April 2014
- Surrey County Council Child and Adolescent Mental Health Services (CAMHS) Re-procurement Recommendations Paper

Complete the table below asking “how will this group be affected by this service change proposal/policy/strategy/guidance?”

Does the ‘activity’ have the potential to:

- Have a POSITIVE impact (benefit) on any of the equality or vulnerable groups? Answer YES or NO. If YES please explain (Reasons) and detail amendments.
  - If there is an impact is this HIGH (H), MEDIUM (M) OR LOW (L)? If no impact, insert N/A
- Have a NEGATIVE impact / exclude / discriminate against any of these groups? Answer YES or NO. If YES please explain (Reasons) and detail amendments.
  - If there is an impact is this HIGH (H), MEDIUM (M) OR LOW (L)? If no impact, insert N/A
You must be familiar with what your activity wants to achieve and/or what would result and the corresponding evidence base before being able to complete this assessment comprehensively.

For the different Equality Groups and Vulnerable Communities please make sure you are familiar with the Joint Strategic Needs Assessment and the Health Profile for this CCG.

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<tr>
<th>AGE</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
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Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

There is plenty of evidence suggested in the G&W CCG Engagement Report that raising the age range of CAMHS to 18-25 will have a positive impact on young people aged 18-25

**Engagement data** – The majority of stakeholders who responded to the survey felt that CAMHS should be available 18-25

A **public health report** demonstrated that the transition from childhood to adulthood (usually from age 16 - 25) has a significant psychological impact on a young person. For some young people, adolescence is a time when mental health problems may emerge or become more severe and may lead to a mental health crisis, requiring support and intervention

In 2013/14 49 young people engaged in CAMHS transitioned into to adult mental health services. However an additional 699 young people in that period were recorded as inappropriately referred to adult mental health services on the basis that they did not meet the adults’ threshold.

By raising the age of CAMHS it would hope that those 699 18 year olds could continue receiving support.

**What amendments can be/have been made to the activity in order to eliminate or reduce the adverse impact on different groups?**

In the service description pathway of the service specification, it states that:

- Ensure services are available to all children and young people without regard to gender, sexuality, religion, ethnicity, social, or cultural determinants. However, where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the existing provision.
- Offer children, young people and parents/carers age-appropriate information about their condition and care.
- Ensure that services have age-appropriate physical settings.

The transition from school to adulthood is a time of celebration, change and challenges for all young people. They will be considering and

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3 Public Health, Surrey County Council (2014) – Does the current neuroscience evidence surrounding brain development indicate that extending the age of children’s and adolescents mental health services would provide better mental health outcomes for young people.
making decisions about their career, their continuing education, their social life and where they will live. Most children find ways to adapt successfully to change but some children may be more vulnerable when facing transition and find change much harder to cope with. Vulnerable young people (e.g. young people leaving care; not in education, employment or training or young offenders) will have a significant psychological impact on a young person. For some young people, adolescence is a time when mental health problems may emerge or become more severe and may lead to a mental health crisis, requiring support and intervention\(^4\). It is often the case that not all young people will meet the threshold for the adult community mental health recovery service (CMHRS) or Increased Access to Physiological Therapy (IAPT) services.

Health commissioners are considering increasing investment into the Mindful service. A small resource, which proactively seeks to support young people aged 16-25 years, with emerging-to-moderate mental health difficulties that stop them being able to cope and/or leave them unable to manage other areas of their lives such as relationships, college or employment and who find it difficult or who do not wish to engage with statutory services. In September 2014, Adult Social Care invested an additional £60k into the Care Leavers service to fund a dedicated mental health worker supporting young people leaving care, aged 16-21 (or up to 25 if in full time education). By investing in Mindful it would be possible to extend this resource to many more young people who are care leavers.

**Recommendation: to increase provision for vulnerable 18-25 year olds**

In the Local Quality Standards, the following has been added:

‘There is a robust transition pathway for those service users likely to transition to adult service. Young people have a transition plan in place and agreed prior to transition’.

<table>
<thead>
<tr>
<th>DISABILITY</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
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**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

In 2011 the Government produced its mental health strategy *No health without mental health*\(^1\). The report states that children with medical conditions have a higher incidence of mental illnesses that the average child population. Those children with a physical illness are twice as likely to suffer from emotional or conduct disorders.

Children with developmental delay and learning disabilities have higher levels of mental health morbidity than children without, and are more likely to be admitted to paediatric wards because of a higher prevalence of physical problems.

**Challenges have been raised (complaints, contract queries, MP queries and stakeholder engagement feedback) in regard to where children**

\(^4\) Public Health, Surrey County Council (2014) - Does the current neuroscience evidence surrounding brain development indicate that extending the age of children’s and adolescents mental health services would provide better mental health outcomes for young people.
are referred and seen if they have a significant behavioural difficulty, particularly when they are of school age. This has resulted in some inequity across the county and more importantly children being 'bounced' across the system as current providers challenge whether provision is within their current contract.

This has particularly (but not exclusively) been in regard to children and young people who have/may have conditions such as: Attention Deficit Hyperactivity Disorder (ADHD), Autistic Spectrum Disorder (ASD), Foetal Alcohol Syndrome (FAS) or Conduct Disorders.

The introduction of a county wide behavioural pathway therefore will have a positive impact on children and young people whose disabilities mean they have a significant behavioural difficulty.

The category of children with disabilities includes a range of areas of need. Information from the Department of Work and Pensions (DWP) states there are approximately 800,000 disabled children in the UK (6% of all children).

14% (52,300) of Children in Need (CIN) in England (at 31 March 2013) had a recorded disability. Children with a long-lasting physical illness are twice as likely to suffer from emotional problems or disturbed behaviour12.

Emerson and Hatton (2007) report that 36% of children and young people with learning disabilities (one in three) will have a diagnosable mental health problem compared with 8% of non-disabled children. Children with learning disabilities are:

- 33 times more likely to have an autistic spectrum disorder
- 8 times more likely to have Attention deficit hyperactivity disorder (ADHD)
- 6 times more likely to have a conduct disorder
- 4 times more likely to have an emotional disorder
- 1.7 times more likely to have a depressive disorder

Nearly 8 out of 10 young people with learning disability have experienced bullying

**What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

Young people with learning disabilities have an increased incidence of a wide range of physical and mental health conditions. Children with physical or learning disabilities are more vulnerable to the full range of mental health disorders and the additional social, family and emotional stresses of everyday life.

Parent and young carers play a key role in improving the emotional wellbeing and mental health of those they care for and services need to routinely provide an assessment of their needs in order to support them to continue in their caring role. Increase the resilience of emotional...
wellbeing and mental health in families of children with autism and teenagers through targeted parenting programmes. The recently published draft National CAMHS service specification (2014) clearly defines a model service led by CAMHS for mild, moderate and severe emotional and behavioural disorders that crosses both targeted and specialist CAMHS. It also includes children with significant mental health problems where there is co morbidity with mild/moderate learning disabilities or co morbid physical and mental health problems. From the engagement, CAMHS support for children and young people with autism or a learning disability was seen as a current weakness. From the pooled budget there is only one Primary mental health worker supporting 10 schools. Proposed investment would seek to provide a primary mental health learning disabilities role in each area, with greater links with the Primary mental health roles working with schools and in special schools (2.75 Fulltime equivalents).

**Recommendation: increased investment of primary mental health service targeted working with the learning disability service.**

**Equitability of investment and services for the CAMHS Specialist Learning Disability Service**

<table>
<thead>
<tr>
<th>ETHNICITY / RACE / ETHNIC GROUP</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
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**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

Evidence provided in the 2009 CAMHS HNA showed that the prevalence and presentation of child and adolescent mental health disorders varies between ethnic groups and there was no consistent pattern across subgroups. The 2009 CAMHS HNA also provided evidence that:

- Children of Asian origin have a comparable or slightly lower rate of psychiatric disorder than Caucasian children
- There is a ‘statistically significant bias in relation to the referral route to CAMHS and ethnicity of children’. This results in lower referral rates from black and ethnic minorities compared with white peers

The 2009 CAMHS HNA suggested that specialist training of interpreters and other staff is required for those dealing with families and young people whose first language is not English when delivering psychological treatments.

The 2011 Census provides the most up to date data of percentage of children aged 0 – 15 years in ethnic groups at both national, county and borough and district level. It is not possible to compare the current data with the data in the 2009 CAMHS HNA as the groups differ. In the 2011 Census data, Woking and Epsom and Ewell have the highest percentage of children from minority ethnic groups in Surrey
and Woking has a higher percentage of children from these groups than England, the South East and Surrey.

For children and young people current research on mental health and ethnicity is limited and largely inconclusive. The 2004 *Mental health of children and young people in Great Britain* survey included data on children from minority ethnic groups however the data lacked power and reliability. The trend data from this survey suggested differences in the prevalence of mental disorders between ethnic groups may be ambiguous when data on subgroups is examined due to variation in mediating factors such as socio-economic factors.

There are more than 50 authorised Traveller sites within Surrey. There are 19 public sites – 18 are owned by Surrey County Council and one is owned and managed by Tandridge District Council. Reigate and Banstead do not have a site. Boroughs and districts are responsible for Traveller sites in their area. Surrey has no transit sites.

There are an estimated 1,400 GRT children and young people on role in Surrey schools\(^5\).

It is likely that being a young carer is more common amongst GRT children due to high levels of poor health and disability within the community. National evidence suggests that GRT young people are more likely to experience bullying in schools\(^4\).

<table>
<thead>
<tr>
<th>What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?</th>
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<tbody>
<tr>
<td>There are more than 50 authorised Traveller sites within Surrey. There are 19 public sites – 18 are owned by Surrey County Council and one is owned and managed by Tandridge District Council. Boroughs and districts are responsible for Traveller sites in their area. There are an estimated 1,400 GRT children and young people on role in Surrey schools.</td>
</tr>
<tr>
<td>Gypsy Roma and Traveller children have the worst education outcomes of any ethnic group in the UK. They also have high rates of school exclusion, in Surrey six times higher than the Surrey average(^5).</td>
</tr>
<tr>
<td>Research into the health outcomes of GRT communities indicates these communities have the worst physical health outcomes of any ethnic group in the UK. Gypsy and Traveller communities are believed to have rates of anxiety and depression many times greater than the population average and have higher suicide rate(^6).</td>
</tr>
<tr>
<td>Traveller communities prefer to keep their ethnicity ‘hidden’ due to fear of prejudice and discrimination, health inequalities are influenced by(^7):</td>
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<tr>
<td>• Difficulties with access to services (issues with accessing a GP if the family does not have a permanent address);</td>
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\(^5\) Needs analysis for Surrey’s Gypsy, Roma and Traveller children and young people 2014

\(^6\) Annie Yin-Har Lau and Michael Ridge (2011) Addressing the impact of social exclusion on mental health in Gypsy, Roma, and Traveller communities

\(^7\) Surrey (2014) mental health and emotional wellbeing children and young people’s needs assessment
Lack of follow up and preventative care and screening;
Literacy and communication issues and
Lack of understanding of language used can create a barrier to accessing health provision

Mental health within these communities is stigmatised preventing families to seek help when required. Currently there is no targeted CAMHS provision in place to support this vulnerable group of children and young people. Investment into this vulnerable cohort would seek to establish a designated CAMHS Gypsy Roma Traveller (GRT) liaison service providing outreach and therapeutic intervention. Raise awareness of all professionals of the particular emotional and mental health needs of children from the GRT community.

Recommendation: Consider development of a designated CAMHS Gypsy Roma Traveller (GRT) liaison service to raise awareness of all professionals of the particular needs of children from the GRT community and provide outreach and therapeutic intervention across each of the four areas in Surrey.

To increase referral rates to a more appropriate level from black and ethnic minorities compared with white peers. The role of the Prime Provider for CAMHS will work with, coordinate, capacity build and develop voluntary, community and faith organisations to deliver and respond to emotional and mental health needs as part of the delivery model.

NHS Guildford & Waverley GG and other commissioners have adopted the commissioning principle:

‘No door is a wrong door – no referral for a child or young person will be turned away from advice and direction to support will be given.

A National Quality Requirement is for completion of Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users, as defined in Contract Technical Guidance.

<table>
<thead>
<tr>
<th>GENDER</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: MEDIUM</th>
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</thead>
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Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

No negative impact. But in terms of service offered, girls are more likely to take up talking therapies e.g. counselling, than boys. The provider should look at ways to address this imbalance.

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

To address this reduced uptake of the service from boys, the Provider be expected to offer greater support to schools and colleges to manage mental health needs via Targeted Mental Health in Schools (TaMHS). For example, working with schools to reduce stigma/conduct therapy sessions/counselling in boy-friendly facilities?
Professionals will be offered training to develop alternative ways to engage with boys.

<table>
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<th>GENDER REASSIGNMENT</th>
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**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

Most gender variant children do not seek specialist help but may face discrimination and be vulnerable to bullying and hate crime (Reed et al, 2008)

**What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

The procurement would therefore have a positive impact. The service provider will liaise with schools/colleges/youth/community centres to raise awareness of increased risk of bullying and hate crime and to publicise support available if children/young people are questioning their gender (similar to advertising support for other issues). Other agencies involved will also develop this support.

Professionals will be offered training in this area of need.

<table>
<thead>
<tr>
<th>RELIGION &amp; BELIEFS</th>
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**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

Religion and beliefs can affect how a person or family system or community regards mental illness. Certain religions or beliefs can prevent people seeking appropriate support.

**What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

We would expect the service to recognise children and young people who are becoming radicalised (distortion of a religion) and signpost or provide appropriate care and support, working with other services.

Cultural differences will be taken into account by the Provider, such as offering a same sex worker to see service users who prefer this for cultural and or religious reasons.

The role of the Prime Provider for CAMHS will work with, coordinate, capacity build and develop voluntary, community and faith organisations to deliver and respond to emotional and mental health needs as part of the delivery model.

Improvements in the recording of data will be implemented through this Procurement.
**MARRIAGE & CIVIL PARTNERSHIP**

<table>
<thead>
<tr>
<th>Negative Impact: NO</th>
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<td>Level: LOW</td>
<td>Level: MEDIUM</td>
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**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

Arranged marriages in some cultures may have an impact on mental health.

**What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

The role of the Prime Provider for CAMHS will work with, coordinate, capacity build and develop voluntary, community and faith organisations to deliver and respond to emotional and mental health needs as part of the delivery model.

Improvements in the recording of data will be implemented through this Procurement.

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**PREGNANCY & MATERNITY**

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<th>Negative Impact: NO</th>
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<td>Level: LOW</td>
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**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

Some women experience mental health problems for the first time during pregnancy or childbirth. Other women may have an existing mental illness which may persist, deteriorate or recur during this period of their lives when they can experience intense social, psychological and physical changes that may be part of the pregnancy and/or childbirth itself or as a result of a change in medication.

Mental health problems experienced during this period include anxiety disorders, depression and postnatal psychotic disorders. Whilst the level of risk for many mental health problems is the same for women in the peri-natal period as it is for other adults, the risk for certain mental illnesses is increased: increased risk of developing the illness; increased risk in the illness being more severe; and increased risk of experiencing a recurrence.

Depression is the most common mental health problem during the peri-natal period experienced by 10 – 14% of all mothers nationally. Fathers also suffer depression during the first year of a child’s life; one study suggested 4% of fathers suffered from depression during this period and 20-50% of new fathers with a depressed partner experienced depression.

There is no recent data available at a county level however figures for prevalence in Surrey of peri-natal mental health illnesses were previously calculated using the National Institute for Health and Clinical Excellence (NICE) benchmarking tool.

**What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

It is recognized that infant mental health is a fundamental developmental period, physically, psychologically and socially. Many crucial
structures, processes and functions needed for physical and mental functioning are set up or established during the early years. Experiences during infancy influence the course of all later development. Infant development is complex and involves a process of mutual interaction between the infant and the environment in which they live. Adverse developmental experiences during infancy can become risk factors for later development and social and emotional wellbeing.

Over the last couple of decades, a strong evidence base has emerged which highlights:

- the importance of the early years of a child's life, including the establishment of secure attachments.
- the impact of trauma and parental mental illness on a child's wellbeing.
- the need for interventions that are designed to minimize risk and increase protective factors.
- the need for an integrated approach to the delivery of services provided to high risk infants and families.

**Recommendation:** increase the capacity of the Parent Infant Mental Health (PIMH) service to enable greater early intervention and development of stronger more secure attachments.

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<th>SEXUAL ORIENTATION</th>
<th>Negative Impact: NO</th>
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**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

It is often assumed that LGBT (lesbian, gay, bisexual, transgender) people’s health and well-being needs are the same as their heterosexual counterparts, except for specific needs relating to sexual health. However, this group experience discrimination on a wide range of levels, not least in being treated differently by professionals in the healthcare sector. Often in society, they are subject to violence, verbal abuse and bullying and experience social isolation. This can lead to a range of health problems, such as alcohol and drug abuse, depression, suicide and self-harm, as well as problems around housing and employment.

Negative reactions to a young person’s sexual orientation or gender identity may result in homelessness or housing vulnerability or may exacerbate an existing housing crisis (Albert Kennedy Trust, 2008)

Levels of self-harm and suicide are higher amongst LGBT people than in the wider population (Hunt & Fish, 2008)

Research carried out by the University of Cambridge on behalf of (2012) found that 55% of LGBT pupils in Britain’s secondary schools experience homophobic bullying and the majority have symptoms consistent with depression. Young people said that they often or always experienced negative comments or conduct at school – the highest rate from surveyed European Union (EU) countries. The research, based on a national survey of 1,614 young people, also found that nearly a quarter (23%) of gay young people have attempted to take their
own life, and more than half (56%) have deliberately harmed themselves.

There is very little data on LGBT young people in Surrey.

4,166 LGBT young people aged 11-16 years were identified in Surrey. This document also stated that LGBT young people are more likely to be bullied at school, face barriers in accessing health care and suffer poorer health than the heterosexual population.

The Surrey JSNA Lesbian Gay Bisexual and Transgender chapter stated that young people discover they are lesbian, gay or bisexual or have feelings of being different from the age of 11, but some do not ‘come out’ until later and consequently 11-16 years is a critical period for most LGBT young people. A strong support network can help LGBT young people by improving resilience to the unique pressure they face.

A third of LGBT young people aged 11-16 years who responded to a Surrey based survey had been bullied by a parent. LGBT young people in Surrey continue to feel unable to be open with others about their identity due to fear or personal experience of homophobia and transphobia.

**What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

In the service description pathway of the service specification, it states that:

- Ensure services are available to all children and young people without regard to gender, sexuality, religion, ethnicity, social, or cultural determinants. However, where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the existing provision.

- Offer children, young people and parents/carers age-appropriate information about their condition and care.

- Ensure that services have age-appropriate physical settings.

**NHS Guildford & Waverley GG and other commissioners have adopted the commissioning principle:**

‘No door is a wrong door – no referral for a child or young person will be turned away from advice and direction to support will be given.'
Other categories relevant to CCG’s statutory duty to reduce health inequalities:

<table>
<thead>
<tr>
<th>CARERS</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
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</table>

**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

Increase investment throughout the whole of CAMHS will not only have a positive impact on children and young people but also on their parents/carers.

Engagement data – included the views of many parents and carers. The recommendations in the paper address some of the needs parents and carers have.

Being a young carer can have a severe, significant and long-lasting impact on a young person’s health and wellbeing. The impact of caring can result in physical and mental health impacts such as tiredness and exhaustion, poor diet, interrupted sleep; back injury, stress and trauma. In addition depression, risk of bullying, potentially being disadvantaged at school and at risk behaviours such as self-harm and eating disorders may be a factor.

Conflicts between the young carer and the person being cared may arise, which may lead to feelings of guilt, anger, isolation or being trapped. Young carers are also more likely to suffer traumatic life events such as the death of a parent or sibling.

A 2012 Surrey Young Carers Survey received 265 responses and found that 56% wanted to know about opportunities for the future and nearly 30% wanting to know more about ‘coping methods’ with approx. 18% concerned about bullying.

GPs were highlighted as having a key role in identifying and registering young carers, monitoring their health and signposting them to advice, information and support including ensuring they know they are entitled to a carer’s assessment. GPs and other health professionals can refer the young carer to Surrey Children’s services for an assessment under the Common Assessment Framework. A young carer’s assessment should automatically trigger a community care assessment or review of the person being cared for. Some young carers and their families are reluctant to admit the child’s role as a carer and are fearful of seeking help from social care.

A further Young Carers survey was undertaken in Surrey in 2013 and the key findings included that there are an estimated 14,030 young carers in Surrey (Nottinghamshire University, 2013) with 1,500 young carers (just over 10%) accessing services. *(This is compared to 1,231 young carers known to services in 2009/10).*

Young carers in Surrey feel their physical and emotional health needs are not being recognised or adequately met to give them the best start in life and of the 87 young carers who responded, more than half, (49) said they lived with the person they were caring for, 25 had not registered with their GP as a carer and 32 said their nurse or doctor had not referred them to the Surrey Young Carers Service.
17 said they thought their health had worsened due to their caring role and six (11%) had sustained an injury but over 90% had not sought help from their GP. Stress was the most common health issue respondents said they felt as a result of caring, while 10 carers said they had self-harmed, five had an eating disorder and 15 suffered from depression. 74% were female and 26% male and 86% came from a white British background with 14% from other groups (Surrey BME population approx. 5%)

**What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

More support for parents and carers has been identified as a need in all services and this has been built into the service specifications, in the form of training etc.

From the Local Quality Requirements, the following additions have been added:

- ‘Provider will evidence implementation of the Carer’s Strategy and will maintain a Carers Champion in each community service’.
- ‘Young people have a care plan in place within a week of face to face assessment’
- ‘Care Plan is developed in partnership with children and young people and a copy given to all service users on Care Programme Approach (CYA), with an agreed annual date to review. Subject to exceptions where these are agreed between providers and the co-ordinating commissioner’.
- ‘Service users subject to CPA have an agreed crisis and contingency plan’.

<table>
<thead>
<tr>
<th>AREAS OF DEPRIVATION and GEOGRAPHICAL LOCATION (urban, rural, isolated)</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis</td>
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</table>

When expressed as a percentage of the total number of children living in income deprived households, 10.03% (10.3% IMD 2007) of children in Surrey live in low income households compared with 18.79% (22.4% IMD 2007) in England. This is important as it identifies that Surrey has over 21,200 (18,000 IMD 2007) children living in low income households. The local authority with the largest proportion of children living in low income households is Spelthorne at 15.4% (14.5% IMD 2007) followed by Woking at 12.18% (12.1% IMD 2007).

Free school meals can also be used as a measure of deprivation for children. In the 2009 CAMHS HNA data was provided for the percentage of children eligible for free school meals in 2008 which was 6.49% of children attending state schools. This figure was below the national average of 13.1%. The range for individual schools in Surrey was between 0% and 60%. Elmbridge and Runnymede had the highest percentage of children eligible for free school meals (7.1% and 6.7%) and Epsom and Ewell and Mole Valley the lowest (3.6%).
Young carers spent on average 14 hours per week looking after someone. Two respondents said they were caring 24 hours a day. 62% find it difficult to find time to socialise. 29 people in the survey who said they were caring for someone with a physical disability while 16 looked after someone with mental health issues.

Young carers identified the need for support and information about the condition of the cared for person, free counselling services and time to talk to the doctor/school nurse.

The Interagency Strategy for Young Carers in Surrey 2011-2014 (updated June 2013) has set the following priorities:

- Promoting a positive culture
- Identification of young carers
- Using a whole family interagency approach to assessments and service delivery
- Reducing the number of young people where caring is impacting health and wellbeing; and
- Raising awareness about young carers, their families and their issues

An increased investment will mean a more universal service will be able to be provided county wide. However depending on which CCG’s choose to invest; this could also have a negative effect geographically. Some CAMHS services will not be available in areas of Surrey.

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

Adaption: The Procurement will ensure the Provider recognises areas of deprivation in providing services.

Due to potential inequality in services offered in some CCG areas, it is recommended that CCG’s consider the impact of additional investment.

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<tr>
<th>VULNERABLE GROUPS e.g. ex-military, homeless, looked-after children, those seeking asylum</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: MEDIUM</th>
</tr>
</thead>
</table>

Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

Looked After Children (LAC)

Children looked after, have often sustained significant levels of abuse and neglect connected with substance misuse, low socio- economic income and domestic abuse. Mental health is often a factor in families which experience these issues. As a result, looked after children are 4-5 times more likely to struggle with mental health issues than their peers and there is a clear correlation between a failure to resolve these
problems and poor educational attainment, unemployment, and criminality among care leavers⁸.

SCC and the Surrey CCG Collaborative commission 3Cs, there is growing demand from social work area teams to work with children and young people on interim care orders. There is also demand for young people placed out of county (within a 20 mile radius) to receive support within CAMHS. For children and young people in an out of county placement who require CAMHS, the Responsible Commissioner guidance should be implemented. However not all areas have a dedicated service for children in care, nor is it a requirement for the local CAMHS provider to see a child placed out of county. If the local CAMHS provider does agree, the child/young person is unlikely to be prioritised and could wait up to 18 weeks.

**Refugees and asylum seekers**

The general practice in Surrey is for Unaccompanied Asylum Seeking Children (UASC) to be ‘looked after children’. There is no longer an UASC team in Surrey. Some will inevitably have health issues but these are not recorded and information may only be available through individual files. The first review is held within a month of placement, invariably foster placements or semi-independent in a shared house. The second review is three months on when referral may be made for counselling, however emotional wellbeing and mental health are alien concepts to many children e.g. Afghani boys and Eritreans, so identifying and meeting needs is challenging. The Refugee Council offers an assessment service through solicitors for trauma.

There is an average of 8 new UASC per month although this number will fluctuate dependent on the situation and conflict in different parts of the world. The number of UASC decreased slightly between 2009 and 2012 but has increased in 2013 to 78 by October 2013. This is due in part to young people arriving in the UK from Syria. The 2009 needs assessment identified 81 UASC in care as more detailed estimates for Surrey were not available. Of the 840 Looked after Children in Surrey, 83 were UASC at 18.11.2013

**Homeless**

Data on families with children living in temporary accommodation was not available when the 2009 CAMHS HNA was published. The Government currently publish a range of datasets on homeless people including the number of families with children living in bed and breakfast accommodation for more than six weeks (excluding those pending review) by local authority. As of 31 December 2012 a total of 21 families were living in bed and breakfast accommodation for more than six weeks. The majority of these families were living in Epsom and Ewell, Reigate and Banstead and Surrey Heath (5 in each borough). Five local authorities did not have any families living in bed and breakfast accommodation for more than 6 weeks however it is not possible to deduce from the data whether they had families living in this type of accommodation for a shorter period.

Children from homeless families have many barriers to accessing services the main issue being their mobility between different and health and care sectors. They are less likely to be registered with a general practitioner and this reduces access to health at primary and

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⁸ Couldn’t Care less (2007) – The Centre for Social Justice
secondary levels and for prevention initiatives. Homeless children are likely to be out of school and they miss out the social stability school provides by mixing peers, routines and a sense of achievement all important protective factors for mental wellbeing.

Children from Armed-Forces Families

In 2011 the government published the Armed Forces Covenant which set out the relationship between the nation, the state and the armed forces based on the premise that the whole nation has a moral obligation to members of the armed forces and their families and establishing how they should expect to be treated. In 2012 Surrey signed a community covenant which is a voluntary statement of mutual support between the civilian community and the local Armed Forces Community. A health needs assessment of the Surrey based Armed Forces, their families and veterans (AFCHNA) was carried out to support the Community Covenant58; the report is published on Surrey-i. The AFCHNA includes information on the mental health of the Armed Forces personnel, military veterans and military families.

The prevalence of mental disorders for Armed Forces personnel and veterans is similar and is broadly similar to the general population. Studies have shown the most common mental disorders experienced by military veterans are alcohol problems, depression and anxiety disorders. The AFCHNA suggests that whilst the mental health of veterans is broadly similar to the general population their level of reported alcohol abuse is over twice that of the general population. Data is not collected at a Surrey level on the number of veterans accessing alcohol or drug treatment services.

Deployment of Armed Forces personnel leads to increased levels of stress, anxiety and depression for their wives and partners. A study reported that spouses of deployed military personnel had significantly increased rates of psychiatric diagnoses compared to spouses of those who had not deployed. The prevalence of reported depression, anxiety disorders, sleep disorders, acute stress reaction and adjustment disorders were also found to be higher. Factors, such as being pregnant or already having children, have also been associated with increased levels of reported stress.

A recent report by the Centre for Mental Health (CMH) looked at the practical initiatives required to support service families including health care initiatives. The report concluded that further support is required by families to deal with the impact of mental health problems and the impact of alcohol misuse and domestic abuse.

A study is currently being undertaken by Kings College London examining the mental health outcomes of military children aged between 3 – 16 years59.

There are issues on discharge as will have previously received military provision. Post Traumatic Stress Disorder (PTSD) has significant implications for the whole family so CAMHS involvement needs to have a family focus. There are referrals from boarding schools (Royal Alexandra and Albert & Gordon’s) and Adult Mental Health services have referrals from Nepalese and Ghurka families. There is schools funding for military families with pastoral services in some sites e.g. Pirbright.
What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

Recommendation: to increase capacity of 3Cs to work with children and young people on interim care orders and to provide a service to those children looked after placed in neighbouring authorities.

As a result of Procurement, more investment will go into the Mindful Service, which is specifically for vulnerable young people who do not meet Adult criteria.

Providers will provide interpreters where appropriate for all services.

**For Looked after children:**

From the Local Quality Requirements, the following additions have been added:

- ‘Provider will evidence implementation of the Carer’s Strategy and will maintain a Carers Champion in each community service’.
- ‘Young people have a care plan in place within a week of face to face assessment’
- ‘Care Plan is developed in partnership with children and young people and a copy given to all service users on Care Programme Approach (CPA), with an agreed annual date to review. Subject to exceptions where these are agreed between providers and the co-ordinating commissioner’.
- ‘Service users subject to CPA have an agreed crisis and contingency plan’.

**We would expect the Provider to work with substance misuse and domestic abuse services to support service users.** This recommendation is included in each service specification.

**In the service description pathway of the service specification, it states that:**

- Ensure services are available to all children and young people without regard to gender, sexuality, religion, ethnicity, social, or cultural determinants. However, where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the existing provision.
- Offer children, young people and parents/carers age-appropriate information about their condition and care.

Ensure that services have age-appropriate physical settings.

**CONCLUSION: What is your overall assessment regarding the equality impact of this activity?**

Overall the increased investment will have a highly positive impact on the mental health services available for the above groups within Surrey. However, there will be inequity if different CCGs choose not to provide additional investment. This EA has illustrated the equality
groups and vulnerable groups that could be affected.

**RECOMMENDATIONS: What steps, if any, should be taken to ensure the activity does not have an adverse impact?**

The recommendations outlined above for each equality group should be implemented. The additional investment that each CCG contributes to the Services should be considered in light of the geographical inequality differences outlined above. This would mean that some service users in the geographical areas where their CCG has additionally invested may have access to a better service.

Several of the recommendations above have Quality Standard requirements/reporting requirements written into the contract, which means the Provider has to ensure it meets the requirements.

**Once implemented, how do you intend to monitor the actual equality impact of this activity?**

Include the CAMHS Service in an Equality Delivery System Review with the Provider, 1 year after contract start. The Provider will also be monitored at monthly contract review meetings. There will be close monitoring of their abidance to the service specifications, quality standards and reporting requirements. All of these have been amended in order to eliminate/reduce adverse impact on different community groups.

<table>
<thead>
<tr>
<th>Name of person completing EA: Caroline Bedford</th>
<th>Job Title: CAMHS Assistant Project Lead</th>
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<table>
<thead>
<tr>
<th>Name of lead Manager / Director: Sarah Parker</th>
<th>Signature:</th>
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Date completed: 13.07.2015