

**Emotional Wellbeing and Mental Health Needs
Assessment 2013
*Lambeth and Southwark***

Everybody's business

Public Health Lambeth and Southwark

Introduction

- National policy emphasises that emotional wellbeing and mental health are everybody's business
- As about 50% of lifetime mental health disorders (excluding dementia) start by 14 years old and 75% by 24, prevention and early intervention are critical
- This needs assessment (NA) covers Lambeth and Southwark boroughs and was overseen by a stakeholders group. It aims to inform the commissioning strategies of the two boroughs and partner agencies
- A public health approach has been followed, based on:
 - literature review and best practice
 - epidemiology and activity data
 - stakeholder consultation
 - lifecourse and care pathways perspective
 - equity and health inequalities

Epidemiology

Prevalence of mental disorders

5- 16 year olds

- No local surveys of mental disorders – based on national data
- Higher in boys than girls (11.4% vs 7.8% aged 5-16 – any mental disorder)
- Increases with age 7.7% of 5-10 year olds vs 11.5% of 11-16 year olds
- Estimates vary for prevalence in under 5s but consensus similar to older children

Estimated number (%) of children and young people with mental disorders

| | Prevalence (5-10 yrs, 11-16 yrs) | | Lambeth | Southwark |
|-----------------------------------|-------------------------------------|-------|---------|-----------|
| Any mental health disorder | 7.7%, | 11.5% | 3,472 | 3,412 |
| Conduct disorder | 4.9%, | 6.6% | 2,036 | 2,070 |
| Emotional disorder | 2.4%, | 5.0% | 1,339 | 1,326 |
| Hyperkinetic disorder | 1.6%, | 1.4% | 555 | 543 |
| Less common disorders | 1.3%, | 1.4% | 497 | 487 |

Epidemiology

16 and 17 year olds

- Higher rates than in younger children
- Often higher in girls than boys
- Common mental disorder: 11.9% ♂ (male), 21% ♀ (female)
- Eating disorder
 - 1.7%♂, 5.4% ♀(all diagnostic criteria)
 - 6.1% ♂ , 20.3% ♀ (some criteria)
- Psychotic disorder: 0.0% ♂, 0.4% females – not local picture at all
- Post traumatic stress disorder (PTSD): 5.1% ♂, 4.2% ♀

| Condition | Lambeth | | Southwark | |
|-----------------------------------|----------|-----------|-----------|-----------|
| | No. Boys | No. Girls | No. Boys | No. Girls |
| ADHD (4/6 of criteria 13.8% pop.) | 374 | 387 | 380 | 412 |
| PTSD | 138 | 118 | 140 | 126 |
| Common mental disorder | 322 | 589 | 327 | 628 |
| Psychotic disorder | 0 | 11 | 0 | 12 |
| Eating disorder | 46 | 152 | 47 | 161 |

Epidemiology – other disorders

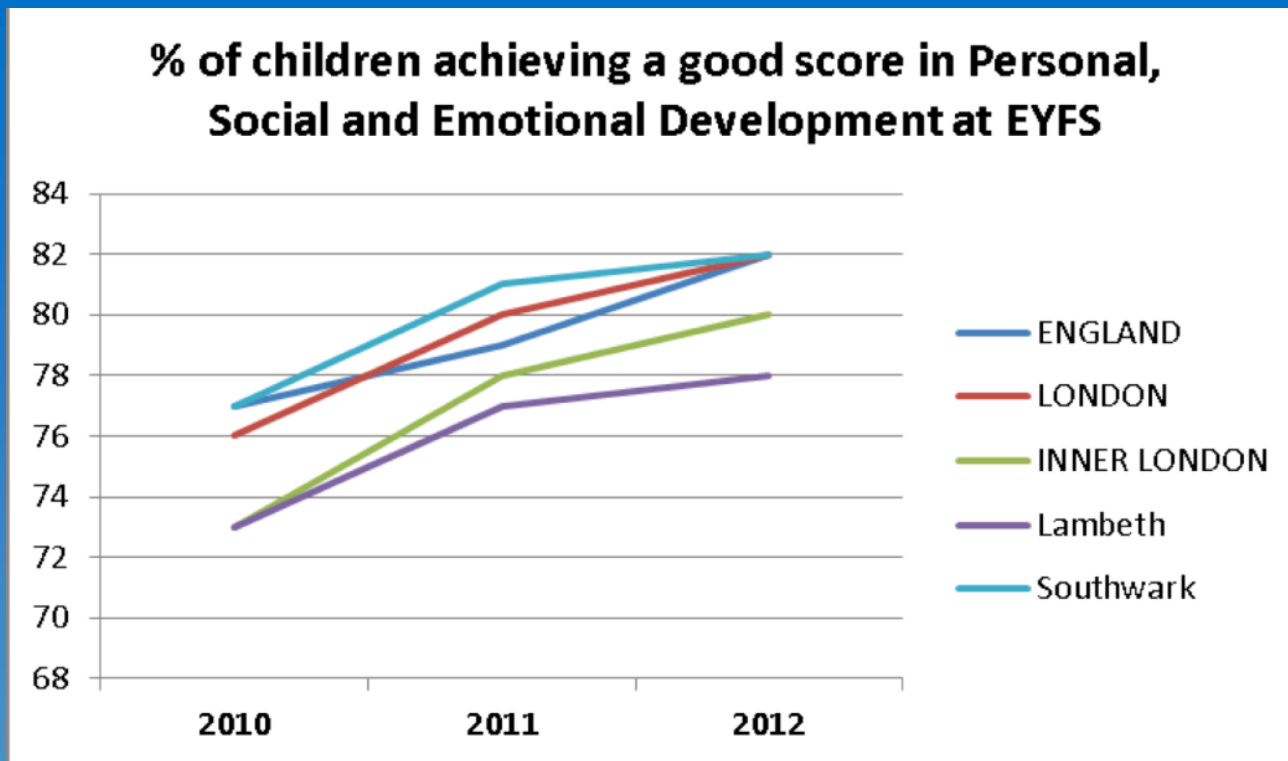
- Estimates for autism and autistic spectrum disorder vary:
 - Autism 0.39%
 - ASDs 0.77% -1.57%
- Internationally, trend for greater reported prevalence over time (?greater recognition and/or true increase)
- ADHD
 - Under 10 years 3-6%
 - Teenagers 2-4%
- Perinatal MH:

National estimates suggest

 - 0.2% post partum psychosis,
 - 3% post traumatic stress disorder (6% post caesarean);
 - 15-30% adjustment disorder
 - In 2009 at booking 12% of women at St Thomas's disclosed a mental disorder to the midwife (prevalence more likely to be upper end of national range of 13.2-18.2%)

Epidemiology-Wellbeing

Early Years Foundation Stage



- Results from a progress check on all aged 2 years
- Nationally and locally the percentage of children with a good PSE score at age 2 has increased since 2010
- Southwark: 82% in 2012 achieved a good score; Lambeth 78%

Epidemiology...

Self harm

- Increasing since 2006
- 2011 29 admissions per year per borough

Ethnicity

- National data found few ethnic differences in prevalence
- Compared to children of white ethnicity, children from Indian or Pakistani backgrounds were less likely to have conduct disorders (OR 0.02-0.96)

LAC

- L & S have higher rates of LAC than England >80 per 10,000 child population vs <60 (2011-12)
- LAC have much higher rates of mental health disorders than general child population (45% vs 10%)
- SDQ scores of concern (2012): 43% Lambeth vs 37% Southwark and 36% England

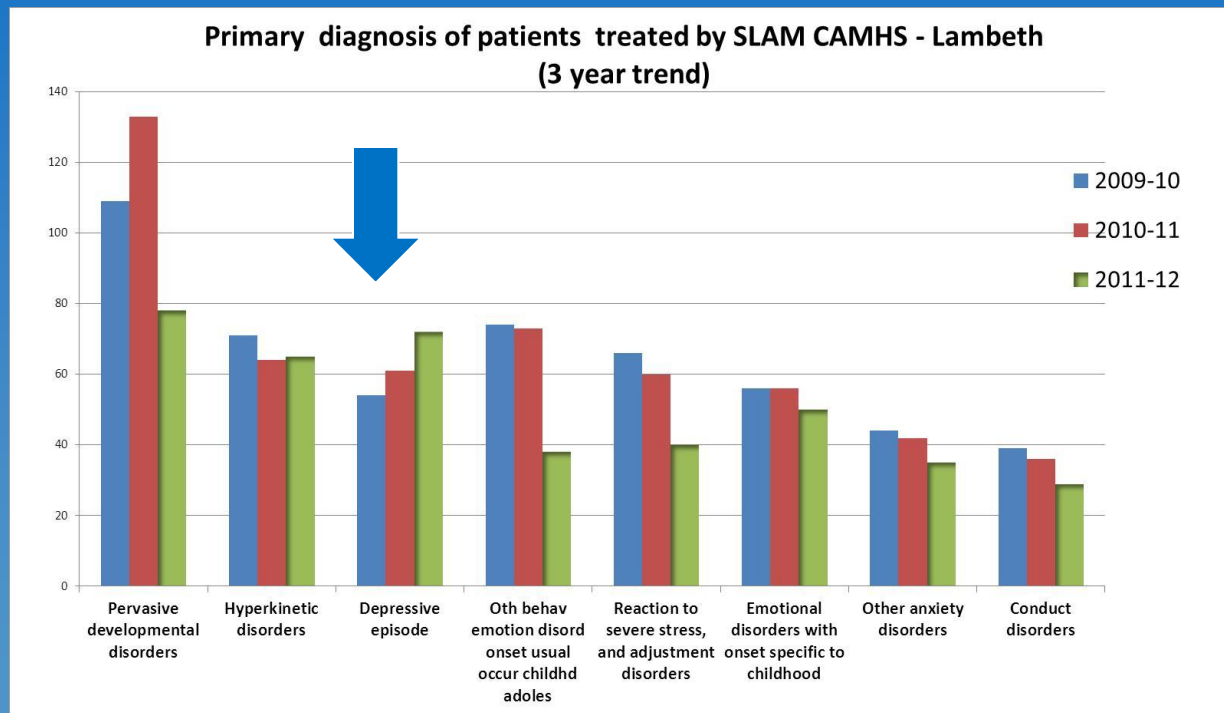
Youth Offending

- Lambeth and Southwark have higher rates than London and England
- UK study found 31% of YP in youth justice system had mental health needs

Service Activity – Lambeth

Top 10 diagnoses

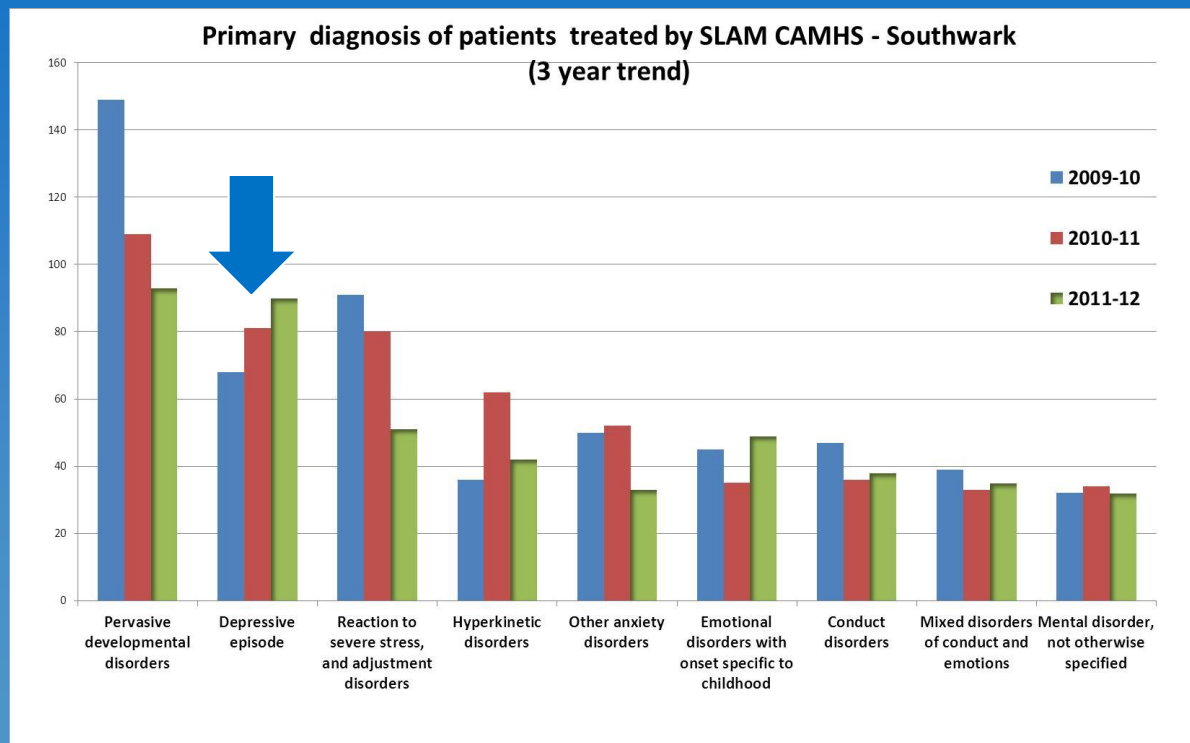
- In 2011-12 45% no diagnosis recorded
- Total no. seen falling
- 2009-10 – 1588
- 2010-11 – 1433
- 2011-12 – 1079
- ↑ Depressive episodes
- Other diagnoses ↓



Service Activity Southwark

Top 10 diagnoses

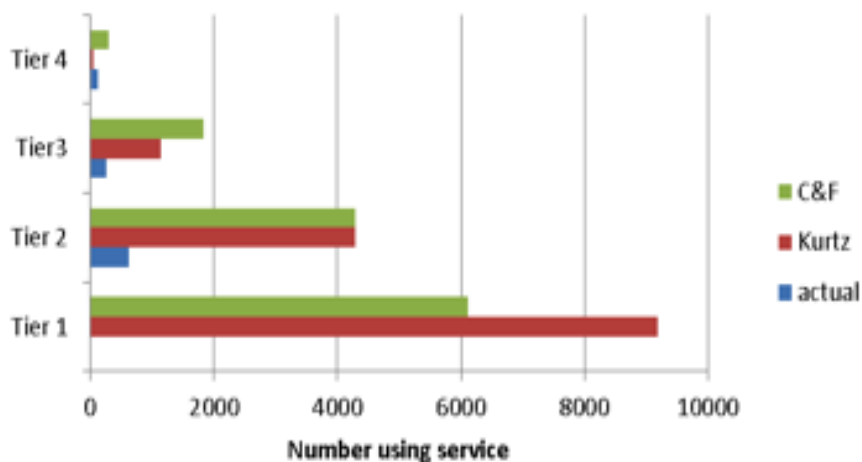
- In 2011-12 57% no diagnosis recorded
- Total no. seen falling
- 2009-10 – 1844
- 2010-11 – 1743
- 2011-12 – 1434
- ↑ Depressive episodes
- ↓ Other diagnoses



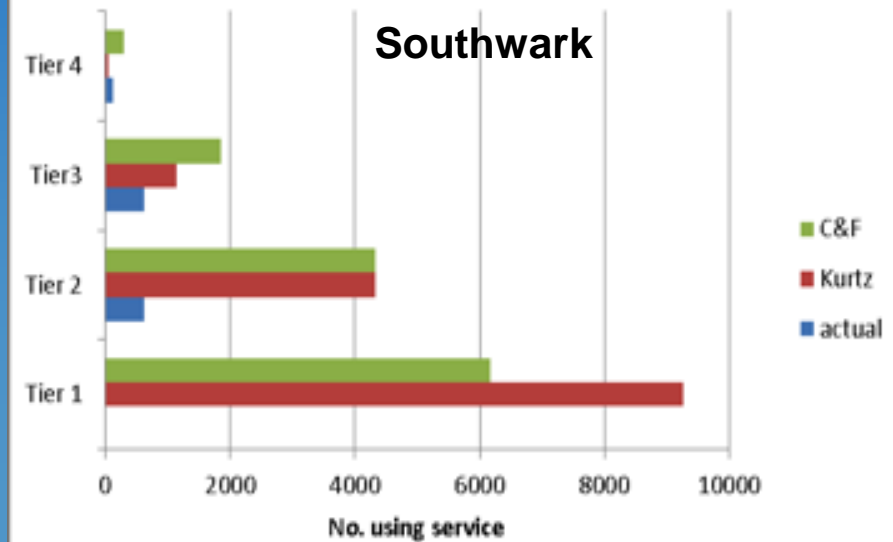
Service Activity Seen vs Expected – crude modelling

- Predicted need based on published models using national data
- Activity much lower than predicted need, esp Tier 2 (no data for Tier 1)
- Overall 17% of predicted need met in Lambeth and 23% in Southwark (national/international benchmarking suggests 25% - 40%)

Lambeth



Southwark



General (acute) hospital admissions for MH

- Hospital admissions increase steeply after age 14 particularly Lambeth ♂ 20-24 years
 - Mental and behavioural disorders due to alcohol (142/708, 20%)
 - Paranoid schizophrenia (100/708, 14%)

Stakeholder Interviews – Clinicians, Specialists and PCT Representatives

Working well in the borough

- Co-location of CAMHS workers with other services
 - Value input, expertise, skilling up of other professionals
- TAHMS
- Targeted, Specialist and Acute services great once child is referred
- Carelink
- School commissioned talking, play, art therapy
- Charities e.g. Kids Company* (Southwark), Building Bridges
- Children's Centres
- Adult service for parents of young children (S)
- YOS service re sexual exploitation (S)
- Perinatal psychiatry (need more capacity though)

Challenges in borough

- Capacity constraints (Schools, Lambeth)
- Specific services needed:
- More family link workers for schools
- More MH support in schools (ring-fence school £) – evaluation of outcomes
- Intensive long term work with LAC
- Child health assessment
- Services for adolescents particularly Asperger's, Autism, ASD
- Counselling service for parents (L)
- Earlier intervention – build on early years framework, engage with more vulnerable parents, attachment building in antenatal / post natal classes,
- Communications from CAMHS too slow
 - Need feedback on referrals and outcomes
- Quality of CAF referral
- Variable quality voluntary sector provision (L)

Stakeholder Interviews – Clinicians, Specialists and PCT Representatives

How to improve services

Rethinking services and delivery

- Client-centered – child not diagnosis,
- Innovative ways of working,
- Review current service offer
- More outreach, particularly re gangs
- Swift response in crisis / window of opportunity
- Review referral thresholds
 - improve access at lower level of need e.g. CBT for sub tier 2 need
- Manage risk by screening e.g. children of parents with MH issues, children who have experienced significant loss

Joint strategic analysis by children's and adults services

Multiagency working

- Improve Joint systematic ways of working e.g. forums for understanding role of other professionals
- Co-location of services

Improving mental health of C&YP

- Reduce stigma about MH, rebadge as wellbeing / part of holistic health approach, education of public,
- Address diversity imbalance between professionals and clients – recruiting outreach worker from local communities - peer education and coproduction of mental health
- Tackle social and economic problems
- Improve uptake of nursery places for 3 year olds.
- Challenge expectations of life story ending in school exclusion / prison (also rehab, unemployment, A&E)
- Educational achievement improves resilience , get parents into child achievement, get children and young people to find things they are good at / enjoy

Limitations – the main ones encountered

Information and data:

- >50% MH cases had a diagnosis, limiting analysis but due to nature of MH
- Better recording of YOS activity (Southwark) and learning disability (both boroughs)
- Outcomes data reporting needed at individual level
- Little information on:
 - parental risk factors
 - Rejected referrals
 - Systematic patient feedback

Areas with limited coverage:

- User/public consultation (some local survey findings used)
- Troubled Families initiative
- Adopting parents
- Learning difficulties/physical disability

Effectiveness: key examples

- National Strategies support early intervention and prevention
- Family Nurse Partnership has well-evidenced long term benefits
- Parenting Programmes (0-3years)
 - Some evidence to support improvement, but not primary prevention of emotional and behavioural problems
- Whole school approach e.g. SEAL
 - Primary teachers trained to manage behaviour, train parents and improve social skills improve MH, bullying and violence outcomes
 - Secondary: conflict resolution training, peer mediation, parental involvement
- Perinatal – MH screening in pregnancy (NICE guidance)
- TAMHS – reduced behavioural problems in primary pupils
 - no effect on emotional difficulties in 1 or 2° pupils
- Parental MH / Substance misuse – wide range of interventions effective in preventing mental disorders in children
- LAC – Treatment Foster Care (family based) effects positive changes

Effectiveness – specialist interventions (12-17 yrs)

- CBT or Behavioural Therapy for OCD – appears effective
- Depression – not enough evidence on relative effectiveness of medication vs psychological therapy
- Psychosis- NICE recommends not prescribing antipsychotics for prevention / delay
 - More research needed on dietary, psychological and psychosocial interventions
- Eating Disorders – at 6-12 months follow up family based treatment better than individual therapy for AN and BN
- Conduct disorder: range of interventions e.g:
 - Group parent / carer training programmes (3-11 year olds)
 - Selective prevention classroom based (3-7 year olds)
 - Multi-modal interventions e.g. MST (11-17 year olds)
 - Initial costs offset by savings to e.g NHS/LA/Criminal justice

Discussion – main issues

- Fewer (17% L, 23% S) children seen than estimated to need MH services esp. younger children
- Strategic shift needed:
 - Prevention/early intervention (but keep current acute needs met)
 - “Everybody’s business” i.e. use other services/commissioning (GPs, Health Visiting, School nurses, Schools etc)
- Many preventative programmes delivered through classroom but no formal mechanism to influence provision in schools
- Widen focus to support well-being, not just treating mental disorder
- Little collated information about wider services which may help keep children and young people out of CAMHS

Discussion...

- CAMHS specialist knowledge seen as valuable for consultancy and training of wider workforce, but takes time away from treating
- Vulnerable groups:
 - Unmet need in LAC and YOS
 - No specific information on SEN/CWD

Main limitations

- Data limitations as discussed earlier
- Little systematic patient feedback
- NA did not directly contact service users or CYP
- Little collated information about universal services' work
- Other vulnerable groups e.g Aspergers, gang-connected, particularly girls

Recommendations

1. Develop a comprehensive strategy for each borough over several years

- a) To develop more prevention and early intervention services
- b) To identify unmet need esp in young children
- c) To incorporate partner agencies including universal services such as GPs, community health services i.e. “Everybody’s business”

2. Service Provision

- a) Mapping of provision in tier 1 services to identify gaps in effective interventions
- b) Consider extending CAMHS beyond 18yrs and develop joint commissioning with adults
- c) Improve CAMHS colocation/shared care with other services
- d) Provide schools with quality assurance guidelines to support evidence-based commissioning and encouraging schools to jointly commission
- e) Develop specific interventions:
 - a) scale up and ensure quality of parenting and
 - b) more conduct disorders work including MST
 - c) perinatal MH screening and specialist care

3. Information, monitoring and performance management

- a) Improve data collection in primary care
- b) Improve SLAM data recording e.g. YOS Southwark clients to be flagged to facilitate equity analysis

Recommendations...

- c) Address knowledge gaps e.g. disabilities, SEN
- d) Agree with providers to have regular audit including:
 - Outcomes of treatment and rejected referrals
 - User feedback
 - Tier 4 referrals which do not go via CAF/triage

4. Health promotion and communication

- a) Health promotion work by wider workforce to include child and adolescent mental wellbeing and to tackle stigma associated with mental health diagnoses as well as promoting well being and life skills not mental illness
- b) Develop communication resources on MH services available for schools and other stakeholders with information on e.g. when/who to refer/alternative advice

5. Equalities and community engagement

- a) Develop programme of work with community groups/young carers etc
- b) Increase specific identification of children who go undetected e.g.
 - YOS - ensure repeat ASSET assessments done, include CAMHS worker in fortnightly case worker discussions

Recommendations...

6. Training/workforce development e.g. MH First Aid

- a) Develop universal staff such as schools nurse, health visitors and midwives and vol sector to include wellbeing and early identification of mental health disorders e.g. in parents
- b) Review the formally commissioned training and opportunities for non-mental health professionals working in wider children's services

7. Consider Joint Commissioning across L & S

Principles:

- Areas which are new work for both boroughs
- Areas which require highly specialised clinicians, but numbers of children/young people from each borough are small
- Areas which one borough has developed particular services/expertise more than the other