Mental health and wellbeing in Kensington and Chelsea, and Westminster

Joint Strategic Needs Assessment (JSNA) Report

Full Report

2019

www.jsna.info

This report

This report responds to a recommendation in 'The Roads to Wellbeing'[1], the annual report of the Director of Public Health, to undertake a needs assessment of mental health and wellbeing in Kensington and Chelsea, and Westminster. It has been undertaken to inform and support strategy development, commissioning decision making, and action planning to improve mental health and wellbeing and reduce inequalities across the Bi-borough area.

It specifically aims to:

- Gather and collate evidence which allows us to obtain a comprehensive understanding of the mental health and wellbeing landscape within our communities
- Understand how poor mental health and wellbeing affects our local health and social care economy
- Identify specific strengths and gaps in our current services, and any particularly 'at-risk' groups
- Identify best practice in this field
- Recommend priority areas for action

Data has been drawn from a number of sources including population level data analysis, local service data, national and local research and literature, and service user feedback.

Authors and contributors

This report was written by Colin Brodie, Katie Clare, Elizabeth Dunsford, Katie Hodges, Clare Lyons-Amos, Annie McKirdy, Charlotte Marro, and Katherine Reid.

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Concia Albert, One Westminster
Senel Arkut, Bi-borough Adult Social Care and Health
Mike Booker, Central and North West London NHS Foundation Trust (CNWL)
Simon Brauner-Cave, Central London Clinical Commissioning Group
Olivia Clymer, Healthwatch
Jonathan Daly, Bi-borough Integrated Commissioning Unit
Eamann Devlin, Bi-borough Integrated Commissioning Unit

[1] Bi-borough Public Health Department. The Roads to Wellbeing https://www.jsna.info/aphr201617

Gaynor Driscoll, Bi-borough Public Health
Dr Jo Emmanuel, CNWL
Julie Ely, Bi-borough Childrens Services
Isabel Fernandez-Grandon, Central London Clinical Commissioning Group
Mary Fotheringham, Kensington and Chelsea MIND
Shazia Ghani, Bi-borough Integrated Commissioning
Rob Holman, Central London Clinical Commissioning Group
Janice Horsman, Westminster MIND
Andrew Howe, Bi-borough Public Health
John Hughes, CNWL
Amanda McGlennon, Central London Clinical Commissioning Group
Jeremy Monsen, Principal Educational Psychologist, RBKC
Jim O'Donnell, CNWL
David Scoffield, Kensington and Chelsea MIND
Ann Sheridan, CNWL
Syena Skinner, CNWL
Claire Symons, CNWL
David Thomas, Bi-borough Integrated Commissioning
Simon Thompson, Brent, Wandsworth and Westminster MIND
Hayley Turner, Kensington and Chelsea Social Council
Jane Wheeler, West London Clinical Commissioning Group

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Glossary

Adjustment disorder – A mental disorder characterised by poor adaption to identifiable stressful life events, such as divorce, loss of job, physical illness, or natural disaster; this diagnosis assumes that the condition will remit when the stress ceases or when the patient adapts to the situation.

Adverse childhood experiences – A range of stressful or traumatic experiences that affect children whilst they are growing up.

Antenatal – Occurring before birth; during or relating to pregnancy.

Anxiety - Anxiety is defined as generalised and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances. The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, light-headedness, palpitations, dizziness, and discomfort.

Behavioural disorder - A disorder characterized by displayed behaviours over a long period of time which significantly deviate from socially acceptable norms for a person's age and situation

Bi-polar disorder - Bipolar disorder is defined as a condition that is characterised by repeated episodes in which someone's mood and activity levels are significantly disturbed, with some occasions of an elevation of mood and increased energy and activity (mania or hypomania), and on others of a lowering of mood and decreased energy and activity (depression).

Care plan – A plan, preferably drawn up with the service user, setting out their integrated health and social care needs and how the package of care meets them. Service users should be given a copy of their care plan and it should be reviewed regularly.

Child protection plan – Local authorities draw up a child protection plan to set out how to keep the child safe, how things cans be made better for the family and what support they will need.

Cluster suicides - A chain of completed suicides, usually among adolescents, in a discrete period of time and area, which have a 'contagious' element.

Cognitive function - Intellectual process by which one becomes aware of, perceives, or comprehends ideas. It involves all aspects of perception, thinking, reasoning, and remembering.

Cognitive impairment – The loss of intellectual function.

Common mental disorders – Mental disorders characterised by a variety of symptoms such as fatigue and sleep problems, forgetfulness and concentration difficulties, irritability, worry, panic, hopelessness, and obsessions and compulsions, which present to such a degree that they cause problems with daily activities and distress. For example depression and anxiety.

Community resilience – Communities, businesses, and individuals are empowered to harness local resources and expertise to help themselves and their communities to: 1) Prepare, respond and recover from disruptive challenges. 2) Plan and adapt to long term social and environmental changes to ensure their future prosperity and resilience.

Dementia - Overall term that describes a group of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities. Frequently characterised by memory disorders, personality changes and impaired reasoning.

Dementia friendly communities – A city, town or village where people with dementia are understood, respected and supported. In a dementia-friendly community people will be aware of and understand dementia, so that people with dementia can continue to live in the way they want to and in the community they choose.

Depression - Depression is characterised by a lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common.

Dual diagnosis - When a person is diagnosed as suffering from a mental illness alongside an alcohol or drug problem.

Emotional disorders – Category of disorders which includes a range of anxiety and depressive disorders that manifest themselves in fear, sadness, and low self-esteem.

Holistic approach - Taking into consideration as much about a person as possible in the treatment of an illness, including their physical, emotional, psychological, spiritual, and social needs.

Loneliness - Subjective feeling occurring when there is a perceptual gap between actual and desired social relationships.

Looked after children – A child is looked after by a local authority if the court has granted a care order or has been in their care for more than 24 hours.

Mental health – A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Mental health issues – Broad term which goes beyond a diagnosed mental illness to include factors, challenges and consequences that impact on mental health.

Mental illness – A medically diagnosed mental health condition, problem or disorder which includes both mild and moderate forms of mental illness, to severe mental illness.

Mental wellbeing - Mental wellbeing covers the positive end of mental health covering both the 'feeling good' and 'functioning well' components. Feeling good is subjective and embraces happiness, life satisfaction and other positive affective states. Functioning well embraces the components of psychological wellbeing (self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and environmental mastery).

Perinatal – Occurring immediately before and after birth.

Personality disorder - Personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, is stable over time, and leads to distress or impairment.

Postnatal depression – A mood disorder that begins after childbirth and usually lasts beyond six weeks.

Postpartum psychosis – A rare but serious mental health issue which affects a woman soon after birth. Symptoms can include high mood (mania), depression, confusion, hallucinations and delusions

Psychosis – A disturbance in thinking and perception that is severe enough to distort the person's perception of the world and their relationship to events within it.

Psychosocial - Involving both psychological and social aspects; for example, age, education, marital and related aspects of a person's history.

Recovery based model – A model of care which supports people on their personal journey towards a meaningful and satisfying life, where hope, opportunity and choice are key elements.

Social isolation – A sociological category relating to imposed isolation from normal social networks.

Social prescribing - A means of enabling GPs, nurses and other primary care professionals to refer people to a range of community, non-clinical services which aim to improve health and well-being.

Substance misuse – A patterned use of a drug which the user consumers in amounts or with methods which are harmful to themselves or others. The misused drug can be both illegal or legal, such as alcohol.

Abbreviations

ASC - Adult social care

AMHS – Adult mental health service

BFST - Behavioural family support team

CAMHS - Children and adolescent mental health services

CBT - Cognitive behavioural therapy

CCG - Clinical commissioning group

CHRT – Crisis resolution home treatment

CLCCG - Central London CCG

CNWL - Central and North West London NHS Foundation Trust

CPA - Care programme approach

CPD – Continuing professional development

CPN - Community psychiatric nurse

CTO - Community treatment order

CYP – Children and young people

DNA - Did not attend

EIS - Early intervention service

EWMH – Emotional wellbeing and mental health

FNP - Family nurse partnership

GAD7 - Generalised anxiety disorder assessment

HTT – Home treatment team

IAPT - Improving access to psychological therapy

IMHA - Independent mental health advocate

LAS - London ambulance service

LTC - Long term condition

NICE – National Institute for health and care excellence

PCLN – Primary care liaison nurse

PHQ – Patient health questionnaire

PMHW – Primary mental health worker

PTSD - Post traumatic stress disorder

RSL - Registered social landlords

SMART - St Mary Abbots Rehabilitation and Training

SPA - Single point of access

SROI - Social return on investment

TAF – Team around the family

WLCCG - West London CCG

YOT - Youth offending team

1 Recommendation and themes

1.1 Key Recommendation

In order to drive continuous improvement in the mental health and wellbeing of the local population, the Health and Wellbeing Board should ensure that there is a formal mechanism in place to address the themes identified in this JSNA. To promote collaboration and coproduction across the mental health and wellbeing economy this should take the form of a multi-agency partnership. This partnership will provide assurance to the Health and Wellbeing Board that the themes are being addressed in a coordinated manner, and will:

- Develop a framework to identify and map current work programmes that are addressing these themes
- Use this framework to inform progress against these themes
- Ensure that local strategies and delivery plans take account of these themes and the findings of this JSNA
- Identify further opportunities for joint working and collaboration to improve the mental health and wellbeing of the local population
- Identify and report on emerging challenges and risks as they arise and consider how these should be addressed
- Identify innovation and best practice and consider their potential for local implementation

1.2 Themes

This JSNA has identified an opportunity for the Health and Wellbeing Boards to ensure that collective efforts to improve mental health and wellbeing in the Bi-borough have maximum impact. Based upon the findings of this report and in collaboration with local stakeholders across the field, this JSNA has identified seven themes which should be considered at a strategic level in order to further develop the local mental health and wellbeing system

The themes and recommendation are outlined below.

Theme 1: Mobilising local assets, services, and communities

The Bi-borough benefits from a thriving and vibrant third sector who make a significant contribution to promoting mental wellbeing, as well as the expertise and knowledge of a variety of specialist clinicians and centres of excellence. We need to ensure that we build capacity across the system and make the most of these assets, services and communities, ensuring that they are sustainable, and work collaboratively with our residents and patients to promote and maintain mental health and wellbeing.

Theme 2: Prevention and Early Intervention

There is evidence of an increase in demand for mental health services, including indications of increasing needs for children and young people. Consideration will need to be given to focusing on prevention as well as early intervention to address demand and future planning to ensure services are equipped to meet this need.

Theme 3: Pathways

There is emerging evidence that the Perinatal Mental Health Service pathway is helping to provide good care for residents and patients using those services. Similarly, clear and well communicated pathways for children and young people, and adults, need to be developed with the views of services users at the heart of the process. There is also a need for clarity of timescales *within* the pathways, monitoring of the patient's journey from the first point of contact with mental health services, to the point of commencing appropriate treatment.

Theme 4: Funding

Any future strategies and commissioning plans should consider how we work better in partnership with service users in order to maximise outcomes within existing budgets, ensuring value for money, and how funding can be sustained across the system into the future.

Theme 5: Primary care

Primary care, and GPs in particular, play a key role in enabling a cultural shift towards a recovery-based model where patients are discharged in to their care, and their recovery from mental ill-health can continue. Primary care practitioners must build on knowledge and skills to manage mental health conditions and enable these pathways to recovery.

Theme 6: Recovery

To enable lasting, effective recovery and rehabilitation of those with severe mental illness, stable housing, financial stability and employment/ education all need to be maintained or re-established to sustain recovery and prevent relapse. This requires partnership working, multi-agency planning and service user involvement.

Theme 7: Innovation

Work in partnership across local authority, NHS, community and voluntary sector, business and industry, academia, and with residents to develop and trial innovative and integrated solutions to promote good mental health and wellbeing across the Bi-borough, with a particular focus on prevention and early intervention. Use academic collaborations to evaluate effectiveness and cost effectiveness of local initiatives and programmes to ensure value for money.

2 Introduction

2.1 Background

Good mental health and wellbeing is important for us to lead happy, healthy lives. It has a positive impact on our inter-personal relationships and how we cope and engage with the world around us. Research shows that good mental health and wellbeing promotes our overall health, supports recovery from illness, and improves life expectancy. There is also evidence that good mental health and wellbeing also has a positive impact on better educational achievement, reducing risky health behaviours, reduced risk of mental illness suicide, improved employment rates, reduced anti-social behaviour and higher levels of social interaction and participation (Chevelier & Feinstein, 2006; Meltzer et al., 2006).

Mental health and wellbeing is a determinant of and consequence of physical health and wellbeing, and is closely linked with physiological processes. The risk factors for poor physical and mental health and wellbeing often overlap, and the effect of social and environmental determinants on physical health can also have an influence on resilience. People with severe mental illness, for example, are at higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease, and cardiovascular disease. Also, many people with long-term physical health conditions experience poor mental health and wellbeing. These can lead to significantly poorer health outcomes and reduced quality of life.

The foundations for good mental health and wellbeing are established in childhood and adolescence. Unfortunately, at least one in four people will experience a mental health issue at some point in their lifetime, which can affect their daily life, relationships and physical health, and one in six adults have a mental health issue at any one time (McManus et al., 2009). One in ten children aged between 5 and 16 years has a mental health issue, and many continue to have mental health issues into adulthood (Green et al., 2005). Around 75% of mental illnesses are established by the age of 24. This indicates the importance of prevention and early intervention, and addressing the childhood determinants of mental health and wellbeing.

Among adults under 65, nearly half of all ill health is mental illness. In other words, for those of working age, nearly as much ill health is mental illness as all physical illnesses put together (LSE, 2012). Every year in the UK, more than 250,000 people are admitted to psychiatric hospitals and over 4,000 people die by suicide. Mental illness represents up to 23% of the total impact of ill health in the UK – the largest single cause of disability (World Health Organisation, 2008).

Estimates suggest that the cost of mental health issues in England are close to £105 billion per year, which includes costs of lost productivity and wider impacts on wellbeing and treatment costs. These are expected to double by 2030 (Department of Health, 2011).

Positive mental wellbeing is incredibly important to ensure we 'feel good' and 'function well'. 'The Roads to Wellbeing', the 2016/17 annual report of the Director of Public Health for Kensington and Chelsea, and Westminster highlighted how we can take steps to achieve this using the Five Ways to Wellbeing, an evidence-based framework – Connect, Be Active, Keep Learning, Take Notice and Give. The report also noted that we needed to better understand the mental health and wellbeing needs of the local population in order to shape future strategy and commissioning activity. This JSNA aims to address that need.

2.2 Strategy context and policy drivers

Mental health and wellbeing is a priority for both boroughs, the NHS and central government. As a result, there are many local, regional and national strategies on mental health. There is a common consensus about the importance of wellbeing and promoting good mental health, rather than a focus on intervening when an individual becomes mentally unwell. This section summarises some of the more recent strategy and policy drivers.

National

NHS Long Term Plan

The NHS Long Term Plan sets out the NHS plan to redesign health services to meet the challenges and needs of the 21st century. The ambition is for the NHS to be:

- More joined up and coordinated in its care
- More proactive in the services it provides
- More differentiated in its support offer to individuals

Five major changes to the NHS service model are outlined for the next five years in order to bring this about:

- boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services.
- redesign and reduce pressure on emergency hospital services.
- people will get more control over their own health, and more personalised care when they need it.
- digitally-enabled primary and outpatient care will go mainstream across the NHS.
- local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

Prevention is a key feature of the long-term plan, setting out a vision that the NHS not only treats illness but supports people to live healthily, and to help people with long-term conditions to self-manage and prevent emerging problems from worsening.

The Plan includes a number of specific commitments for children's and adult's mental health, including:

- a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24
- the creation of new mental health support teams in schools and colleges (drawn from the Government's green paper *Transforming Children and Young People's Mental Health)*
- the expansion of community-based crisis services for children and young people
- a comprehensive offer for 0-25 year olds to address the issue of transition between child and adult mental health services
- Expanding the availability of specialist perinatal mental health services
- A further expansion in the Improving Access to Psychological Therapies (IAPT) programme, particularly for people with long-term physical conditions
- a new community-based offer which will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance misuse

Integration is also a recurring theme in the plan, setting out a vision for the 'triple integration' of primary and secondary care, physical and mental health services, and health with social care.The Centre for Mental Health has published a briefing on the Long Term Plan and potential implications for mental health[2]

Five Year Forward View for Mental Health

In 2016 the Independent Mental Health Taskforce published the Five Year Forward View for Mental Health for the NHS in England. This strategy brought together health and care leaders, people who use services and experts in the field, and signified the first time a strategic approach had been taken to improve mental health outcomes across the health and care system, in partnership with the health arm's length bodies.

The strategy recognised the importance of creating a shift towards prevention and that mental health should have parity with physical health and wellbeing. The following priorities for action by the NHS were identified in the report:

- A 7 day NHS – right care, right time, right quality
- An integrated mental and physical health approach

[2] Centre for Mental Health. The NHS Long Term Plan Briefing. https://www.centreformentalhealth.org.uk/nhs-long-term-plan

- Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

In July 2016, NHS England published an Implementation Plan to set out the actions required to deliver the Five Year Forward View for Mental Health. The Implementation Plan brings together all the health delivery partners to ensure there is cross-system working to meet the recommendations made by the Taskforce.

Members of the taskforce were responsible for making sure that there was cross-system commitment and alignment when developing actions within the national strategy and that continued partnership, working effectively and meaningfully, enables the strategy to be delivered.

Transforming Children and Young People's Mental Health Provision: a Green Paper

Acknowledging the importance of early intervention and building strong foundations for good mental health and wellbeing in childhood, this paper builds on ambitions set out in the Five Year Forward View for Mental Health and Future in Mind.

The green paper highlights the vital role played by schools and colleges in early identification and referral to services to support mental health need, and sets out the following vision:

"We want to ensure that all children and young people, no matter where they live, have access to high-quality mental health and wellbeing support linked to their school or college. Some children and young people will always need additional support from more specialist services within and beyond the NHS. When a need has been identified, young people should be assessed quickly, and referred to the most appropriate support."

It proposes three new approaches to provide children and young people with an unprecedented level of support to tackle early signs of mental health issues:

1. To incentivise every school and college to identify a Designated Senior Lead for Mental Health to oversee the approach to mental health and wellbeing. All children and young people's mental health services should identify a link for schools and colleges. This link will provide rapid advice, consultation and signposting.

2. To fund new Mental Health Support Teams, supervised by NHS children and young people's mental health staff, to provide specific extra capacity for early intervention and ongoing help. Their work will be managed jointly by schools, colleges and the NHS. These teams will be linked to groups of primary and secondary schools and to colleges, providing interventions to support those with mild to moderate needs and supporting the promotion of good mental health and wellbeing.

3. As the new Support Teams are rolled out, there will be a trial of a four week waiting time for access to specialist NHS children and young people's mental health services.

Better Mental Health for All

This report is intended as a call to action to promote a public health approach to mental health and wellbeing, as well as being a useful resource for practitioners in public health and beyond. It focusses on what can be done individually and collectively to enhance the mental health of individuals, families and communities by using a public health approach.

The report describes why public mental health is important, risk and protective factors for mental health and wellbeing, and interventions and approaches to promote good mental health and wellbeing across the life course.

This JSNA has drawn on the evidence contained in the report to inform the relevant sections in this report.

Being mindful of mental health

This report from the Local Government Association outlines the influence that local authorities on the mental wellbeing of their communities and how their services can promote and support the mental wellbeing of the local population. The report summarises this as:

- Councils make a significant contribution to the mental wellbeing of their local communities.
- Councils have key statutory and non-statutory duties that are an integral part of the mental health services landscape. To improve services and the mental health of our communities, a whole-system review that looks at the future of all mental health services, including the voluntary and community sector, is needed.
- Councils need adequate funding to enable them to fully play their essential part in the mental health system.
- There needs to be a re-focus in mental health policy away from medicalisation and mental ill health to prevention, early intervention and mental wellbeing.

The report articulates what councils should be looking at to enable their residents to live in better mental health, including a number of top tips to create mentally well places:

- Include mental health in all policies.
- Enable people in public and high profile appointments to share stories of mental health experiences, and have a member Mental Health Champion.
- Work closely with the local voluntary and community sector, incorporating their role into local mental health and wellbeing plans.
- Work closely with the NHS and local clinical commissioning groups; consider mental health and mental wellbeing within health and wellbeing board activities.
- Include design for mental wellbeing in planning policies and new developments

- Provide mental health training, awareness, protocols and support for the council's staff and councillors.
- Focus on perinatal and early-years mental health and prevention and early intervention in general.
- Work with schools and other children's facilities to raise awareness of mental health and resilience.
- Emphasise the links between physical and mental health; in both treatment of ill health and in promoting the importance of leisure and outdoor facilities.
- Have regard for the impact of home and place on mental health.

Mental Health Act

In October 2017, the Prime Minister announced an independent review of the Mental Health Act 1983 to make improvements following rising detention rates, racial disparities in detention and concerns that the Act is out of step with a modern mental health system. The review team was also asked to consider how to improve practice within the existing legislation.

Following the publication of the review the government will be introducing a new Mental Health Bill to transform mental health care. The government is accepting two of the review's recommendations to modernise the Mental Health Act.

- Those detained under the Act will be allowed to nominate a person of their choice to be involved in decisions about their care. Currently, they have no say on which relative is contacted. This can lead to distant or unknown relatives being called upon to make important decisions about their care when they are at their most vulnerable
- People will also be able to express their preferences for care and treatment and have these listed in statutory 'advance choice' documents.

Local

Joint Health and Wellbeing Strategies

Mental health and wellbeing has been identified as a priority in both local Health and Wellbeing Strategies, and through that process there is already work with colleagues from across the local authority, community and voluntary organisations, schools, businesses and NHS partners to improve the mental wellbeing of our residents. Both strategies align with the Like Minded ambitions for mental health and wellbeing across North West London.

The Westminster strategy highlights the importance of prioritising and embedding prevention, early intervention and a partnership approach to stop and reverse the negative trends of poor mental health. The strategy makes the following commitments:

Working with individuals, communities, professionals and employers in Westminster we will improve mental health for Westminster people by:

- addressing the stigma associated with all types of mental illness
- treating and caring for people as individuals and recognising the complex factors that impact mental health
- recognising and addressing the wider determinants of mental health, including housing, employment, education and community interactions
- ensuring that statutory, voluntary and community organisations continue to work closely together to identify people early who might require support
- supporting people in the workplace and tackling barriers into work
- working with communities to develop peer support, resilience and cohesion so that individuals, families and neighbours can support and look out for each other
- providing information through a range of mediums that is tailored for people of all ages and situations to access and use.

The Kensington and Chelsea strategy articulates their ambition to prevent, identify and treat mental health across all age groups to:

- Make work a healthy place to be by promoting good workplace mental health and wellbeing and supporting people with mental illness into employment
- Promote better emotional and mental health and early intervention in schools including access to counselling and psychological therapies and work with partners to tackle cyber-bullying
- Provide support for parents and parents-to-be for their own mental health and for the long-term mental health of their families
- Improve access to psychological therapies and children and young people's mental health services.
- Encourage GPs to use 'social prescribing' and non-medical interventions to improve mental health and wellbeing
- Work with professionals to break down the barriers between physical and mental health and ensure both are treated equally
- Encourage awareness and improve the quality of local services and support for people living with dementia and their carers
- Support residents at risk of social isolation including older residents who live alone
- Work with staff in frontline services across the system to build skills and awareness of mental health
- Promote access and signpost to activities that promote wellbeing, volunteering and stronger social networking to improve outcomes
- Provide early support for older people through effective information and advice and signposting to preventative/universal services
- Work with communities to help change attitudes, tackle stigma, and develop understanding of mental health.
- Improve the physical health and lifestyles of people with mental illness, with a particular focus on people with serious mental illness
- Ensure that crisis support is available for people with serious mental illness

Like Minded

The Like Minded strategy for mental health and wellbeing across North West London highlights the importance of working together and co-production to learn best practice and share innovative approaches. The strategy was co-produced with patients, carers, doctors, voluntary organisations and charities and other experts.

The Like Minded vision is:

By working together, our vision is for North West London to be a place where people say:

- "My wellbeing and happiness is valued"
- "I am supported to stay well"
- "My care is delivered at the place that is right for me"
- "The care and support I receive is joined up"
- "As soon as I am struggling, help is available"

The Roads to Wellbeing

The 2016-17 annual report of the Director of Public Health focused on mental wellbeing in Westminster and Kensington and Chelsea, and the importance of protecting and improving our own mental wellbeing, and that of the people around us – our families, friends, neighbours, and local communities.

The key messages from the report are:

- Poor mental wellbeing can affect us and those around us at any point in our lives. Mental wellbeing can impact on all aspects of our lives and is 'everyone's business'
- We can all play a role in improving our own and others' mental wellbeing: Connect, Be Active, Keep Learning, Take Notice, and Give
- To help build the mental resilience of our local communities we need to better understand residents' mental wellbeing and what works to improve this.
- We can achieve this by working in partnership with residents and other organisations and considering mental wellbeing when commissioning and evaluating services
- We need to ensure investment is channelled towards prevention and early intervention not just towards treatment

The report makes a number of recommendations for different sectors and agencies, including one for the local Health and Wellbeing Boards to commission this JSNA in order to better understand the mental health and wellbeing needs of our population.

Dementia strategy

A dementia strategy is currently being developed for the Bi-borough by the local authority and key partners, to address the increasing and varied levels of need in the population and to promote dementia friendly communities. This strategy will take

into account the local JSNA on dementia published in 2015 as well as more recent data and evidence documented in this report.

2.3 Scope and definitions

Scope

In line with recent national and local strategy the focus of the report will be on promoting positive mental wellbeing and preventing mental illness, rather than treatment aspects of clinical mental health issues, although this is also covered in order to provide an overview of the full range of mental health and wellbeing in the two Boroughs. The JSNA will evidence the benefits of promoting positive mental wellbeing to the individual and society, and the importance of shifting the focus to preventing mental health issues.

In July 2018 a workshop was held to identify the key questions that were to be answered by the JSNA. A full table outlining these questions is included in Appendix A. In summary the key questions are:

- What do we mean by mental health and wellbeing?
- What is the local prevalence and characteristics of mental health anda wellbeing across the life course?
- What are the local determinants and factors (risk and protective) for poor mental wellbeing and illness across the life course?
- What local services and assets in the community are available to meet these needs?
- What works to promote or protect mental wellbeing across the life course?
- What are the views and experience of both residents and patients accessing services?
- What are the potential gaps or areas of unmet need which require local action?

The format of the JSNA follows that as recommended in the Mental Health JSNA Toolkit[3] published by Public Health England (PHE) in 2017. In addition, it is worth noting that the What Works for Wellbeing Centre has created an indicator set[4], intended to help local decision-makers understand the wellbeing of their constituents. This set is composed of seven domains that can inform us about levels of wellbeing in our communities: personal wellbeing, equality, education & childhood,

[3] Public Health England (2017) Better mental health: JSNA toolkit. https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit

[4] What Works for Wellbeing. Local Authority Wellbeing Indicator Set. https://whatworkswellbeing.org/product/local-authority-wellbeing-indicator-sets-and-guidance-only/

health, social relationships, place and economy. These domains align with the JSNA toolkit and can be identified within the JSNA.

It is important to note that the potential scope of a JSNA on this topic is considerable as so many factors are a cause and consequence of mental health and wellbeing. We acknowledge that there will inevitably be gaps in this JSNA as a consequence.

Grenfell and North Kensington

The fire at Grenfell Tower on June 14, 2017 had a devastating impact on many people. 71 people lost their lives in the fire and another resident died later. Many others have experienced trauma, loss and displacement.

Over time this is likely to affect wider mental health, physical health, and in turn cause a range of social challenges including family breakdown, educational and employment challenges. This will have an impact on the mental health and wellbeing of those affected by the fire.

A separate health needs assessment – The Journey to Recovery - has been undertaken which considers the primary impacts on health and wellbeing, including mental health and wellbeing, of those affected by the Grenfell disaster. This JSNA report does not attempt to duplicate that document and should be read in conjunction with The Journey to Recovery needs assessment. However, services that have been put in place to meet the additional needs of the survivor's, bereaved and the wider community are included here in section 8.8.8.

Information on services to support anyone affected by the Grenfell Tower tragedy can also be found at https://www.grenfell.nhs.uk/

Definitions

Mental wellbeing

Mental wellbeing covers the positive end of mental health covering both the 'feeling good' and 'functioning well' components. Feeling good is subjective and embraces happiness, life satisfaction and other positive affective states. Functioning well embraces the components of psychological wellbeing (self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and environmental mastery)

Our emotional or mental wellbeing is closely linked with our physical health, and is strongly associated with positive relationships and healthier communities

Mental health

The World Health Organisation defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses

of life, can work productively and fruitfully, and is able to make a contribution to her or his community[5].

The "Better mental health for all" report (Faculty of Public Health, 2016) describes how the term mental health is a "spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health."

2.4 Relation to commissioning

The overall purpose of the JSNA is to inform strategy development, commissioning decision making, and action planning to improve mental health and wellbeing and reduce inequalities across the Bi-borough area.

[5] WHO (2014) Mental health: a state of wellbeing. http://www.who.int/features/factfiles/mental_health/en/

3 Understanding people and place

To inform strategy and service planning the JSNA describes the local population, the levels of mental wellbeing, the prevalence and incidence of mental illness, and the characteristics of the population of the two Boroughs (for example, size, age and gender) which may drive demand for mental health services now and in the future.

Inequalities exist in the prevalence of mental health issues, access to services and outcomes. There are specific groups of people who are more likely to have poor mental wellbeing and are more at risk of developing mental health issues whose needs must be met.

There are also important causes and consequences of mental health and wellbeing such as health behaviours like smoking and physical activity and misuse of alcohol and drugs. Although not considered in depth in this JSNA, they have been included.

Note: In all comparative analyses utilizing Public Health England published comparative data, Kensington and Chelsea and Westminster indicators are compared to London averages. England rates are also provided for information.

3.1 Key Messages

Key messages: Understanding People and Place

Understanding Place

Wider determinants

- Of the wider determinants of mental ill health, key challenges in the borough are deprivation, poverty and homelessness.
- Employment rates are lower than the London average, however long-term unemployment rates are lower than the London average as are unemployment rates for young people in Westminster
- Educational outcomes are good with children from both boroughs achieving a higher rates of GCSE A-C passes compared to the London average
- While rates of first time offences for adults and juveniles in both boroughs are below the London average, however rates of violent crime (including sexual violence) are higher than the London average.
- Rates of reoffending among adults and among juveniles from Kensington and Chelsea are above the London average.

Well-being

- Over the past 7 years well-being scores for happiness, finding life worthwhile and life satisfaction have increased in Westminster, but declined for Kensington and Chelsea. Scores for anxiety have remained relatively stable.
- In 2017/18 Westminster scored higher than the London average on measures of well-being: happiness, finding life worthwhile and life satisfaction, while Kensington and Chelsea scores were lower
    - Anxiety scores for both boroughs were slightly higher London average

Understanding People

Population demographics

- Both boroughs have a lower percentage of BME residents, but a higher proportion of mixed ethnicity residents compared to the London average

Prevalence

- Rates of depression recorded by GP practices in Kensington and Chelsea are above the London average, while rates in Westminster are below the London average
- The recorded prevalence of serious mental illness in both boroughs is higher than the London average

Smoking

- Rates of smoking in the general adult population are lower than the London average, but higher than the London average among those with a serious mental illness

Alcohol and Substance Misuse

- Both boroughs have a higher rate of hospital admissions for mental and behavioural disorders due to the use of alcohol. Rates of alcohol dependence in both boroughs are comparable to the London average
- The estimated prevalence of opiate and/or crack cocaine use is higher than the London average in both boroughs, as is the rate of hospital admissions for substance misuse among young people in Kensington and Chelsea

Suicide and Self-harm

- Suicide rates for both boroughs are similar to the London average for both sexes.
- The rate of hospital admissions for self-harm, at all ages, is lower than the national average in both boroughs, as are rates of self-harm among young people compared to the London average

3.2 Understanding People: demographics

The following section provides an overview of the demographics of the bi-borough.

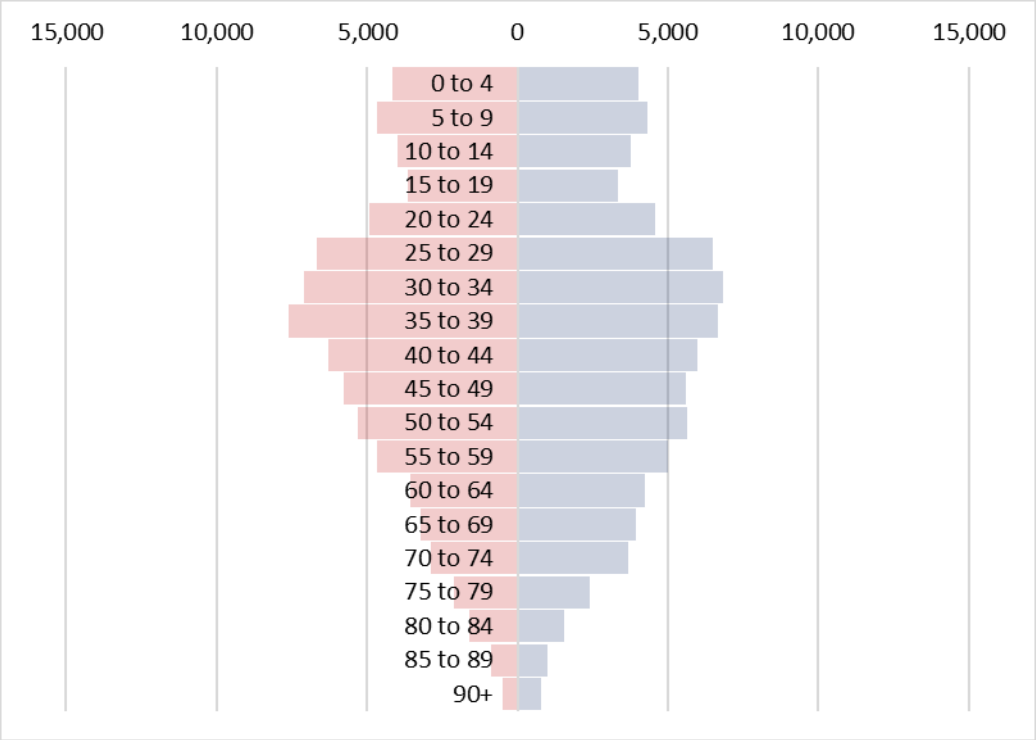
Population size and change

The Greater London Authority (GLA) estimate that the respective population sizes of Kensington and Chelsea and Westminster in 2018 are 159,298 and 254,371.

Chart 1 and Chart 2 show both boroughs have a high percentage of young adults, the biggest group being the 35 to 39 year olds in Kensington and Chelsea and 30 to 34 year olds in Westminster.

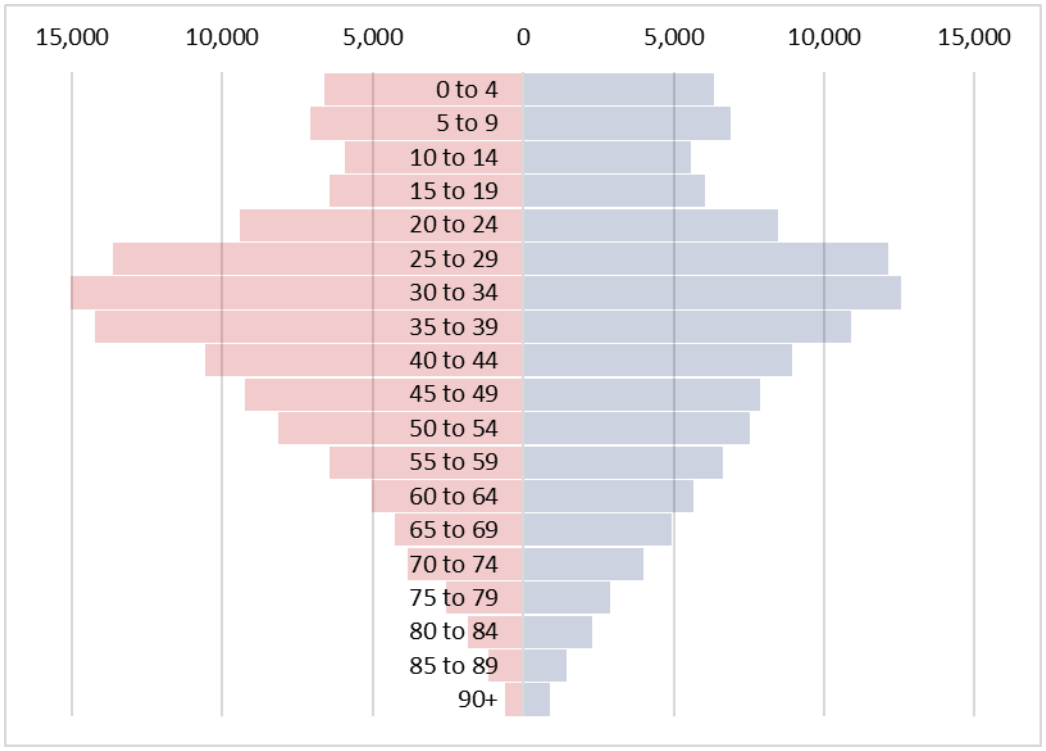
Chart 3 and Chart 4 show that over the next 10 years Kensington and Chelsea is expecting an increase in the population aged 60 years and over and also the population aged 15 to 24 years. By comparison, increases in most age groups are expected in Westminster, with the exception of the 0 to 9 years and 25 to 39 years age groups where reductions in numbers are expected.

Chart 1: Estimated change in population size 2018 to 2028 by age group: Kensington and Chelsea



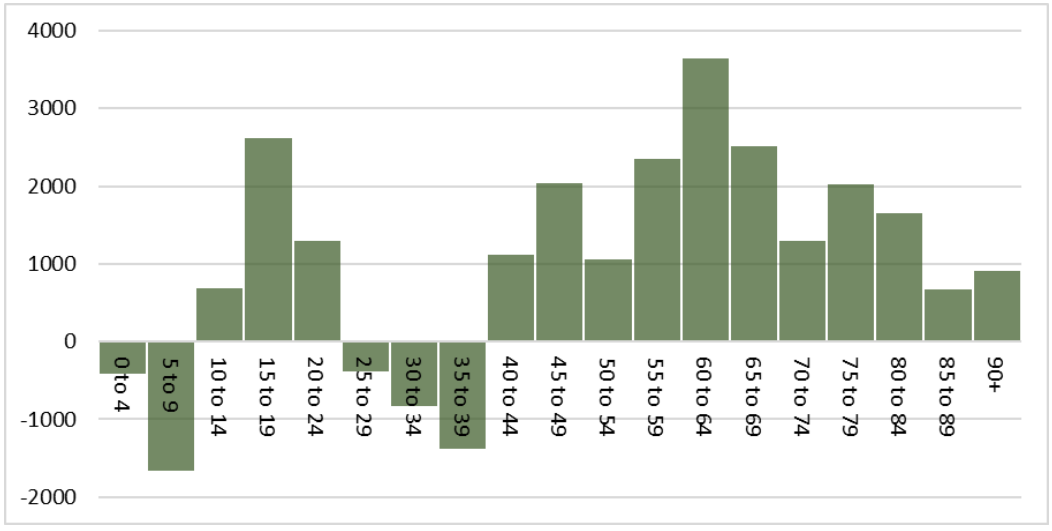
Source: Greater London Authority Housing-led population projections (published 2019)

Chart 2: Estimated change in population size 2018 to 2028 by age group: Westminster



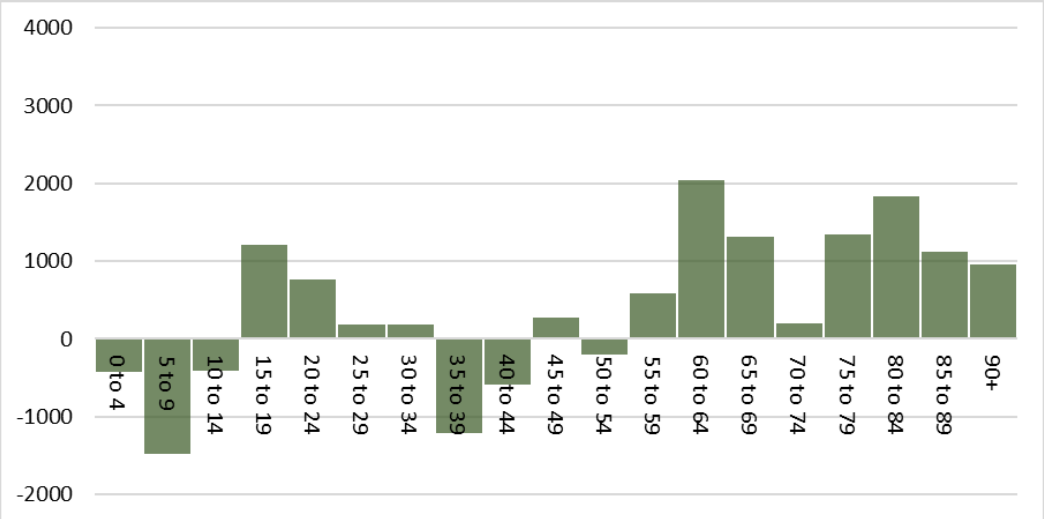
Source: Greater London Authority Housing-led population projections (published 2019)

Chart 3: Estimated change in population size 2018 to 2028 by age group: Westminster



Source: Greater London Authority Housing-led population projections (published 2019)

Chart 4: Estimated change in population size 2018 to 2028 by age group: Kensington and Chelsea

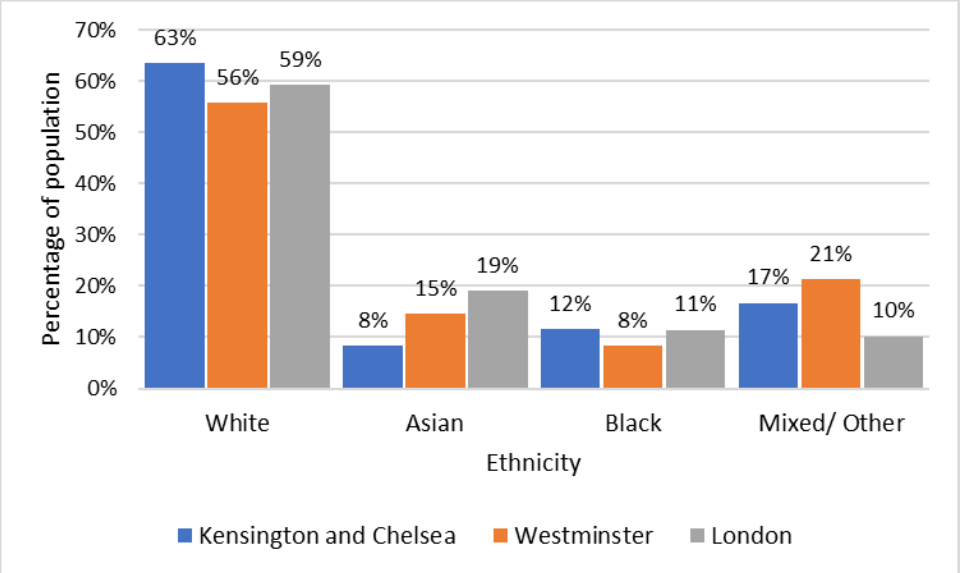


Source: Greater London Authority Housing-led population projections (published 2019)

Ethnicity

Chart 5 compares the distribution of ethnic origin by borough to London in 2017. Kensington and Chelsea has a higher percentage of residents of White origin compared to London. By contrast, Westminster has a higher percentage of residents on non-White ethnic origin compared to London and Kensington and Chelsea, most commonly mixed or 'other' ethnic origin.

Chart 5: Distribution of ethnicity by borough compared to London, 2017

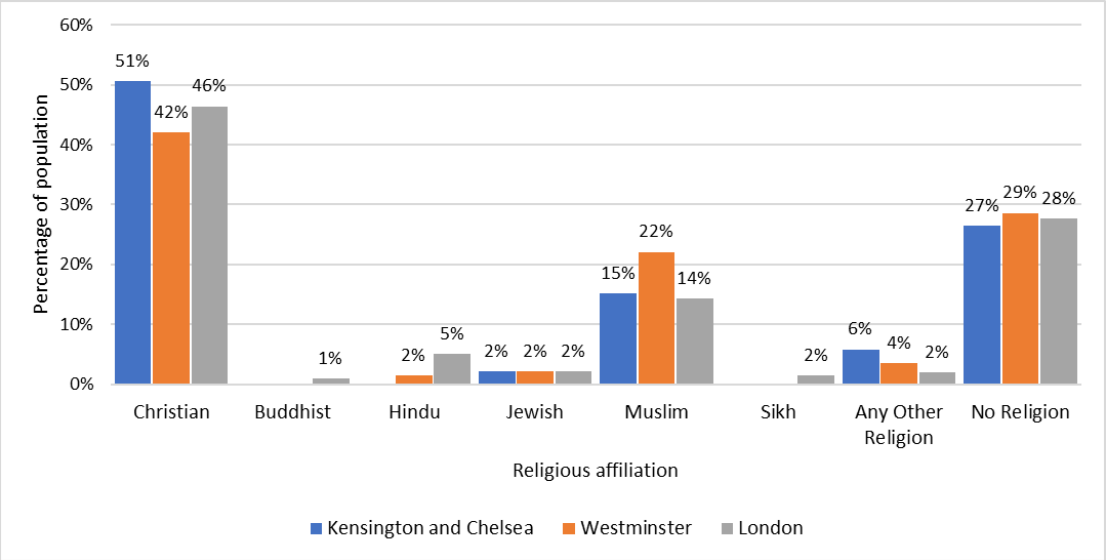


Source: Annual Population Survey (published by the Greater London Authority 2019)

Religion

Chart 6 shows the distribution of religious affiliation by borough compared to London in 2017. From Chart 6, Christian is shown to be the most common religions affiliation in the bi-borough and across London as a whole. The next most common religious affiliation followed by Muslim in all areas. Kensington and Chelsea has a higher percentage of residents who are Christian compared to London, while Westminster has a lower percentage of residents who are Christian compared to London and Kensington and Chelsea.

Chart 6: Distribution of religious affiliation by borough compared to London, 2017



Source: Annual Population Survey (published by the Greater London Authority 2019)

Socio-economic deprivation

The Index of Multiple Deprivation (IMD) is the official measure of deprivation in England. The IMD is a weighted score based on information captured across seven domains (income, employment, education, health and disability, crime, barriers to housing and services and living environment). Scores are calculated at Lower Layer Super Output Level (LLSOA) and presented in quintiles: Quintile 1, LLSOAs within the 20% most deprived LLSOAs in England, through to Quintile 5, LLSOAs within the 20% least deprived LLSOAs in England.

Comparative data shows that both Kensington and Chelsea and Westminster have a higher proportion of residents living in areas classified in the most deprived quintiles compared to the London average (Table 1). Table 2 shows the estimated number of residents living in areas classified deprivation quintile 1 to 5 in each borough. The population counts presented in Table 1 are the 2017-based Lower Level Super Output (LLSOA) estimates and therefore likely to differ from the Greater London Authority based estimates of the total borough populations in the sections above.

Table 1: Percentage and estimated number of residents living in the 20% most deprived areas

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Living in 20% most deprived areas	2014	23.6%	28.6%	22.9%	20.2%	36,824	66,829

Source: Public Health England Fingertips (2019)

Table 2: Estimated population size (all ages) by deprivation quintile (IMD 2015) and borough, 2017

	Deprivation quintile					
Borough	**1 (most deprived)**	**2**	**3**	**4**	**5 (least deprived)**	**Total**
Kensington and Chelsea	36,302	36,803	27,833	53,184	1,619	155,741
Westminster	68,114	70,578	69,906	36,198		244,796

Source: Office for National Statistics (ONS) Lower Level Super Output Area (LLSOA) population estimates, published 2019. Index of Multiple Deprivation (IMD), 2015.

3.3 Understanding people: mental health and wellbeing in the population

Wellbeing in the Boroughs

Since 2011, the ONS has asked a large sample of UK adults aged 16 and over about their wellbeing. In 2017-18, UK wide, 30.1% of the population had a very high satisfaction with their life overall. Around a third (35.8%) had a very high rating of how worthwhile they feel the things they do are. 34.8% rated their happiness as very high for the day preceding, with 40.5% rating their anxiety for the day preceding as very low. (ONS, 2017-18)

Table 3 shows the latest estimates of personal wellbeing in Kensington and Chelsea (RBKC) and Westminster (WCC), 2017/18. From Table 3 while scores in both boroughs are similar to the London and England averages, RBKC is shown to have lower mean well-being scores –particularly for happiness–and a larger anxiety score compared to the London average. Westminster scores better than the London average on all but anxiety which is higher.

Table 3: 2017/18 Life-satisfaction scores

Indicator	Description	RBKC	WCC	London	England
Happiness	Overall, how happy did you feel yesterday	6.82	7.56	7.44	7.52
Life satisfaction	Overall, how satisfied are you with your life nowadays	7.31	7.58	7.52	7.68
Purpose/ meaning	Overall, to what extent do you fell the things you do in your life are worthwhile	7.55	7.77	7.73	7.88
Anxiety	Overall, how anxious did you feel yesterday?	3.71	3.33	3.13	2.90

Source: ONS 2017/18. Responses to each question are rates on a scale of 0 to 10

Incidence and prevalence of mental Illness

This section covers the estimated and recorded prevalence of mental illness in the Kensington and Chelsea and Westminster.

Population prevalence rates of diagnosed and undiagnosed case of mental illness are taken from The Adult Psychiatric Morbidity Study (APMS), while the recoded prevalence, diagnosed prevalence rates are taken from Quality and Outcomes Framework (QoF) registers, the GP Survey and social care data. All of which are publically available.

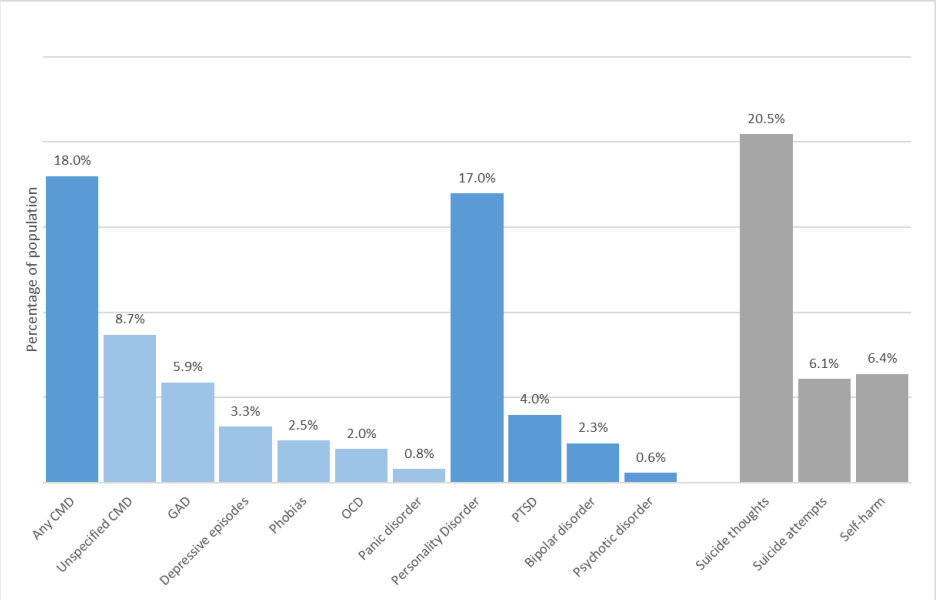
Population prevalence

The Adult Psychiatric Morbidity Study (APMS) provides estimates the population level prevalence of mental illness (diagnosed and undiagnosed) and by key sociodemographic characteristics:

- age
- sex
- ethnicity
- household structure
- employment status
- benefit status
- geographic region

While this study does not provide prevalence rates at borough level, adjusted estimates of prevalence are provided for the London region. Chart 7 shows the estimated prevalence of mental illness and self-harm in London. Table 4 shows the estimated number of cases of mental illness, by borough, should London estimates prevail.

Chart 7: The relative prevalence of common mental health conditions and mental illness in the London region, population aged 16+



APMS (2014). Estimates of the prevalence of psychiatric disorders are based APMS 2007 and 2014 data. Estimates for London region

Table 4: Estimated numbers affected by mental illness by borough, 18+, 2018, London region estimates

Illness/ presentation	Borough	Rate	Count
CMD	RBKC	18.0%	23,943
	WCC	18.0%	38,484
CMD Unspecified	*RBKC*	*8.7%*	*11,572*
	WCC	*8.7%*	*18,601*
GAD	*RBKC*	*5.9%*	*7,848*
	WCC	*5.9%*	*12,614*
Depressive episodes	*RBKC*	*3.3%*	*4,390*
	WCC	*3.3%*	*7,055*
Phobias	*RBKC*	*2.5%*	*3,325*
	WCC	*2.5%*	*5,345*
OCD	*RBKC*	*2.0%*	*2,660*
	WCC	*2.0%*	*4,276*
Panic Disorder	*RBKC*	*0.8%*	*1,064*
	WCC	*0.8%*	*1,710*

Illness/ presentation	Borough	Rate	Count
Personality Disorders	RBKC	17.0%	22,613
	WCC	17.0%	36,346
PTSD	RBKC	4.0%	5,321
	WCC	4.0%	8,552
Bipolar disorder	RBKC	3.3%	3,102
	WCC	3.3%	4,986
Self-harm	RBKC	6.4%	8,507
	WCC	6.4%	13,674
Suicidal thoughts	RBKC	20.5%	27,218
	WCC	20.5%	43,748
Suicide attempts	RBKC	6.1%	8,098
	WCC	6.1%	13,016

APMS (2014). Estimates of the prevalence of psychiatric disorders are based APMS 2007 and 2014 data. Estimates for London region. Italic (Subset of CMD). CMD (Common Mental Disorders), GAD (Generalised Anxiety Disorders), OCD (Obsessive Compulsive Disorders)

Table 5: Variation in the Population prevalence of mental illness by key demographic characteristics (APMS, 2014), aged 16+, England estimates

		Relationship to:						
Illness/ presentation	**Prevalence 16+**	**Age**	**Sex**	**Ethnicity**	**Household type**	**Employment status**	**Benefit status**	**Region**
Bipolar disorder	2.0%	Clear gradient - **Higher at younger ages**: 16-24yrs: 3.4% vs. 65-74yrs: 0.4%	**Higher among Males:** 2.1% vs. Females, 1.8%	**Highest among Black/ Black British** 3.5% vs. lowest in Asian/Asian British, 1.4%	**Highest - Single person household:** 5.5% vs. Lowest: 2 adults 60yrs+, no children, 0.4%	**Highest among economically inactive:** 4.3% lowest in employment, 1.9%	**Higher on benefits** than not: Highest on **ESA:** 12.4%	**Higher in London**, 2.3% vs. England, 2.0%
Personality disorder - Antisocial	3.3%	Clear gradient - **Higher at younger ages**: 16/18-24yrs: 4.9% vs. 55-64yrs: 2.2%	**Higher among Males:** 4.9% vs. Females, 1.8%	**Highest among Mixed ethnicity** 4.8% vs. lowest in Asian/Asian British, 1.4%	**Highest - Single person household:** 6.6% vs. Lowest: Adults with children, 2.9%	**Highest among economically inactive:** 4.7% lowest in employment, 2.8%	Personality disorder: **Higher on benefits** than not: Highest on ESA: (3-48% vs. 12-14%), **ESA:** 48%	**Higher in London**, 4.4% vs. England, 3.3%
Personality disorder - Borderline	2.4%	Clear gradient - **Higher at younger ages**: 16/18-24yrs: 5.7% vs. 55-64yrs: 1.0%	**Higher among Females:** 2.9% vs. Males, 1.9%	**Highest among White British** % vs. 2.6% lowest in Black/Black British, 1.4%	**Highest - Single person household:** 3.9% vs. Lowest: Adults with children, 2.0%	**Highest among economically inactive:** 5.3% lowest in employment, 1.5%		**Lower in London**, 2.2% vs. England, 2.4%
PTSD	4.4%	Clear gradient - **Higher at younger ages**: 16/18-24yrs: 8.0% vs. 55-64yrs: 0.6%	**Higher among Females:** 5.1% vs. Males, 3.7%	**Highest among Black/Black British** 8.3% vs. lowest in White Other, 2.2%	**Highest - Single person household:** 10.8% vs. Lowest: 2 adults 60yrs+, no children, 1.4%	**Highest among economically inactive:** 10.5% lowest in employment, 2.7%	**Higher on benefits** than not: Highest on ESA: (16-34% vs. 3.4-4.2%), **ESA:** 34%	**Lower in London**, 4.0% vs. England, 4.4%
Common Mental Health Disorders	15.7%	**Higher at younger ages peaks at: 35-44yrs** 19.3% vs.75 yrs+: 8.8%	**Higher among Females:** 19.1% vs. Males, 12.2%	**Highest among Mixed ethnicity** 19.8% vs. lowest in White Other, 1.4%	**Highest - Single person household:** 29.4% vs. Lowest: 2 adults 60yrs+, no children, 10.4%	**Highest among economically inactive:** 33.1% lowest employed full-time, 14.2%	**Higher on benefits** than not: Highest on ESA: (35-66% vs. 15-17%), **ESA:** 66%	**Higher in London**, 18.0% vs. England, 15.7%
Psychotic disorders	0.5%	**Parabolic, peaks at: 35-44yrs** 1.0% vs.75 yrs+: 0.1%	**Higher among Females:** 0.6% vs. Males, 0.5%	**Highest among Black/Black British** 1.4% vs. lowest in White, 0.5%. No data on Mixed ethnicity	**Highest - Single person household:** 1.1% vs. Lowest: adults no children, 0.4%	**Highest among economically inactive:** 2.3% lowest employed full-time, 0.1%	**Higher on benefits** than not: Highest on ESA: (5-13% vs. 0.2-0.3%), **ESA:** 13%	**Higher in London**, 0.6% vs. England, 0.5%
Self- harm	7.3%	**Most common at 16-24yrs:** 17.5% vs. 75yrs+:0.3%	**Higher among Females:** 8.9% vs. Males, 5.7%	**Highest among White British** 8.1% vs. lowest in White, 5.5%.	**Highest - Single person household:** 14.9% vs. Lowest: adults no children, 1.5%	**Highest among economically inactive:** 14.6% lowest employed full-time, 7.6%	**Higher on benefits** than not: Highest on ESA: (15-34% vs. 7-8%), **ESA:** 13%	**Lower in London**, 7.1% vs. England, 7.3%
Suicidal thoughts	20.6%	**Most common at 16-24yrs** driven female prevalence, men most common at- 55-64yrs	**Higher among Females:** 22.4% vs. Males, 18.7%	**Highest among White British** 21.6% vs. lowest in Asian/ Asian British, 13.1%.	**Highest - Single person household:** 40.2% vs. Lowest: adults no children, 11.4%	**Highest among unemployed:** 30.5% lowest employed, 20.8%	**Higher on benefits** than not: Highest on ESA: (37-66% vs. 19-22%), **ESA:** 66%	**Lower in London**, 20.6% vs. England, 21.3%
Suicide attempts	6.7%	**Most common at younger ages 16-34yrs, peaks at 16-24 yrs,** 9.0% driven female prevalence, men - 55-64yrs	**Higher among Females:** 8.0% vs. Males, 5.4%	**Highest among White British** 6.9% vs. lowest in Asian/ Asian British, 5.3%.	**Highest - Single person household:** 16.0% vs. Lowest: adults no children, 2.5%	**Highest among economically inactive:** 16.1% lowest employed full-time, 5.8%	**Higher on benefits** than not: Highest on ESA: (5-7% vs. 20-43%), **ESA:** 43%	**Lower in London**, 6.4% vs. England, 6.7%

Source: Adult Psychiatric Morbidity Survey, 2014. Estimates for England

Other estimates

Public Health England reports the estimated prevalence of long-term mental health issues and of anxiety and depression (in the community and among social care users).

Table 6 shows that, based on these estimates, the prevalence of long-term mental health issues in Kensington and Chelsea is similar to the London average, while in Westminster the rate is higher than the London average. It also shows that the percentage of the population and care users with depression and anxiety is higher than the London average, while in Westminster the percentage is lower than the London average

Table 6: Further estimates of long-term mental illness and anxiety and depression

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON**	**ENG.**	**RBKC**	**WCC**
Long-term mental health problems (GP Survey)	2016/17	5.6%	6.1%	4.8%	5.7%	141	202
Depression and anxiety prevalence (GP Survey)	2016/17	14.7%	14.2%	12.4%	13.7%	399	500
Depression and anxiety: social care users	2017/18	61.6%	65.8%	55.8%	54.5%	-	-

Source: Public Health England Fingertips (2019)

Recorded prevalence

Table 7 shows the incidence and prevalence of diagnosed cases of mental illnesses based on GP registers in 2016/17 and claimant data from 2016. The following key points are made:

- The recorded incidence of depression Kensington and Chelsea is the same as the London average, while in Westminster the incidence is below the London average. In 2017/18 the number of new cases of depression were 1,994 and 2,636 for Kensington and Chelsea and Westminster respectively.
- Over 13,000 residents in each borough are recorded on GP registers as having depression
- The prevalence of severe mental illness in both boroughs and the prevalence of depression in Kensington and Chelsea, are higher than the respective London averages. Rates of depression recorded in Westminster are lower than the London average.
- In 2017/18 the number of adults registered with a Serious Mental Illness were 3,851 and 3,215 for Kensington and Chelsea and for Westminster respectively
- In both boroughs the rate of Employment Support Allowance (ESA) for mental and behavioural disorders is above the London average.
- Rates of hospital admission for self-harm in adults and young people are below the London average in both boroughs.
- 2015-17 pooled data show suicide rates in Kensington and Chelsea and Westminster to be comparable to the London average for both genders.

Table 7: Incidence and prevalence of mental illnesses 2016/17 by borough

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Depression incidence [a]	2017/18	1.2%	1.1%	1.2%	1.6%	1,994	2,636
Depression prevalence[a]	2017/18	8.5%	5.7%	7.1%	9.9%	14,341	13,562
Severe Mental Illness [a]	2017/18	1.5%	1.4%	1.1%	0.9%	3,851	3,215
ESA claimants for mental & behavioural disorders per 1,000 16 to 64 years	2016	26.8	28.1	23.0	27.5	2,930	4,930
Hospital admissions for self-harm, DSR all ages	2016/17	-	64.6	102.1	207.2	-	7
Hospital admissions: Self-harm/ 100,000 15-19 years	2016/17	-	224.5	305.2	619.9	-	26
Hospital admissions: Self-harm/ 100,000 20-24 years	2016/17	75.4	57.2	188.6	393.2	7	10
Suicide rate: Persons	2015-17	9.5	8.3	8.6	9.6	40	49
Suicide rate: Male	2015-17	15.8	12.1	13.1	14.7	32	35
Suicide rate: Female	2015-17	-	4.5	4.4	4.7	8	14

Source: Public Health England Fingertips (2019) [a] Quality and Outcomes Framework data. DSR (Directly Standardised Rate). – No data or insufficient numbers to present as counts or rates

Well-being

Over time, fluctuations are seen in levels of wellbeing. For our boroughs, changes over the last six years have largely been small, as demonstrated in the below charts (the scale is enlarged to show the detail). However, it is noticeable that while the trend in scores for life satisfaction (Chart 8), finding life worthwhile (Chart 9) and Happiness (Chart 10) is increasing and the trend for anxiety score (Chart 11) is declining, the converse is observed for Kensington and Chelsea.

Chart 8: Life satisfaction trend

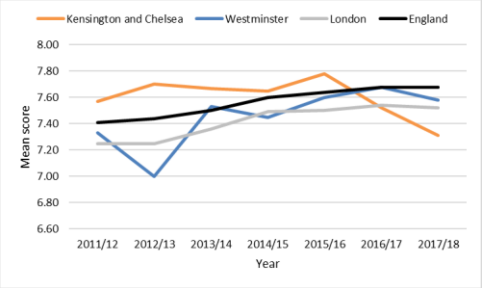


Chart 9: Life worthwhile trend

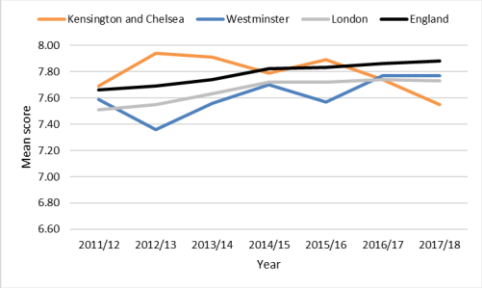


Chart 10: Happiness trend

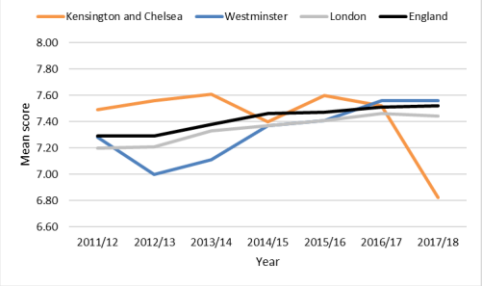
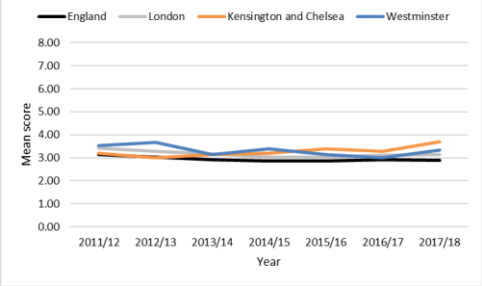


Chart 11: Anxiety trend



Source: ONS 2017

Well-being and age and sex

Borough level data on the association between well-being scores and age and sex are not available therefore Chart 12 to Chart 19 describe the associations for the UK as a whole.

Chart 12, Chart 14 and Chart 16 show life satisfaction, finding life worthwhile and happiness peaks at around 65 and 79 years, while lowest scores are seen between the ages of 40 and 59 years – the same age anxiety scores peak (Chart 18).

Chart 13, Chart 15, Chart 17 and Chart 19 show life satisfaction, finding life worthwhile, happiness peaks and anxiety scores are higher among women compared to men. The biggest gaps in scores by gender are for finding life worthwhile (Chart 15) and anxiety (Chart 19).

The same charts also show scores for both sexes have followed a comparable upward trend for life satisfaction, finding life worthwhile and happiness, and comparable reduction in anxiety scores over the past six years.

Finally, finding life worthwhile and happiness scores are typically higher for almost all ages in 2016/17 compared to 2011/12, and anxiety scores lower at almost all ages. Exceptions include lower life satisfaction scores at ages 90 and over (Chart 12) and higher anxiety scores at ages 16 to 24 years (Chart 18) in 2016/17 compared to 2011/12.

Chart 12: Life satisfaction and age

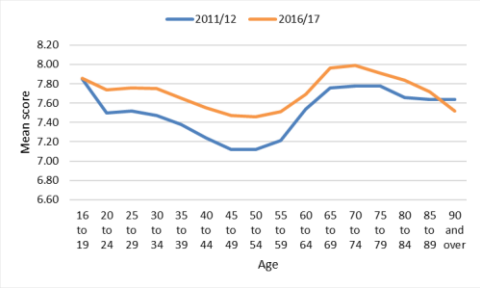


Chart 13: Life satisfaction and sex

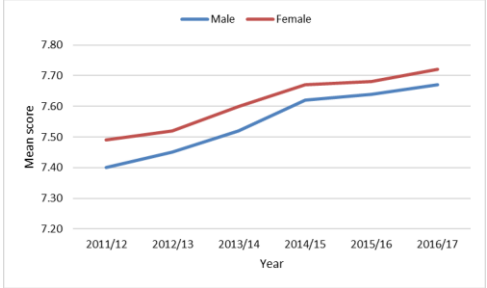


Chart 14: Life worthwhile and age

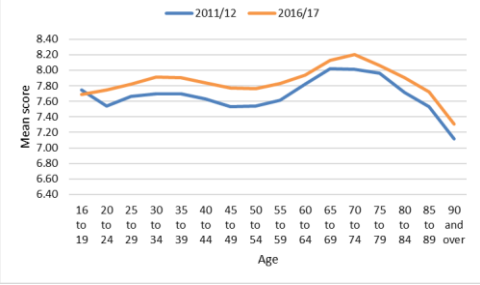


Chart 15: Life worthwhile and sex

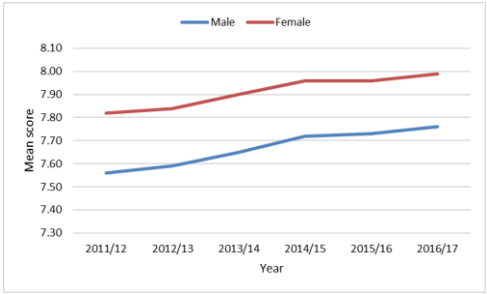


Chart 16: Happiness and age

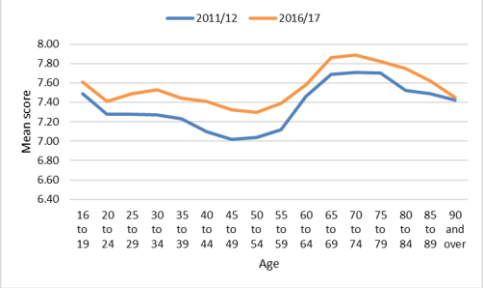


Chart 17: Happiness and sex

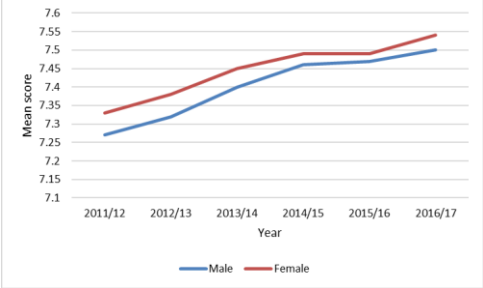


Chart 18: Anxiety and age

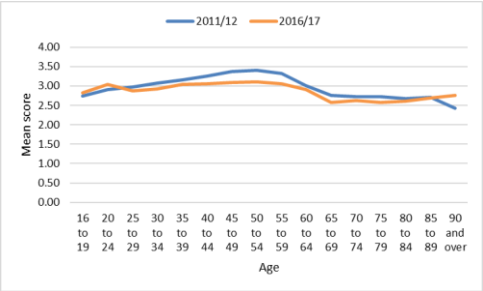
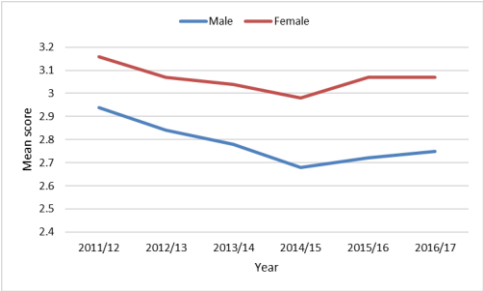


Chart 19: Anxiety and sex



Source: ONS 2018

Mental illness

Table 8 shows the estimated numbers of residents to have a mental illness by type of illness in 2018 and over the next 5 to 10 years. These numbers are calculated by applying the APMS prevalence rates to Office for National Statistics population projections for each borough.

Assuming that prevalence of mental illnesses and rates of diagnosis remain unchanged over the next 5 to 10 years, the following future numbers of residents could be expected to experience mental illness.

Table 8: Estimated cases of mental illness by type and borough 2018, 2023 and 2028

Illness/ presentation	Borough	London	2018	2023	2028	2018-2023	2018-2028
Common Mental Disorder	RBKC	18.0%	23,943	24,805	25,720	862	1,777
	WCC		38,484	40,691	42,123	2,207	3,639
Common Mental Disorder- Unspecified	RBKC	8.7%	11,572	11,989	12,431	417	859
	WCC		18,601	19,668	20,360	1,067	1,759
Generalised anxiety disorder	RBKC	5.9%	7,848	8,131	8,431	283	583
	WCC		12,614	13,338	13,807	724	1,193
Depressive episode	RBKC	3.3%	4,390	4,548	4,715	158	326
	WCC		7,055	7,460	7,723	405	667
Phobias	RBKC	2.5%	3,325	3,445	3,572	120	247
	WCC		5,345	5,652	5,850	307	505
Obsessive compulsive disorder	RBKC	2.0%	2,660	2,756	2,858	96	197
	WCC		4,276	4,521	4,680	245	404
Panic disorder	RBKC	0.8%	1,064	1,102	1,143	38	79
	WCC		1,710	1,809	1,872	98	162
Personality Disorders	RBKC	17.0%	22,613	23,427	24,291	814	1,679
	WCC		36,346	38,431	39,783	2,085	3,437
PTSD	RBKC	4.0%	5,321	5,512	5,716	192	395
	WCC		8,552	9,043	9,361	491	809
Bipolar disorder	RBKC	2.3%	3,102	3,214	3,332	112	230
	WCC		4,986	5,272	5,458	286	472
Psychiatric disorder	RBKC	0.6%	798	827	857	29	59
	WCC		1,283	1,356	1,404	74	121
Self-harm	RBKC	6.4%	8,507	8,813	9,139	306	631
	WCC		13,674	14,458	14,967	784	1,293
Suicide thoughts	RBKC	20.5%	27,218	28,198	29,238	980	2,020
	WCC		43,748	46,258	47,885	2,509	4,137
Suicide attempts	RBKC	6.1%	8,098	8,390	8,699	292	601
	WCC		13,016	13,763	14,247	747	1,231

Source: Adult Psychiatric Morbidity Survey, 2014

3.4 Comparative data on understanding people

This section looks at how Kensington and Chelsea and Westminster compare to the London average on key areas of understanding people.

Table 9 summarises comparative data published by Public Health England.

The following key points are made:

- Both boroughs have a lower percentage of BME residents, but a higher proportion of mixed ethnicity residents compared to the London average
- Rates of both long-term illness (adults and children) and learning disabilities in adults are lower than the London average
- Compared to London, both boroughs have lower rates of first time offenders, first time entrants into the youth justice system and young people in the youth justice system
- The rate of unpaid carers is lower than the London average
- The prevalence of residents registered deaf or hard of hearing is below the London average in both boroughs, while the prevalence residents registered blind or partially sighted is higher than the London average at ages 18-64 years in Kensington and Chelsea and 75 years plus in Westminster
- Compared to the London average, both boroughs have a higher rate of homeless people in temporary accommodation. In addition, Kensington and Chelsea also has a higher rate of people homelessness not in priority need. By contrast rates of family homelessness in both boroughs are lower than the London average.
- Rates of smoking in the general adult population are lower than the London average, but higher than the London average among those with a serious mental illness
- Both boroughs have a higher rate of hospital admissions for mental and behavioural disorders due to the use of alcohol. Rates of alcohol dependence in both boroughs are comparable to the London average
- The estimated prevalence of opiate and/or crack cocaine use is higher than the London average in both boroughs, as is the rate of hospital admissions for substance misuse among young people in Kensington and Chelsea
- 2015-17 pooled data show suicide rates in Kensington and Chelsea and Westminster to be comparable to the London average for both genders.
- The rate of hospital admissions for self-harm, at all ages, is lower than the national average in both boroughs, as are rates of self-harm among young people compared to the London average

Table 9: Indicators on 'understanding people'

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON**	**ENG**	**RBKC**	**WCC**
Ethnicity: White	2011	70.6%	61.7%	59.8%	85.4%	112,017	135,330
Ethnicity: Mixed	2011	5.7%	5.2%	5.0%	2.3%	8,986	11,395
Ethnicity: Black	2011	6.5%	7.5%	13.3%	3.5%	10,333	16,472
Ethnicity: Asian	2011	10.0%	14.5%	18.5%	7.8%	15,861	31,862
Ethnicity: Other	2011	7.2%	11.1%	3.4%	1.0%	11,452	24,337
Long-term health problem (GP Survey)	2011	13.1%	13.8%	14.2%	17.6%	28,803	21,645
Learning disabilities known to GPs	2016/17	0.2%	0.3%	0.4%	0.5%	406	667
15 yr olds diagnosed long-term illness, disability/medical condition	2014/15	11.3%	11.6%	12.6%	14.1%	-	-
First time offenders: /100,000	2017	161	159	215.3	166.4	252	384
First time entrants to the youth justice system 10-17 yrs/ 100,000	2017	231	250	380.3	292.5	26	43
Children in the youth justice system: 10-18 yrs/ 1,000	2016/17	5.2	4.8	6.2	4.8	-	-
Unpaid carers: % of population	2011	1.2%	1.6%	1.8%	2.4%	1,954	3,426
Registered deaf/ hard of hearing 18-64yrs/ 100,000	2009/10	120.5	146.4	170.2	172.8	140	275
Registered deaf/ hard of hearing 65-74yrs/ 100,000	2009/10	204.0	366.0	581.0	620.0	25	50
Registered deaf/ hard of hearing 75yrs+/ 100,000	2009/10	1104	2212	2970	3089	125	285
Registered blind/ partially sighted 18-64yrs/ 100,000	2013/14	261.2	213.8	221.2	214.1	280	345
Registered blind/ partially sighted 65-74yrs/ 100,000	2013/14	859	732	818.0	569.0	105	105
Registered blind/ partially sighted 75yrs+/ 100,000	2013/14	4977	6026	5197	4255	440	725
Households in temporary accommodation /1,000 households	2017/18	28.1	20.7	14.9	3.4	2,235	2,521
Eligible homeless not in priority need/1,000 households	2017/18	1.2	0.7	1	0.8	99	87

Homelessness applications: decisions made/ 1,000 households	2015/16	14.3	8.2	9.1	5	1,131	956
Family homelessness/ 1,000 households	2016/17	3.1	3.1	4.0	1.9	245	372
Smoking Prevalence in adults - current smokers (APS)	2017	13.2%	14.1%	14.6%	14.9%	16,890	27,922
Smoking prevalence in adults with serious mental illness (SMI)	2014/15	43.6%	40.8%	38.9%	40.5%	819	1,110
Estimated adults with alcohol dependence	2014/15	1.4%	1.4%	1.4%	1.4%	1,738	2,728
Hospital admissions for mental and behavioural disorders due to alcohol/ 100,000	207/18	42.9	51.3	51.3	69.2	65	116
Estimated prevalence of opiate and/or crack cocaine use	2014/15	11.3	13.2	8.9	8.6	1,250	2,249
Hospital admissions: substance misuse Young people: 15-24yrs /100,000	14/15 - 16/17	73.2	51.2	67.2	89.8	36	45
Hospital Admissions: Self-Harm - All ages	2017/18	73.1	70.7	83.6	185.5	108	176
Hospital admissions: Self-harm - 10-14yrs / 100,000	2016/17	-	64.6	102.1	207.2	-	7
Hospital admissions: Self-harm - 15-19yrs / 100,000	2016/17	-	224.5	305.2	619.9	-	26
Hospital admissions: Self-harm 20-24yrs / 100,000	2016/17	75.4	57.2	188.6	393.2	7	10
Suicide/ 100,000 - Person	2015-17	9.5	8.3	8.6	9.6	40	49
Suicide / 100,000 - Male	2015-17	15.8	12.1	13.1	14.7	32	35
Suicide/ 100,000 - Female	2015-17	-	4.5	4.4	4.7	8	14

Source: Public Health England Fingertips (2019)

It is worth noting that although both boroughs have lower rates of people with a long term condition or disability that physical and mental health and wellbeing are linked. People with severe mental illness, are at higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease, and cardiovascular disease. Also, many people with long-term physical health conditions experience poor mental health and wellbeing. These can lead to significantly poorer health outcomes and reduced quality of life.

3.4 Understanding place: determinants of mental health and wellbeing

One of the aims of the JSNA is to understand the determinants of health in an area and consider social and contextual factors that affect mental health and wellbeing, such as employment, crime, safety and housing. The mental health and wellbeing of each individual is influenced by their social setting, such as having the ability to earn enough money and feeling part of a community[1]. This section considers these determinants which lead to unfair and avoidable differences in health within and between populations.

Understanding these aspects of 'place', or social factors in a local area can help to quantify levels of risk, protection and resilience within a community. It can help to identify vulnerable groups and consider what interventions could help to reduce vulnerability and develop resilient communities. Greater community resilience has the potential to:

- reduce the prevalence of mental health issues
- increase the prevalence of good mental health
- improve recovery and support for individuals who have become unwell

Interventions which affect the social determinants of mental health and wellbeing require joint working and collaboration across a range of partners, for example the education sector working with health and wellbeing boards.

Deprivation

Experiencing disadvantage can increase the risk of poor mental health and wellbeing. People with mental health issues can be affected by a 'spiral of adversity'[1] where factors such as employment, income and relationships are impacted by their condition.

People who live in deprived areas are more likely to need mental healthcare but less likely to access support and to recover following treatment[4]. This compounds and worsens mental health issues. Data from the European Quality of Life Survey shows material deprivation index to be the single strongest predictor of both life satisfaction and happiness (Understanding Wellbeing Locally, 2017).

The Index of Multiple Deprivation (IMD) is the official measure of deprivation in England. The IMD is a weighted score based on information captured across seven domains (income, employment, education, health and disability, crime, barriers to housing and services and living environment). Scores are calculated at Lower Layer Super Output Level (LLSOA) and presented in quintiles: Quintile 1, LLSOAs within the 20% most deprived LLSOAs in England, through to Quintile 5, LLSOAs within the 20% least deprived LLSOAs in England.

Table 10 shows how Kensington and Chelsea and Westminster compare to the London average. Both Kensington and Chelsea and Westminster are shown to have higher rates of deprivation compared to London.

Table 10: Percentage and estimated number of residents living in the 20% most deprived areas

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Living in 20% most deprived areas	2014	23.6%	28.6%	22.9%	20.2%	36,824	66,829

Source: Public Health England Fingertips (2019)

Poverty & financial security

Having a very low income or experiencing economic deprivation is associated with poor wellbeing[6]. Poverty can be both a causal factor and a consequence of poor mental wellbeing and mental ill health. Across the UK, both men and women in the poorest fifth of the population are twice as likely to be at risk of developing mental health issues as those on an average income. The cumulative impacts of poverty are present throughout the life course, starting before birth and continuing into older age.

Table 11 provides comparative data on poverty and financial security and, where available, estimates of the numbers affected. The following key points are noted:

- compared to London, Kensington and Chelsea and Westminster have higher rates of children aged under 16 years and children and young people aged under 20 years living in poverty
- rates of fuel poverty are estimated to be lower than the London average in both boroughs
- compared to the national average both boroughs have a higher percentage of people aged 60 years and over living in income deprivation - There is no comparative data on rates of income deprivation affecting older people in London.

Table 11: Indicators of poverty and financial security, comparison to London

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Children under 20 in poverty	2015	20.1%	28.5%	19.2%	16.6%	3,820	8,325
Children under 16 in poverty	2015	19.4%	27.3%	18.8%	16.8%	3,195	6,875
Fuel poverty % of households	2016	8.7%	9.3%	10.0%	11.1%	7,157	10,266
Older people 60yrs+ living in poverty	2015	21.6%	24.9%	-	16.2%	-	-

Source: Public Health England Fingertips (2019)

[6] Brown H, Abdallah S, Townsley R (2017) Understanding local needs for wellbeing data. Measures and indicators. What Works for Wellbeing

Housing & homelessness

Stable, good quality housing is critical to positive mental wellbeing, as well as being a protective factor for mental health and a vital element of recovery. Insecure, poor quality and overcrowded housing causes stress, anxiety, and depression, and exacerbates existing mental illness. Homelessness and poor quality housing are risk factors for mental health issues.

Homeless people experience poorer levels of general physical and mental health than the general population, and there is a substantial evidence base documenting multiple morbidities and complex health needs. Rough sleeping is associated with tri-morbidity (the combination of physical ill-health with mental illness and drug or alcohol misuse), complex health needs and premature death.

Research by St Mungo's[7] indicates that between 2009-10 and 2014-5 the number of people in London recorded as sleeping rough with an identified mental health support need more than tripled from 711 to 2,342. This may partly be explained by increased awareness of mental health issues among street outreach workers. Over half of all UK nationals who sleep rough need support for a mental health issue, and 60% of women sleeping rough who had their needs assessed had a mental health need.

27% of rough sleepers in England were counted in London. Westminster is the local authority with the largest number of rough sleepers with 306 counted in 2018. Local research undertaken in 2012 for the JSNA programme found that mental health accounted for the largest number of outpatient appointments and hospital admissions.

Table 12 provides comparative data on housing and homelessness and, where available, estimates of the numbers affected. The following key points are noted:

Compared to London;

- both boroughs have higher rates of households in temporary accommodation, but lower rates of family homelessness
- rates of homelessness – people not in priority need - are higher in Kensington and Chelsea, but lower in Westminster
- rates of decisions on applications for homelessness are higher in Kensington and Chelsea, but lower in Westminster
- both boroughs have a lower rates of estimated fuel poverty
- Both boroughs have higher rates of adult social care clients with mental illness living at home
- both boroughs have higher rates of men and women – who are in touch with mental health services – placed in stable and appropriate accommodation
- both boroughs have a higher percentage of single person households

[7] St Mungo's. Stop the Scandal. https://www.mungos.org/publication/stop-scandal-investigation-mental-health-rough-sleeping/

Table 12: Indicators of housing and homelessness, comparison to London

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Households in temporary accommodation /1,000 households	2017/18	28.1	20.7	14.9	3.4	2,235	2,521
Eligible homeless not in priority need/1,000 households	2017/18	1.2	0.7	1	0.8	99	87
Homelessness applications: decisions made/ 1,000 households	2015/16	14.3	8.2	9.1	5	1,131	956
Family homelessness/ 1,000 households	2016/17	3.1	3.1	4.0	1.9	245	372
Fuel poverty: % of households	2015	8.7%	9.4%	10.1%	11.0%	6,975	10,067
Social care mental health clients aged 18-64yrs receiving home care / 100,000	2013/14	60.6	133.2	46.1	42.2	65	-
Stable & appropriate accommodation: % of adults in contact with mental health services - Persons	2017/18	88.0%	83.0%	61.0%	57.0%	-	-
Stable & appropriate accommodation: % of adults in contact with mental health services - Male	2017/18	87.0%	80.0%	59.0%	56.0%	-	-
Stable & appropriate accommodation: % of adults in contact with mental health services - Female	2017/18	91.0%	89.0%	63.0%	59.0%	-	-
People living alone: % of households occupied by a single person	2011	23.4%	22.5%	12.8%	12.8%	36,524	47,893

Source: Public Health England Fingertips (2019)

Education & lifelong learning

Education is a key determinant of later health and wellbeing. It improves people's life chances, increases their ability to access health services and enables people to live healthier lives.

Education develops skills that help people to function and make decisions in life. It increases peoples' ability to get a job and avoid living in poverty. It helps people to understand how social and health systems work allowing them to improve their health and wellbeing[20].

Schools have an important role in promoting mental wellbeing among children[21]. Pupils with emotional and conduct disorders are more likely to fall behind in their learning[23]. Those not in education, employment or training (NEET) after the age of 16 are at increased risk of depression and suicide and the damaging effect of unemployment at this stage of life lasts into later life

Table 13 provides comparative data on indicators of education and life long-learning and, where available, estimates of the numbers affected. The following key points are noted:

- compared to London, both boroughs have higher rates of primary school aged children with social, emotional and mental health needs, however at secondary level, compared to the London average rates of need are higher in Westminster but lower than the London average in Kensington and Chelsea
- compared to the London average Kensington and Chelsea has higher rate of youth unemployment – 16 to 18 years olds Not in Education, Employment or Training (NEET) compared to the London average. In Westminster the rate of NEETs is below the London average.
- GCSE achievement is higher than the London average in both boroughs, however comparative data for children in care is not available

Table 13: indicators of education and life-long learning, comparison to London

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
% Primary school pupils with social, emotional and mental health needs	2018	2.3%	2.0%	2.2%	2.2%	169	207
% Secondary school pupils with social, emotional and mental health needs	2018	1.9%	4.3%	2.5%	2.3%	103	500
16-18 yrs NEET	2017	9.3%	2.8%	5.0%	6.0%	130	70
5 GCSEs A*-C including English & Maths	2015/16	65.0%	63.6%	61.3%	57.8%	362	700
Children in care 5 or more GCSEs	2015	-	-	16.8%	13.8%	-	-

Source: Public Health England Fingertips (2019)

Employment & working conditions

Meaningful, stable and rewarding employment is a protective factor for mental wellbeing and can be a vital element of recovery from mental health issues. Equally, periods of unemployment (particularly long term) and unstable employment are risk factors for mental health issues.

There are strong links between employment and mental health[1]. The workplace provides an opportunity to promote well-being and support people to 'build resilience, develop social networks and develop their own social capital'. Employers can play an important role in supporting mental health and wellbeing. People who are unemployed are between 4 and 10 times more likely to report anxiety and depression and to complete suicide[31].

A negative cycle can be established when poor mental health and wellbeing can be compounded by unemployment, which then can in turn lead to challenges with, for example, housing and debt causing an individual's mental health and wellbeing to deteriorate and mental illness to become more severe.

The data in Table 14 provides comparative data on employment outcomes. The following key points are noted:

- both boroughs have lower rates of working –age residents in employment, but lower rates of long-term unemployment compared to the London average
- both boroughs have a smaller gap between the employment rate of people in contact with secondary mental health services and the general employment rate
- In London 40% of people with a mental illness or learning disability are in employment

Table 14: indicators of employment and working conditions comparison to London

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Employment: % of population aged 16-64	2017/18	65.4%	64.4%	74.2%	75.2%	71,000	113,100
Long-term unemployment: % 16-64	Jul-17	0.31%	0.35%	0.39%	0.31%	330	630
Gap in employment rate -in contact with secondary mental health services vs. overall employment rate %pt difference: Persons	2017/18	58.4	58.4	68.2	68.2	-	-

Gap in employment rate -in contact with secondary mental health services vs. overall employment rate %pt difference: Male	2017/18	65.4	67.1	75.1	74.0	-	-
Gap in employment rate -in contact with secondary mental health services vs. overall employment rate %pt difference: Female	2017/18	50.0	47.7	61.2	61.5	-	-
% with mental illness/ learning disability employed	2018 Q1	43.3%	35.4%	43.6%	45.7%	5,700	7,900

Source: Public Health England Fingertips (2019)

Information on services to get people into (or back into) work are provided in 8.8.2

Crime & justice

The relationship between crime and mental health and wellbeing is complex. It can also be controversial, as public perception about the relationship can contribute to stigma, discrimination and social exclusion.

While there is public perception that people with mental health issues are offenders, most crimes are committed by people who do not have mental health issues. People with mental health issues are three times more likely to be a victim of crime than the general population and five times more likely to be a victim of assault (rising to 10 times more likely for women).

Good mental health and wellbeing growing up is an important factor in preventing criminal activity. Concerns around mental health and behaviour in children and young people need to be addressed early to break the cycle of offending.

Being a victim of crime, or exposure to violent or unsafe environments can have a negative impact on mental wellbeing and increases the risk of developing a mental health issue. The most serious example of this at a young age is child abuse, which can have a sustained detrimental impact on their mental health throughout their life.

A study by UCL into the effect of local area crime on the mental health of residents found that crime has a significant, negative impact on the mental wellbeing of residents. Though residential crime (burglary, vandalism etc) has the highest impact on mental wellbeing, the impact is only seen in the immediate residential location. Violent crime is found to high levels of mental distress throughout the surrounding neighbourhood, and this type of crime impacts individuals' daily routines. It can

impact residents' sense of feeling safe in the community, uptake of local services and facilities, and exacerbate issues such as social isolation.

As the recent annual report of the Director of Public Health has shown, crime and safety (and its impact on wellbeing) is a key issue of concern to young people in our Boroughs.

Addressing the links between mental health and crime requires partnership work between a range of agencies including education, health, public health, police, the judiciary, places of custody and the range of community organisations which help people in contact with justice services

The data in Table 15 provides comparative data on crime among children and adults. The following key points are noted:

- Rates of first offences among adults and juveniles in both boroughs are lower than the London average. However, rates of reoffending among juveniles in Kensington and Chelsea are above the London average
- Rates of violent crime in Westminster are above the London average
- Rates of reoffending among adults are higher than the London average in both boroughs, and reoffending rates in juveniles are among the highest in London.

Table 15: Indicators of crime and justice, comparison to London

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
First time offenders/ 100,000	2017	160.7	158.7	215.3	166.4	252	384
First time entrants to the youth justice system 10-17 yrs/ 100,000	2017	231.2	250.3	380.3	292.5	26	43
Children in the youth justice system: 10-18 yrs/ 1,000	2016/17	5.2	4.8	6.2	4.8	-	-
Youth re-offending levels: % of offenders*	2016	55.3%	38.6%	46.7%	41.9%	126	117
Violence offences (incl. sexual violence)/ 1,000	2017/18	24.9	39.9	22.9	23.7	3,908	9,661
Re-offending levels: % of offenders*	2016	30.9%	30.2%	27.8%	28.6%	824	1,292

Source: Public Health England Fingertips (2019). More recent data from the (MOJ 2018)*

While the boroughs have lower than the London average number of resident offenders who have come to notice in the criminal justice system, it is noticeable that the proportion of these offenders who reoffend is higher than the London average and recidivism is a challenge for the Boroughs. In addition, crime levels in Westminster are highest across London and increasing greater than other boroughs. Violence against

the person offences are higher (particularly in Westminster) than across London and, for the year 2018, this is also true of sexual offences at London[8].

The London Assembly Health Committee conducted an investigation into Offender Mental Health in 2017. The following information is based on these findings and recommendations:

- The offender and ex- offender population is particularly vulnerable to mental ill health before, during and after contact with the police, courts, prison and probation services. Many offenders and ex-offenders have experienced other characteristics which increase the likelihood of experiencing mental health issues.
- A third of male prisoners and over half of female prisoners suffer from depression.
- The proportion of male prisoners with a diagnosed personality disorder is 64 per cent. Seven per cent of male prisoners have experienced a psychotic disorder within the previous year, which is 10 times the prevalence in the general population.
- According to the British Medical Association (BMA), "female offenders are more likely than their male contemporaries to have been identified with indicators or diagnosis of mental ill health prior to entering prison", with 30% having already had a psychiatric admission, and 46% had attempted suicide at some point.
- Children of offenders are three times more likely to have mental health issues or to engage in anti-social behaviour than their peers.

Organisations across the health and justice systems agree that violence, overcrowding, understaffing and drug abuse in prisons exacerbate poor mental health and wellbeing of inmates and officers. Prison reform charities and others in the health and justice systems have called for improvements in these areas to ensure the physical and mental health of prisoners and staff.

For many, leaving prison can be as traumatic as entering the system. In many cases, mental health, housing and employment support needed after prison is not sufficient. Probation services are struggling to handle the mental health needs of their service users. It is essential that to rehabilitate ex-offenders effectively and reduce reoffending levels, these core needs of stable housing, employment support and continued access to mental health and substance misuse services are sustained.

[8] Metropolitan Police. https://www.met.police.uk/sd/stats-and-data/met/crime-data-dashboard/

Domestic Abuse

In 2018, 2060 domestic abuse incidents were recorded by the Metropolitan Police in Kensington and Chelsea (13.1 per 1,000 population) and 3193 in Westminster (13.5 per 1,000 population). Unfortunately, this is just the tip of the iceberg as only a fraction of domestic abuse incidents are reported to the authorities.

Last year over 2 million adults aged 16-59 experienced domestic abuse across the nation (1.3 million people, 695,000 men) - 8.5% of the population of women and 4.5% population of men.[9] Applied locally, this means that an estimated 10,953 adults in Westminster and 6,509 adults in Kensington and Chelsea experienced some form of domestic abuse last year. An estimated 28% of women have experienced domestic abuse at some point since the age of 16,[10] and a quarter of 13-18 year of girls report experiencing physical abuse in their own intimate relationships, and one third sexual abuse.[11]

Those who have experienced or continue to suffer from domestic abuse, either physical, sexual or psychological, are at a greatly increased risk of mental health issues:

- 40% of high-risk domestic abuse victims report having mental health issues.
- 16% of victims have considered or attempted suicide, and 13% of victims report self-harming.
- Victims are at a high risk of Post-Traumatic Stress Disorder, with one study reporting many as two thirds of victims of abuse developing PTSD.
- Between 30% and 60% of psychiatric in-patients have experienced severe domestic abuse[12].

Source: SafeLives Policy & Evidence 2018

Community wellbeing & Social capital

Mental wellbeing is a combination of an individual's experience (such as happiness and satisfaction) and their ability to function as both an individual and as a member of society. It includes a sense of control, resilience, self-efficacy and social connectedness.

The mental wellbeing of individuals is influenced by factors at a community level such as social networks, sense of local identify, levels of trust and reciprocity and civic engagement. The benefit of this "social capital" can be felt at an individual level (for example, through family support) or at a wider collective level (for example, through volunteering). Social capital is associated with values such as tolerance, solidarity or trust. These are said to be beneficial to society and are important for people to be able to cooperate

[9] ONS Domestic Abuse in England and Wales, March 2018 *Office for National Statistics*
[10] ONS Domestic Abuse in England and Wales, March 2018 *Office for National Statistics*
[11] Partner Exploitation and Violence in Teenage Intimate Relationships, NSPCC London, 2011
[12] Howard L.M et al, Domestic violence and severe psychiatric disorders: prevalence and interventions in 'Psychological Medicine', 2010

Community assets improve the health and the quality of the community. They include physical assets such as public green space, play areas and community buildings and social assets such as volunteer and charity groups, social networks and the knowledge and experiences of local residents. These assets have potential to protect and increase community wellbeing and thus strengthen resilience.

Case Study – Queens Park Community Theatre-Community Champions

The Queens Park Community Theatre is a weekly theatre workshop aimed at people with long term low level mental illness, with public performance every quarter. By thinking about mental health creatively and in the context of characters in a theatre production, service users feel more able to challenge their assumptions and test out different coping strategies in a way they are not able to when thinking directly about their own mental health.

One participant's wife died two years ago. He recently disclosed that since then he has found that he did not want to live without her. He opened up to the group some of whom are Mental Health First Aid trained. They were able to provide mental health first aid and ongoing support.

The resident has fed back that he is now enjoying parts of his life and its very much thanks to being part of the group. Through speaking to the Community Champions, he has been sign posted to many other things which he now uses. He has created his own script and is very much looking forward to preforming at the upcoming community theatre performance.

"it has made me less isolated much more hopeful, meeting lovely people...it is a fantastic project that is helping and changing people's lives... this project is healing"

The data in Table 16 provides comparative data on measures of community well-being and social capital. The following key points are noted:

- Levels of well-being among young people in Westminster are estimated to be lower than the London average, while levels in Kensington and Chelsea are above.
- Both boroughs score higher than the London average on the Office for National Statistics measure of life-satisfaction and happiness
- In both boroughs a higher percentage of residents are indicated to get enough physical activity and to have sports club membership compared to the London average
- Both boroughs have a higher percentage of older adults living alone compared to the London average

Table 16: Indicators of community well-being and social capital

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Wellbeing aged 15yrs mean WEMWBS score	2014/15	48.6	47.4	47.8	47.6	-	-
Self-reported -high satisfaction	2015/16	83.9%	81.2%	79.6%	81.2%	-	-
Self-reported -high happiness	2015/16	77.2%	76.3%	74.3%	74.7%	-	-
Enough physical activity 19yrs+	2016/17	68.2%	66.7%	64.6%	66.0%	-	-
Sports club membership 16yrs+	2015/16	30.9%	27.7%	-	22.0%	-	-
Older people (65yrs+) living alone % households single occupancy	2011	10.5%	10.4%	9.6%	12.4%	8,240	11,035

Source: Public Health England Fingertips (2019)

4 Spotlight on Loneliness & Social Isolation

4.1 Introduction

Loneliness and social isolation are harmful to our health and a key public health issue. Research indicates that lacking social connections is as damaging to our health as smoking 15 cigarettes a day and increases the likelihood of early death (Holt-Lunstad, 2015).

There is evidence that loneliness is a significant risk factor for a wide range of physical and mental health issues, including depression (Cacioppo et al, 2006; Green et al, 1992), heart disease and stroke (Valtorta et al, 2016), high blood pressure (Hawkley et al, 2010), sleep problems, reduced immunity and cognition in the elderly (James et al, 2011; Holwerda et al, 2012).

People that are lonely are more likely to visit their GP, use A&E services, have higher medication use, and higher incidence of falls

Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill (Marmot, 2010).

There are some specific life changing events which are significant triggers for loneliness, such as retirement or bereavement, as well as a number of groups who are more likely to be at risk. Areas of material deprivation are more likely to have higher levels of loneliness as can be seen in section 4.3 below, which reflects many of the key risk factors for loneliness and social isolation.

Definitions

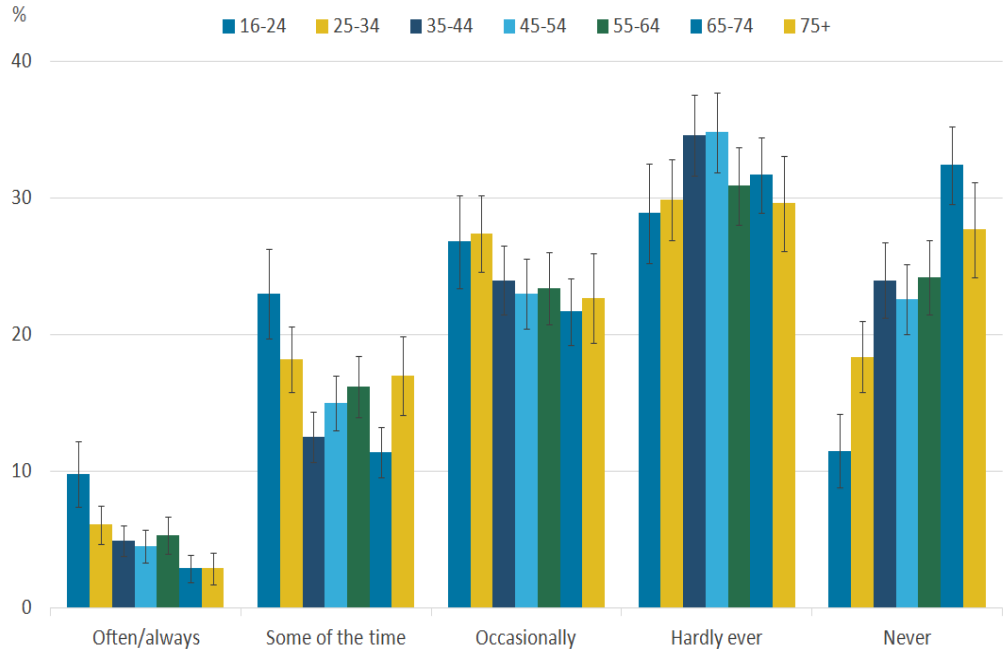
Although many of the studies on loneliness and/ or social isolation use these words interchangeably, it is important to note the distinction between the two. Social Isolation is 'A sociological category relating to imposed isolation from normal social networks'. It is objective and based on the amount of people in a person's social network.

'Loneliness' is a subjective feeling occurring when there is a perceptual gap between actual and desired social relationships. Although social isolation can lead to loneliness, loneliness can be experienced by anyone and social isolation is not a pre-requisite.

Prevalence of loneliness and social isolation

Loneliness and social isolation occur across the life course. Although loneliness has traditionally been associated with older people, recent analysis (2016/17) by the Office for National Statistics shows that that levels of loneliness are at least as high if not higher in those aged under 25. Chart 20 shows the percentage of people within each age group who report themselves as feeling lonely 'Often/always'; 'Some of the time'; 'Occasionally'; 'Hardly ever'; and 'Never'.

Chart 20:Loneliness levels broken down by age



In addition, in data from published findings from research into *Children's and young people's experiences of loneliness* (2018) found that 11.3% of children said that they were "often" lonely. This percentage was higher among younger children aged 10 to 12 years (14.0%), among children in receipt of free school meals (27.5%) children living in a city (19.5%), children who also reported "low" satisfaction with their health (28.3%), and children who reported "low" satisfaction with their relationships with family and friends (34.8% and 41.1%, respectively).

Who is at an increased risk of loneliness and social isolation?

The following groups or characteristics are identified as being at greater risk of loneliness or social isolation:

- People who are living alone, single, widowed or divorced/ separated
- Those who are economically inactive or unemployed
- Those in debt or a low income
- People who are carers
- People living in rented accommodation
- Children with special needs and young care leavers
- Refugees and homeless people
- Perinatal mothers
- People with poor physical or mental health
- Anyone with poor mobility or sensory impairment
- Ethnic minority communities
- Those who identify as LGBTQ
- People abusing alcohol or drugs

4.2 Strategic Context

National

In October 2018 the government launched their first loneliness strategy. The Government's vision is for the UK to be a place where we can all have strong social relationships and where loneliness is recognised and acted on without stigma or shame.

To achieve this requires a society-wide change. The strategy sets out how government, local authorities, businesses, health, the voluntary sector, communities and individuals can all help to build a more socially connected society.

Three overarching goals guide government's work on loneliness.

- to improve the evidence base to better understand what causes loneliness, its impacts and how best to tackle it.
- to embed loneliness as a consideration across government policy
- to build a national conversation on loneliness, to raise awareness of its impacts and to help tackle stigma.

The strategy builds on previous governmental announcements to tackle loneliness. In June 2018, the Prime Minister announced £20m of funding to support voluntary, community and charitable organisations to tackle loneliness. Since June, the Prime Minister also announced the Ageing Society Grand Challenge, as part of government's Industrial Strategy.

Social prescribing is a cornerstone of the strategy. By 2023, government will support all local health and care systems to implement social prescribing connector schemes across the country, supporting government's aim to have a universal national offer available in GP practices.

The Health Secretary confirmed the government's commitment to tackling loneliness and social isolation in the policy paper "Prevention is better than cure: our vision to help you live well for longer" on 5 November 2018). The vision for putting prevention at the heart of the nation's health include reducing loneliness and social isolation, and making social prescribing available in every local area by 2023.

Local

Both the Westminster and RBKC's joint Health and Wellbeing Strategies outline commitments to tackle loneliness in each borough.

The Westminster Health and Wellbeing Strategy acknowledges that positive social interactions are crucial to mental and physical health and wellbeing and sustained loneliness and lack of interaction with others can lead to poorer mental and physical health. The strategy commits health and social care services to work closer together with partners and communities to minimise loneliness and isolation.

RBKC Health and Wellbeing Strategy similarly recognises the role of social interaction in supporting good health. The strategy includes the commitment of health and social

care partners to encourage partnership working between community and voluntary services, the NHS and local authorities to put in place strategies that will reduce social isolation and loneliness in the community.

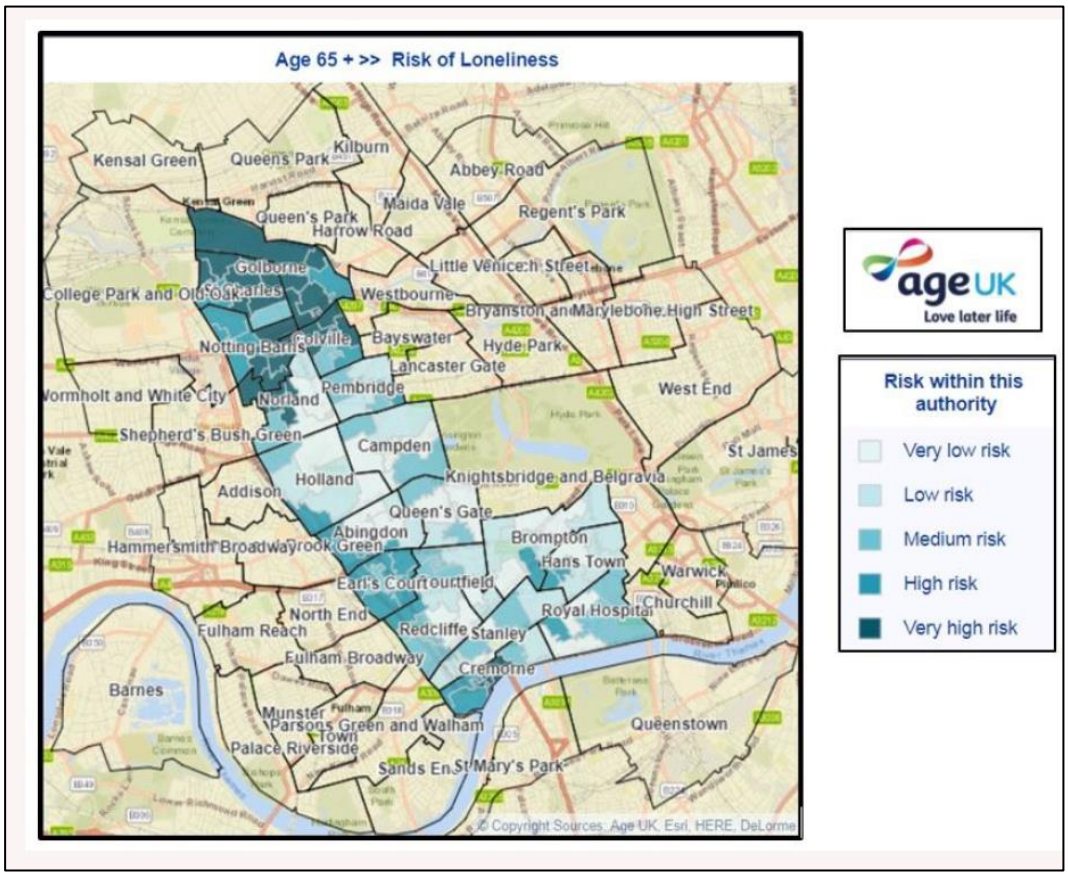
4.3 The Local Picture

People who have good social relationships have higher wellbeing and better mental health (Understanding Wellbeing Locally, 2017).

The population of Westminster has one of the highest 'churn' rates in London (meaning that people move around a lot). The likelihood of social bonds existing between residents is lower in areas with high churn, increasing the risk that people may be socially isolated. (GLA, 2015). 45% of all households in Westminster and 47% of Kensington and Chelsea households are one person households (Westminster JSNA Highlights Report, 2013-14). Living alone correlates with social isolation.

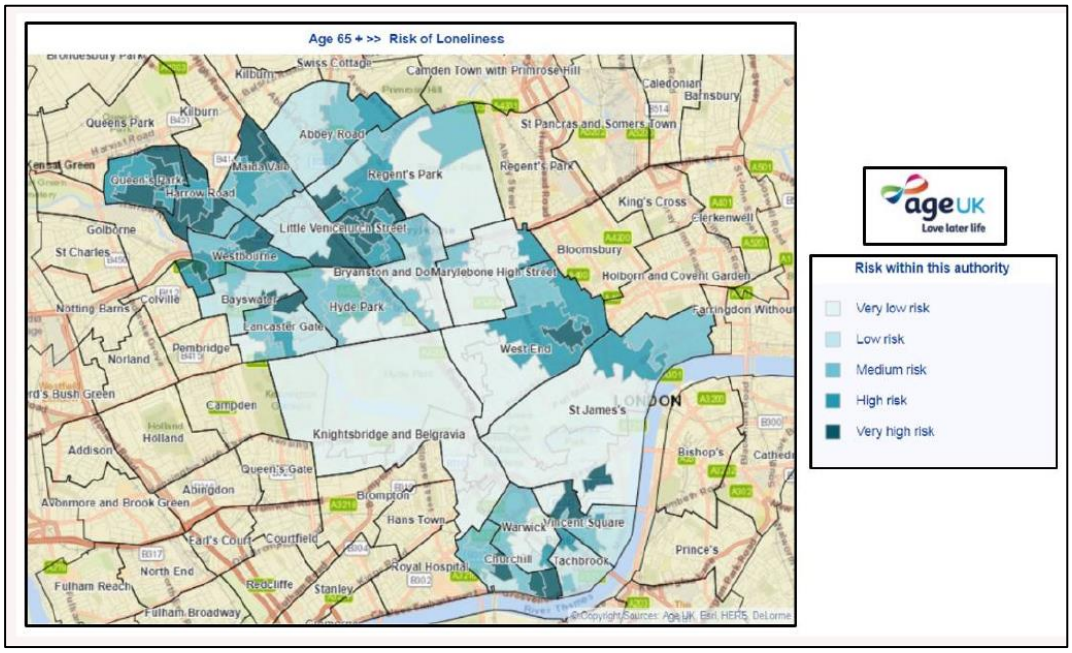
Nationally, it is estimated that around 10% of the population aged over 65 is lonely. In Kensington and Chelsea, 14% of the population are aged 65 or over. The maps below below show the risk of loneliness in those aged over 65 years in Kensington and Chelsea and Westminster (based upon 2011 census figures).

Map 1: Kensington and Chelsea



Source: Age UK http://data.ageuk.org.uk/loneliness-maps/england-2016/kensington%20and%20chelsea/

Map 2: Westminster



Source: AgeUK http://data.ageuk.org.uk/loneliness-maps/england-2016/westminster/

Less than half of adult social care users in both boroughs have as much social contact as they would like: 39.4% in Kensington and Chelsea and 29.7% in Westminster. This is similar to the rest of London (36.5%) in Kensington Chelsea but worse in Westminster (PHOF, 2012-13).

4.4 What works to prevent and tackle loneliness and social isolation across the life course?

Various schemes have proven effective in preventing and tackling social isolation across the life course. However, to date studies on the effectiveness of interventions to tackle loneliness have largely focused on those aged 55+. There is a lack of knowledge on the effectiveness of interventions in other age groups, although approaches deemed effective in older age participants may also be applicable across different age groups, such as group interventions and befriending.

Many reviews recognise the important role that social networks and community programmes have on improving social integration and tackling loneliness. All reviews note that a holistic approach to intervention is needed, and there is no one-size-fits-all model. This is reflected in the My Care, My Way model developed across West London CCG (see section 9.8.2 for more information).

Befriending & Community Navigators

Befriending is the most commonly used type intervention to tackle loneliness and isolation in the elderly and is also used in pregnancy and early years. Many reports into befriending have found that it has a modest to significant positive impact on loneliness.

The Care Connect project in Leeds focussed on re-engaging Irish males with their local communities through volunteer befriending services. Loneliness was reportedly alleviated when people took part in activities that reconnected them with their heritage.

Overall, the evidence suggests slightly more positive outcome levels for one-to-one befriending interventions compared to group based befriending activities.

Evidence suggests that the Community Navigator style services have a positive impact, with users becoming less lonely and socially isolated following such contact. Community Navigators provide support and encouragement to individuals and, based on their interests, signpost to local social activities in order to improve their wellbeing, confidence, and reduce loneliness.

Group-based interventions

Many creative group interventions report a widespread, positive impact on the feelings of loneliness. These interventions include artistic and inspiring activities, discussions, group exercise, therapeutic writing and group therapy.

Various forms of music therapies have a positive impact on loneliness levels. These included choirs, group music making sessions, music learning and performance. Local examples of this include our community choirs such as the Live to Sing, Sing to Live! programme.

Evidence suggests that group-based interventions with a creative focus have a greater positive impact on loneliness than groups focusing on principles of social integration and friendship.

Additional / Specific Interventions across the Life Course

Pregnancy & Early Years

Family Action Perinatal support service uses volunteer befrienders to visit perinatal pregnancy stage, offering social, emotional and practical support. The scheme is successful in providing support to the mother; improving mother- baby relations; encouraging the mother to use health services, children's centres, parks and other community areas; and signposting and support with matters such as housing and benefits. It is targeted at at-risk mothers, deemed vulnerable or who have mild to moderate mental health issues.

The Birth Companions scheme is an example of an effective intervention targeting vulnerable women in the perinatal stage, in prisons or detention centres. It offers a one-to- one service including antenatal classes, support during labour and birth, practical assistance, breastfeeding support and community visits.

Children & Young People

Effective social isolation prevention programs focus on promoting the rights of others and respecting others in society through education. As well as behaviour- change approaches to reduce bullying, schemes such as peer mentoring, cyber mentoring and creative workshops helped to establish social interactions for at risk children.

Initiatives encouraging outdoor play and activity increase opportunities for social interaction.

Schools and school nursing teams are well placed to identify and support young carers, who are at an increased risk of social isolation and who often go under the radar. The school nursing model 'Getting it Right for Children, Young People and Families' sets out a framework to plan and structure service delivery to support young carers through partnership and effective approaches.

Working Age Adults

The TimeBanks approach is being used increasingly in local areas to build strong and mutually supportive social networks in low income communities. Through the TimeBanks scheme, people can give and receive support from each other by contributing different skills and practical help.

Men in Sheds is an example of an initiative specifically aimed at combatting loneliness and building friendships amongst men, who often find it more difficult to build social connections and discuss health and personal concerns.

Later Life

Homesharing (lodgers providing companionship and low- level care in the home in exchange for affordable rent) has proven effective. Householders reported a reduction in the loneliness and social isolation they previously faced. Companionship was identified as a mechanism for reducing loneliness.

Evidence for Reminiscence Therapy is mixed, with some reports of improvement in loneliness levels (Chiang, 2010). Other programs report no effect on loneliness, however there was no decline in levels of loneliness (Bergman Evans 2004).

A humour based therapy program has been successful in alleviating loneliness through fun and creative group sessions, telling jokes and laughing.

Animal Assisted Therapies (AATs) range from placing caged birds in resident's rooms, to the introduction of actual and robot animal in both 1-2-1 settings and into group

environments. AATs were found to be most effective on those reporting the highest levels of loneliness. Evidence on the impact of robot animals is conflicting, with some studies finding no impact on loneliness, and another finding a positive impact. It should be noted that using robotic animals on mentally impaired elderly people raises moral and ethical concerns. The quality of this evidence is not assured as there is a high risk of bias.

Internet & media

In terms of loneliness, social media and the internet is often seen as double sided and can arguably contribute to feelings of loneliness as well as being part of the solution (Robbins 2014, LPHO). A recent study has shown that the use of social media sites is only effective in reducing loneliness when it is used with the intention of making new friends (Teppers 2014), or to stay connected to family and friends. It is argued that training more lonely people to use the internet to stay connected with friends and family could have a positive impact on loneliness, however studies on this so far have proved inconclusive.

Case study…OpenAge

Elizabeth lives alone, with little help available. Her children live away from her and require her to look after them at times. She was feeling somewhat isolated and although she wanted to get out of the house, found it difficult without support. Particularly as there was a lot of building work going on around her.

The OpenAge Linkup Coordinator visited Elizabeth at home discussing activities and groups that might be suitable. She felt the social group in Campden Ward would be something she would like to attend. After she was accompanied on the first visit she has never looked back. She takes an active part in the group and has presented at one.

“OpenAge literally saved my life, it’s true. Having someone come to my home and finding out abit about me, and pointing me the direction of OpenAge activities that might suit me - because of interest and location - was a real help. I go to a group they run every week and have been able to share my Art History knowledge by giving a talk myself to the group - it’s great.”

5 Spotlight on Suicide Prevention

5.1 The importance of suicide prevention

Every day in England around 13 people take their own lives. For every person who dies 10 people are directly affected. The effects can reach into every community and have a devastating impact on families, friends, colleagues and others. Preventing suicide requires the combined actions by local authorities, mental health and health care services, primary care, community based organisations and voluntary agencies, employers, schools, colleges and universities, the police, transport services, prisons and others.

Local Authorities lead the coordination of the work to prevent suicide because their work on public health addresses many of the risk factors, such as alcohol and drug misuse, and spans efforts to address wider determinants of health such as employment and housing. There are also important and varied opportunities to reach local people who are not in contact with health services through on-line initiatives or working with the third sector.

5.2 10 things that everyone needs to know about suicide prevention

The effects of suicide can reach into every community and have a devastating impact on families, friends, colleagues and others.

1. Suicides take a high toll

There were 4,575 deaths from suicide registered in England in 2016 and for every person who dies at least 10 people are directly affected.

2. There are specific groups of people at higher risk of suicide

Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic areas group living in the most affluent areas.

3. There are specific factors that increase the risk of suicide

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in co-ordinating local suicide prevention efforts and making sure every area has a strategy in place.

4. Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in co-ordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.

6. Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restriction, as well as improving opportunities for intervention.

7. Supporting people bereaved by suicide is an important component of suicide prevention strategies.

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.

8. Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or copycat behaviour.

9. The social and economic cost of suicide is substantial and adds to the case for suicide prevention work.

The economic cost of each death by suicide of someone of working aged is estimated to be £1.67million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings and the intangible costs associated with pain, grief and suffering.

10. Local suicide prevention strategies must be informed by evidence

Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

5.3 Suicide Incidence and Prevalence

2015-17 pooled data shows suicide rates in Kensington and Chelsea of 9.5 deaths/100,000 and Westminster of 8.3 deaths/100,000, to be similar to the England rate of 9.6 deaths/100,000.

Like the rest of England, men make up three in four deaths in the boroughs.

Steps have been taken in 2018 to put in a new suicide data surveillance mechanism in the bi-borough to improve to add to the information collected on a national basis. It is hoped that this will improve the picture we have on suicide in the boroughs.

National data indicates that the following groups are at higher risk of death by suicide: men (15 to 59 years), looked after children, older people, some minority ethnic communities, people with previous suicide attempts and people in crisis (for example bereaved by suicide, relationship breakdown, loss of employment).

5.4 Local Action on Suicide Prevention

A JSNA on suicide prevention was published in 2013 https://www.jsna.info/document/suicide-prevention.

A multi-agency group developed **Towards Zero Suicide, A Suicide Prevention Network Action Plan for the Royal Borough of Kensington and Chelsea, City of Westminster2018-2021** which was ratified by the Health and Wellbeing Boards of both boroughs in March 2018

Work to prevent suicide in the boroughs is co-dependent on existing and developing work to promote good mental health, particularly amongst men, young people and minorities. The priorities for the action for 2018 -2021 seek to build on the progress that has been undertaken to date, ensure that those gains are held and concentrate efforts on a limited number of achievable priority areas.

5.5 Suicide Prevention Priorities

Tackling suicide prevention is an iterative process over the long term across many settings. Action needs to take place on a number of levels, working with partners at London Region, at North West London and at borough level. Below are the 2018-21 action plan priority areas. Action on suicide prevention is overseen by a multi-agency Suicide Prevention Steering Group which reports on progress to the Health and Wellbeing Boards.

Borough level priorities areas:

a. Reducing risk in high-risk groups

   Taking cross-cutting and coordinated approaches to address high risk groups is critical to maximising efforts to reduce suicide and improve mental health. Groups that have been chosen to focus on for the next three years include:

   - Men aged 15 to 59
   - People who have attempted suicide
   - Substance misusers

b. Tailoring approaches to improve mental health in specific groups
   - Schools and Early Years
   - Ensuring up to date information on services is easily accessible for individuals, care givers and service providers.
   - To better understand the mental wellbeing needs and issues for the local population.
   - Provision of specialist mental health promotion services for target groups

c. Provide better information and support to those bereaved or affected by suicide

   Post-suicide interventions at family and community level are essential to deal with the effects of suicide, the risk of contagion and cluster suicides and the on-going impact on the mental health of the bereaved. There is a key role here for the police and the Coroner's office in offering immediate help to bereaved families in access to information and to find support from local and national organisations.

d. Promotion of a multiagency approach

North West London sub-regional priority area:

- Improving data collection and monitoring

London Regional level priority area:

- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

6 Perinatal mental health and wellbeing

6.1 Key Messages

Key messages: Perinatal Mental Health

Prevalence

- Literature based estimates suggest that perinatal mental illness will occur in 20% of births. In 2018 this would be equate to 335 cases in Kensington and Chelsea and 533 in Westminster.
    - Of perinatal mental illnesses, the most common disorders are adjustment disorders and distress in the perinatal period and mild to moderate depressive illness and anxiety in the perinatal period.

Risk factors

- Key risk factors for perinatal mental ill health include a history of mental health issues, childhood abuse and neglect, domestic violence, unplanned or unwanted pregnancy, still birth and infant death, inadequate support, alcohol and substance misuse, lone parenthood
    - Comparative data show indicate that both boroughs have lower rates of infant mortality, teenage conceptions, single parenthood and children aged under 18 years on a child protection plan compared to the London average. However, the rate of parents in drug treatment in Westminster and the rate of parents in alcohol treatment in Kensington and Chelsea, the still-birth in Kensington and Chelsea and the percentage of parents that were not born in the UK are all above the London average.

What Works

- There is high quality evidence that the following are effective:
    - Home visiting and peer support interventions for women at high risk of postnatal depression.
    - Home visiting programmes are effective at promoting parenting and infant mental health
- There is moderate quality evidence that the following are effective:
    - Programmes that involved men's active participation with and/or observation of their own children can improve the father-child relationship
    - Antenatal classes can improve parental wellbeing, parent-child attachment and parenting/problem solving skills

- Skin to skin contact can improve attachment and mother-child interaction

- Better Mental Health for All (2016) provides a helpful summary of interventions across the life course and Parenting support is also recommended.
- See also relevant NICE guidance PH40, QS115, CG158 and CG192

6.2 Background

The physical and mental wellbeing of the mother, and the family environment during pregnancy, infancy and childhood is of fundamental importance to mental health. A parent's ability to bond with and care for their baby, their parenting style and the development of a positive relationship can predict numerous physical, social, emotional and cognitive outcomes through to adulthood[4].

While the relationship between mother and child is particularly important, the mental health of fathers and other caregivers should also be considered. Paternal and maternal depression is shown to have a negative impact on how parents interact with children[4] and can have long-term consequences if left untreated[1].

During pregnancy and the year after birth, many women experience common mild mood changes. Some women can be affected by common mental health issues, including anxiety disorders (13%) and depression (12%)[2]. The risk of developing a severe mental health condition is low, but increases after childbirth. The impact of poor mental health can be greater during this period, particularly if left untreated[5].

6.3 Prevalence and incidence

Population prevalence

Perinatal mental health issues are estimated to affect 10-20% of women during pregnancy and the first year after birth. Based on Office for National Statistics birth estimates for 2018 (ONS SNPP, 2016 –based birth projections) up to 335 women in Kensington and Chelsea and up to 533 women in Westminster, could be affected by perinatal mental illness.

Table 17 shows the projected numbers of births by borough in 2018 and over the next 5 to 10 years. It also estimates the cases of perinatal mental illness assuming 20% of women are affected.

Table 17: births by age of mother 2018, 2023 and 2028

	Borough	2018	2023	2028
Births	RBKC	1,673	1,501	1,414
	WCC	2,663	2,515	2,405
Estimated cases of perinatal mental illness	RBKC	335	300	283
	WCC	533	503	481

Source: Office for National Statistics SNPP projections 2017. Estimated prevalence

Other estimates

The Public Health England Perinatal Mental Health Profiles provide estimates of the prevalence of maternal mental illness by Local Authority based on survey data (see Table 18).

From Table 18, adjustment disorders are estimated to be the most common maternity related mental illness (up to 300 cases per 1,000 deliveries), followed by mild-moderate depressive episodes (up to 150 cases per 1,000 deliveries).

Table 18: Estimates cases of perinatal mental illness by borough

	Period	Rate / 1,000 deliveries	RBKC	WCC
Severe depressive illness in the perinatal period	2015/16	30	45	65
PTSD in perinatal period	2015/16	30	45	65
Chronic mental illness in the perinatal period	2015/16	2	5	5
Postpartum psychosis	2015/16	2	5	5
Mid-moderate depressive illness and anxiety in perinatal period	2015/16	100 to 150	140 to 210	215 to 325
Adjustment disorders and distress in the perinatal period	2015/16	150 to 300	210 to 415	345 to 645

*Source: Public Health England Perinatal Mental Health Profiles (2019). * All values rounded to the nearest 5*

Recorded prevalence

There are no registers for perinatal mental illness.

6.4 Risk factors

Public Health England have identified the following key risk factors for postpartum depression:

- history of mental health issues
- childhood abuse and neglect
- domestic violence
- interpersonal conflict
- inadequate social support
- alcohol or drug abuse
- unplanned or unwanted pregnancy
- migration status

The risk of developing postpartum psychosis is significantly increased by a family or personal history of bi-polar disorder, while bereavement by miscarriage, stillbirth or neonatal death are risk factors for mental health issues in both parents.

Table 19 summarises the available data on the prevalence of identified risk factors locally, while Table 20 shows the estimated numbers of men and women of reproductive age estimated to have bi-polar disorder. From Tables 4.2 and 4.3 the following key points are identified:

- At the last measurement 2011/12 the rate of parents in drug treatment were higher than the London average in Westminster and lower in Kensington and Chelsea, while the converse was true for the rate of parents in alcohol treatment: higher in Kensington and Chelsea and lower in Westminster compared to the London average
- In Westminster the rate of still births is higher than the London average, while the rate in Kensington and Chelsea is lower
- Both boroughs perform better than the London average in areas of lone parenthood, infant mortality, teenage conceptions and children with a child protection plan
- Rates of children born to non-UK parents and rates of children in need are higher than the London average in both boroughs
- Based on the estimates from the Adult Psychiatric morbidity study 2.3% of people (men, 2.7%; women, 2.0%) are estimated to have Bi-polar. Applied to the borough populations of reproductive age, 16 to 45 years, this equates to around 1,700 people in Kensington and Chelsea and 3,000 people in Westminster.

Table 19: Risk factors for maternal mental illness

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Parents in treatment/ 100,000 0-15yrs - Drugs	2011/12	81.6	137.2	104.1	110.4	20	45
Parents in treatment/ 100,000 0-15yrs - Alcohol	2011/12	134.7	91.5	108.2	147.2	33	30
Stillbirths: Rate per 1,000 births	2014 - 16	4.3	5.0	4.9	4.5	23	40
Sole registered births: % births	2014	3.9%	3.8%	5.6%	5.4%	71	100
Lone parent families: % of households	2011	4.9%	5.7%	8.5%	7.1%	3,816	6,002
Under 18's conception rate	2016	11.3%	4.6%	17.1%	18.8%	22	14
Infant mortality: Rate per 1,000 births	2015-17	3.2	3.1	3.3	3.9	17	24
Children on child protection plan per 10,000 <18	2014/15	22.0	27.8	40.6	42.9	61	113
Children in need per 10,000 children <18	2014/15	894	851	702	674	2,482	3,464
Looked after children aged <5 per 10,000 pop <5	2016/17	5.6	14.4	-	36.9	5	20
Births to non-UK parents: % of live births	2015	80.7%	81.6%	66.2%	34.0%	1,457	2,208

Source: Public Health England Perinatal Mental Health Profiles (2019)

Table 20: Estimated prevalence of bi-polar disorder among men and women of reproductive age, 16-45 years

	2018		2023		2028	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Borough/ prevalence	*2.7%*	*2.0%*	*2.7%*	*2.0%*	*2.7%*	*2.0%*
Kensington and Chelsea	990	687	994	685	1,000	689
Westminster	1,904	1,192	1,956	1,210	1,953	1,203

Source: Adult Psychiatric Morbidity Survey 2014, GLA population estimates

6.5 Protective factors

Public Health England has highlighted that understanding people and understanding place are key elements of protecting all people from mental illness. In particular, understanding inequalities/ hard to reach groups and ensuring equality of access to service. Specific to maternal mental health the following are key aspects of protection maternal mental health:

- promoting healthy pregnancies
- promoting healthy lifestyles
- primary and secondary prevention
- early identification
- timely provision of quality specialist care.

6.6 What works

In an evidence review undertaken in 2015 on public mental health in the three Boroughs, Shah reports that the following interventions are supported by good quality evidence:

- Home visiting and peer support interventions for women at high risk of postnatal depression.
- Home visiting programmes are effective at promoting parenting and infant mental health

The review reported that home visiting is dependent on a range of process factors such as the intensity and frequency of visits and skills of the provider. Effect sizes are stronger for interventions that:

- last for more than 6 months and involve at least 12 home visits
- started earlier rather than later in parenthood
- are delivered by professionals rather than paraprofessionals or lay people
- are focussed on a broad range of outcomes

The following had a moderate quality evidence base:

- Programmes that involved men's active participation with and/or observation of their own children can improve the father-child relationship
- Antenatal classes can improve parental wellbeing, parent-child attachment and parenting/problem solving skills
- Skin to skin contact can improve attachment and mother-child interaction

Finally, there is a low quality evidence base for:

- Providing advice on infant capabilities to improve parental stress and prevent sleep related problems
- Mixed method interventions combining home visiting with other support for teenage mother parenting skills

Better Mental Health for All (2016) provides a helpful summary of interventions across the life course. For perinatal support the following are recommended:

- Universal infant programmes, including antenatal care and programmes to help all parents develop sensitivity to their infants, have been shown to be effective in improving parental mental health as well as that of the infant.
- Promotional interviewing, which focuses on the positive and aims to empower and support parents as well as to identify needs, is recommended in the English Child Health Promotion Programme
- Suicide prevention plans developed should address the perinatal period:
    - Identify those at increased risk of developing perinatal conditions;
    - Develop a personalised care plan for each woman at increased risk
    - Ensure that women with a history of serious illness are prepared for pregnancy and receive preventative management when pregnant
- The Maternal Mental Health Pathway sets out guidance for healthcare professionals supporting mothers during pregnancy and after birth
- The Family Nurse Partnership Programme addresses parenting and parental wellbeing from pregnancy to the end of the first year of life in teenage parents.

Parenting support is also recommended:

- Baby Steps is a programme designed to help parents cope with the pressures of a new baby which has been developed by the NSPCC
- Mellow Parenting is a suite of programmes covering different age groups from Mellow Baby to Mellow Teen

What NICE says…

NICE guidelines (PH40) emphasise '*the importance of the child's relationship with their mother or main carer, which is in turn dependent on the carer's social, emotional and economic stability*.'

They also emphasize the greater vulnerability to mental health problems of children from socioeconomically disadvantaged backgrounds.

They report that '*current service provision highlights that exposure to the healthy child programme (estimated only 50% of 2-2.5 y olds in 2010,) perinatal and parenting support varies greatly in provision and quality of implementation (Care Quality Commission 2010; DH 2010b)'*

There is currently no measurement of social and emotional wellbeing in the under 5s.

NICE guidelines (CG158) recommend:

Offer a group parent training programme to the parents of children and young people aged between 3 and 11 years who:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or**
- have oppositional defiant disorder or conduct disorder **or**
- are in contact with the criminal justice system because of antisocial behaviour.

6.7 Service Activity

Routine antenatal and postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health issues. Maternity, GP and health visiting services have frequent contact with the mother, baby and family during the perinatal period and are well placed to provide support, make initial assessment and refer onwards if problems are identified. (NICE Quality Standard QS115 -Antenatal and Postnatal Mental Health)

The current Public Health England perinatal mental health profiles still show health visiting performance in the boroughs in 2015/16. At this time, with the exceptions of 8-week review rates in Kensington and Chelsea and 12-month review rates in Westminster, health visitor review rates were worse than the London average. The service has since gone through major transformation and the performance of the service now exceeds the London average on all indicators (See Table 21 below).

Table 21: Percentage of births and children receiving a health visitor review by age and borough

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Review by 8 weeks: % births	2017/18	72.2%	81.7%	67.1%	84.3%	1,141	1,779
New birth visits <14 days: % births	2017/18	92.5%	93.0%	92.3%	87.7%	1,607	2,318
12 Month review % children	2017/18	74.3%	80.1%	56.2%	75.6%	1,232	1,999

Source: Health visitor service delivery metrics: 2017 to 2018 (2019)

According to NICE Clinical guideline CG192 (2014). The most common mental health issues that women in the perinatal period experience are depression and anxiety. It is expected that Improving Access to Psychological Therapy (IAPT) services should be able to meet the needs of both the mother and/or father, and the infant (NHS. IAPT: Perinatal positive practice guide [2009]).

Data on IAPT service performance indicators can be found in Chapter 8.7.

Local data

The Healthy London Partnership dashboard provides the following comparative information on Perinatal Mental Health activity:

- Perinatal admissions per 100,000 (2016/17): Central London CCG has a lower rate, 0.4 compared to the London average of 0.7. No data were available for West London CCG
- The number of women accessing community mental health services per 100,000 (2016/17): Both CCGs have lower rates of use of community based perinatal mental health services compared to the London average, Central London 51, West London 39.8 compared to London, 56.9

In addition, data provided by Central and North West London NHS Foundation Trust (CNWL) provides the following further information. The evaluation of the CNWL Perinatal Mental Health Service reports that between July and December 2017, 294 referrals for community based Perinatal Mental Health Service (PMHS) team.

Table 22 shows the majority of referrals to the Kensington and Chelsea and Westminster service, 55%, were made by primary care clinicians, followed by 22% from hospitals. The evaluation report found 39.5% of referrals to the PMHS were women known to mental health services.

Table 22: Referrals to Kensington and Chelsea and Westminster PMHS July – December 2017

Referral Source	Number or referrals
Primary Health Care	161
Acute Secondary Care	66
Other – Unknown	52
Self-referral	9
Internal referral	<5
Other – Source known	<5
Local Authority Services	<5
Independent or voluntary sector	-
Total	294

Source: CNWL Perinatal Mental Health Interim Report (May-18)

Demand

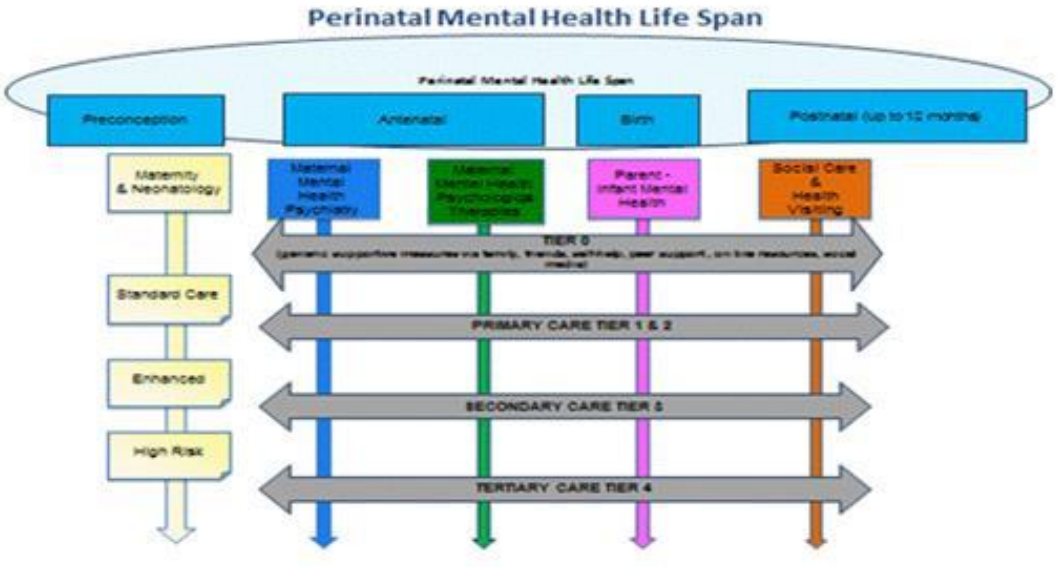
CNWL report that there has been a 140% increase for Kensington and Chelsea and Westminster in the number of perinatal service contacts between July and December 2017 compared to the pre-launch equivalent 6-month period between Dec 2016 and May 17: New contacts increased by 90%, while follow-up contacts increased by 170%.

6.8 Local services and asset mapping

In 2015, Central & West London CCGs undertook a review of perinatal mental health services with a view to enhancing the existing service and developing a community based model of care that meets the needs of all women who experience perinatal mental health issues. The new perinatal mental health care pathway commenced in April 2018.

The pathway aims to take a holistic approach to addressing the bio- psychosocial wellbeing of mothers, infants, partners and families, drawing on evidence from national guidelines and standards for the treatment and management of perinatal mental illness, including guidance from NICE[1] and the Royal College of Psychiatrists. The service is based on the Tiered Model of Care (set out below) and operates on a hub and spoke basis, where two core virtual hubs are established, for Inner and Outer North West London respectively. The service for Central & West London CCGs spans the inner hub.

Figure 1: Perinatal mental health model of care



The tiered model of care has an integrated care pathway for each level of need consists of the following:

- Standard Care (low risk) for women who have an established history of mild-moderate disorder or who are experiencing mild common disorders, such as anxiety and depression during the perinatal period for the first time.
- Enhanced Care (medium risk) for women who have an established history of moderate-complex mental illness, or who are not responding to treatment within the standard clinical pathway.
- Specialist Care (high risk) for women at high risk of relapse of serious and enduring mental illness such as bipolar affective disorder, schizophrenia, schizoaffective disorder, unstable emotional personality disorder or severe depression.

The 'spokes' of the service are established across the community, at Children's Centre's, GP practices, Maternity Units, wherever it is most appropriate for families.

A copy of the full local care pathway is included in the Appendix. as well as the Perinatal Mental Health GP Referral Assessment, Core Processes and Standards.

The newly commissioned pathway consists of:

- Tertiary care mother and baby unit
- Parent and infant psychotherapy service
- Primary care Increasing Access to Psychological Therapy
- Secondary care mental health service

The Coombe Wood Mother and Baby Unit provides specialist perinatal community service to women with moderate to severe mental health needs who are in the last trimester of pregnancy or who have a baby up to 12 months old.

A training programme over the past 12 months has supported the new service and care pathway. Those who have been trained include GPs, Health Visitors and Midwives.

The outcome for GPs is that they:

- are more aware of mental health issues during the perinatal period,
- know where to refer and are making more referrals
- Know they can also access advice from a psychiatrist as to what action they can take to care for a patient knowing that they will be supported

Outcomes – One year on Central and North West London NHS Foundation Trust (CNWL) are evaluating the impact of this new service, a 6 month review has been done and ND with sent to LD as well as the 1 year review when completed.

The CNWL findings in the six-month evaluation for Brent, Harrow, Hillingdon, Westminster, Kensington and Chelsea show that from its launch the service has seen a steady increase of the number of referrals, with a 53% increase in new assessment. The feedback from referrers and service users confirm that the PMHS has been successful in initiating partnerships with a variety of statutory and non-statutory healthcare agencies to deliver multidisciplinary, evidence-based care to parents, their babies and their significant others.

"The new service is good at delivering care for women who services are aware of at the start of their pregnancy, may need extra specialist care. However, there is still work to look at ensuring that the mental health needs of others who do not have prior mental health issues are picked up e.g. by the health visiting service."

Quote from a local GP.

6.9 Quality and outcomes

Comparative quality and outcomes indicators for perinatal mental health are still being developed by Public Health England.

Service user feedback from Central and North West London NHS Foundation Trust (CNWL) suggests that 82% of service users find waiting times reasonable.

Table 23: Perinatal Mental Health Services: Patient satisfaction - waiting time to first appointment

Agreed the waiting time for the first appointment was reasonable	82%

Source: CNWL Perinatal Mental Health Interim Report (May-18)

6.10 Service User Views

These service user views are taken from the Interim Report on Central and North West London NHS Foundation Trust (CNWL) Perinatal Mental Health Service published in May 2018.

Service user views were gathered at independently run focus groups and through an online questionnaire.

Findings from both the questionnaire and the focus groups are very similar which is predominantly positive. Service users were particularly satisfied with the staff engagement, 100% agreed that staff listened to them and understood their problems and 89% agreed that the staff gave them the care and treatment they needed. 100% agreed that their family and they felt cared for, the service felt friendly and would recommend the service to others.

Table 24: Survey results

Percentage	Survey Question
82%	Agreed the waiting time for the first appointment was reasonable
75%	Were satisfied with the venue
93%	Agreed that appointment letters were clear and efficient
100%	Agreed their confidentiality was respected.
96%	Agreed the service administrator was polite and efficient
89%	Agreed that staff gave them the care and treatment they needed
96%	Agreed that staff helped them to understand their difficulties
93%	Agreed they were involved in their care
86%	Agreed that staff also considered their baby's needs
93%	Agreed they were given the opportunity to involve significant others

Service users noted that information about the service was limited both in relation to the availability of information leaflets and the understanding of the service from other professionals, and that knowledge and understanding of the service could be improved.

Whilst the communications between professionals within the PMHS was generally effective, some partnerships were not experienced as being as positive, with comments about the partnership between the PMHS and the birth centre, midwives and health visitors. There were comments that sometimes they would receive inconsistent quality of the health visitors/midwife service

There was a recommendation for more peer support from previous service users as well as perinatal support groups/coffee mornings.

7 Children and young people's mental health and wellbeing

7.1 Key Messages

Key messages: Children and young people's mental health and wellbeing

Prevalence

- It is expected that 50% of people who have a lifetime mental illness (not including red) will have experienced symptoms by the age of 14 years
- Estimates from the Mental Health of Children and Young People Survey suggest 12.8% of children and young people aged 5 to 19 years will have a mental, emotional or behavioural disorder. The London prevalence is slightly lower at 9.0%. Based on the London estimate, in 2018, 2,137 children and young people from Kensington and Chelsea and 3,416 children and young people from Westminster were estimated to have a mental, emotional or behavioural disorder.
    - Emotional disorders are the most common, of which anxiety disorders are the most common. Emotional disorders are more common in girls compared to boys while behavioural disorders are more common in boys.

Risk factors

Risk and factors for child mental illness are divided into four areas: child, school, family and community.

Child level

- There is a clear contrast between the child level risk factors between boroughs: in general, children in Kensington and Chelsea demonstrate lower rates of child level risk factors compared to London, while children in Westminster experience higher rates.
- Exceptions include the rate of Learning Disabilities, children aged 15 years with a diagnosed illness, disability or medical condition, GCSE performance and looked after children's average difficulties score – both boroughs perform better than London on these indicators, but both boroughs perform worse than the London average on school readiness.

Family

- Rates of looked after children and children subject to a child protection plan are lower than the London average in both boroughs. However, in Kensington and Chelsea, the percentage of children subject to repeat child protection plan is higher than the London average
- Both boroughs have lower rates of children in need and looked after children for abuse or neglect compared to London. However, both boroughs also have higher rates of children in need due to family stress, family dysfunction or absent parenting and children in need due to parental disability or illness compared to London. Westminster, also has a higher

rate of looked after children for family stress, family dysfunction or absent parenting

- Both boroughs have higher rates of children in need due to parental disability or illness, however rates of children and young people providing care were lower than the London average in 2011

School

- Both boroughs have higher rates of secondary school fixed period exclusions and school absences compared to the London average. In addition, Kensington and Chelsea is shown to have higher rates of bullying at age 15.
- Generally, both boroughs have lower rates of risky behaviour at age 15 compared to the London average. The exception is Kensington and Chelsea which has a higher rate of current smokers at age 15 and higher rates of alcohol specific hospital admissions among under 18's, compared to London
- Rates of children and young people in the youth justice system are lower than the London average in both boroughs. However, youth reoffending rates in Kensington and Chelsea are above the London average.

Community

- Both boroughs have a higher percentage of children aged under 16 and under 20 years living in poverty and children receiving free school meals compared to the London average.
- Both boroughs have lower rates of family homelessness

What Works

- Mental health promotion activities can help children develop positive mental wellbeing and prevent mental illness. Pre-school and early education programmes are highlighted in the Under 5's Healthy Child Programme and result in improvements in cognitive skills, school readiness, academic achievement and family outcomes, including siblings. They are also effective in preventing emotional and conduct disorder.
- Targeted approaches such as home visiting programmes improve child functioning and reduce behavioural problems
- School-based mental health promotion interventions can improve wellbeing, with resulting benefits for academic performance, social and emotional skills and classroom behaviour (NICE, 2008a). They can also result in reductions in anxiety and depression (NICE, 2009b). Targeted Mental Health Support in Schools (TaMHS) is also effective.

- *Better Mental Health For All* (2016) reports a number of interventions or programmes to promote mental health and wellbeing among children and young people

- See also relevant NICE guidance PH20 NICE 2008a and NICE 2009b

7.2 Background

Building resilience and promoting good mental wellbeing in children and young people is critical. Research tells us that mental health issues frequently develop in our early and teenage years with half of all mental health issues emerging before the age of 14 and three quarters by age 25[2].

There are numerous opportunities across the life course to help promote positive mental health and wellbeing and to build resilience of children and young people. Early intervention to address the childhood determinants of mental health and wellbeing is important. Of these, family relationships are pre-eminent, as positive attachments result in good emotional and social development for children, equipping people with the necessary skills and knowledge to achieve resilience and positive mental wellbeing in adulthood.

7.3 Prevalence and incidence

Population prevalence

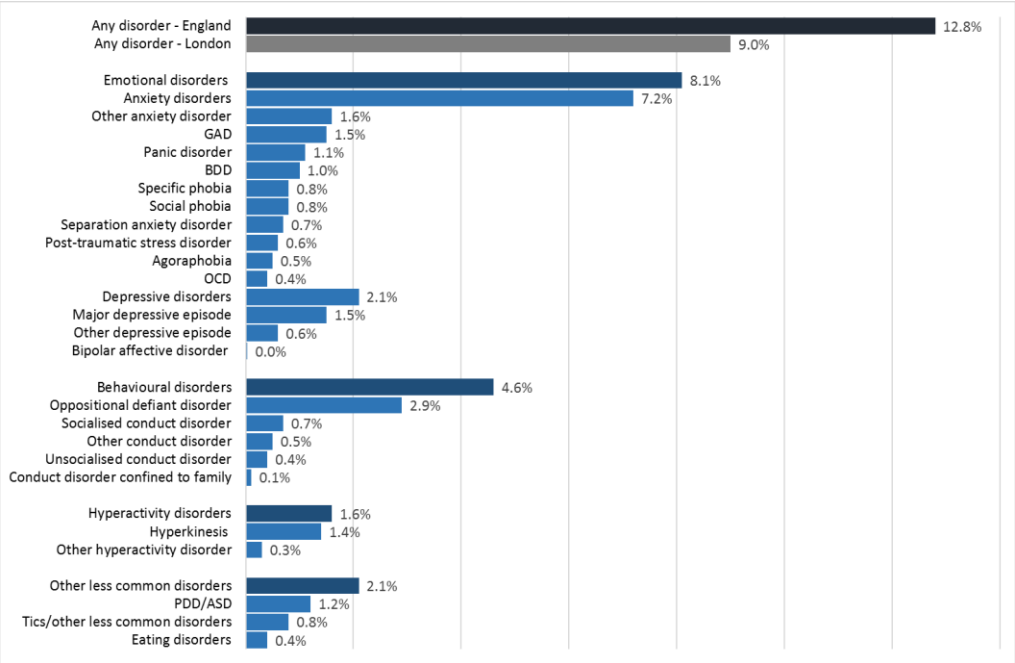
It is expected that 50% of people who have a lifetime mental illness (not including Dementia) will have experienced symptoms by the age of 14 years. This section collates the available estimates of the prevalence of mental illness in children and young people (Chart 15) and translates these into estimated numbers affected across in the Bi-Borough, now and in the future. (See Table 22).

The majority of estimates of the prevalence of mental illnesses in children are taken from the *Mental Health of Children and Young People Survey* (NHS Digital, 2018)

Chart 21 shows the relative prevalance of mental emotional and behavioural disorders in children aged 5 to 19 years as estimated by the Mental Health of Children and Young People Survey for 2017. For all except the Any Disorder – London prevalence rates are based on national rates.

Overall levels of mental ill health in London are expected to be lower than the national average, 9.0% compared to 12.8%. The chart also shows emotional disorders are the most common disorders, of which anxiety disorders have the highest prevalence.

Chart 21: Estimated prevalence of mental, emotional and behavioural disorders in children aged 5 to 19 years, 2017



Source: Mental Health of Children and Young People Survey, NHS Digital, data published 2018. ASD – Autism Spectrum Disorder, Body Dysmorphic Disorder (BDD), GAD – Generalised Anxiety Disorder, OCD – Obsessive Compulsive Disorder, PDD – Pervasive Development Disorder

Applied to the population of the bi-boroughs aged 5 to 19 years, Table 25 shows the estimated number of children and young people affected by mental, emotional and behavioural disorders. Estimates are provided for 2018 and for the next five and ten years.

It is assumed that the prevalence of each disorder will not change from 2017 estimates. Therefore, the reduction in numbers in 2028 is due to an expected reduction in the number of young people residing in both boroughs and not an expected reduction in the prevalence of mental, emotional or behavioural disorders.

Table 25: : Estimated prevalence of mental, emotional and behavioural disorders in the bi-borough, 2017

		Kensington and Chelsea					Westminster				
Disorder/ presentation	Prevalence 5 - 19 years	2018	2023	2028	Change 2018 - 2023	Change 2023 - 2028	2018	2023	2028	Change 2018 - 2023	Change 2023 - 2028
Any disorder - England	12.8%	3,039	3,046	2,952	8	- 94	4,859	5,070	5,070	211	- 1
Any disorder - London	9.0%	2,137	2,142	2,076	5	- 66	3,416	3,565	3,565	149	- 0
Emotional disorders	8.1%	1,923	1,928	1,868	5	- 60	3,075	3,209	3,208	134	- 0
Anxiety disorders	7.2%	1,709	1,714	1,661	4	- 53	2,733	2,852	2,852	119	- 0
Other anxiety disorder	1.6%	380	381	369	1	- 12	607	634	634	26	- 0
GAD	1.5%	356	357	346	1	- 11	569	594	594	25	- 0
Panic disorder	1.1%	261	262	254	1	- 8	418	436	436	18	- 0
BDD	1.0%	237	238	231	1	- 7	380	396	396	17	- 0
Specific phobia	0.8%	190	190	185	0	- 6	304	317	317	13	- 0
Social phobia	0.8%	190	190	185	0	- 6	304	317	317	13	- 0
Separation anxiety disorder	0.7%	166	167	161	0	- 5	266	277	277	12	- 0
Post-traumatic stress disorder	0.6%	142	143	138	0	- 4	228	238	238	10	- 0
Agoraphobia	0.5%	119	119	115	0	- 4	190	198	198	8	- 0
OCD	0.4%	95	95	92	0	- 3	152	158	158	7	- 0
Depressive disorders	2.1%	499	500	484	1	- 15	797	832	832	35	- 0
Major depressive episode	1.5%	356	357	346	1	- 11	569	594	594	25	- 0
Other depressive episode	0.6%	142	143	138	0	- 4	228	238	238	10	- 0
Bipolar affective disorder	0.0%	8	8	8	0	- 0	13	14	14	1	- 0
Behavioural disorders	4.6%	1,092	1,095	1,061	3	- 34	1,746	1,822	1,822	76	- 0
Oppositional defiant disorder	2.9%	688	690	669	2	- 21	1,101	1,149	1,149	48	- 0
Socialised conduct disorder	0.7%	166	167	161	0	- 5	266	277	277	12	- 0
Other conduct disorder	0.5%	119	119	115	0	- 4	190	198	198	8	- 0
Unsocialised conduct disorder	0.4%	95	95	92	0	- 3	152	158	158	7	- 0
Conduct disorder confined to family	0.1%	24	24	23	0	- 1	38	40	40	2	- 0
Hyperactivity disorders	1.6%	380	381	369	1	- 12	607	634	634	26	- 0
Hyperkinesis	1.4%	332	333	323	1	- 10	531	555	554	23	- 0
Other hyperactivity disorder	0.3%	71	71	69	0	- 2	114	119	119	5	- 0
Other less common disorders	2.1%	499	500	484	1	- 15	797	832	832	35	- 0
PDD/ASD	1.2%	285	286	277	1	- 9	456	475	475	20	- 0
Tics/other less common disorders	0.8%	190	190	185	0	- 6	304	317	317	13	- 0
Eating disorders	0.4%	95	95	92	0	- 3	152	158	158	7	- 0

Source: Mental Health of Children and Young People Survey, NHS Digital, data published 2018. London rates applied to Bi-Borough population estimates published by the Greater London Authority (GLA). ASD – Autism Spectrum Disorder, Body Dysmorphic Disorder (BDD), GAD – Generalised Anxiety Disorder, OCD – Obsessive Compulsive Disorder, PDD – Pervasive Development Disorder

Prevalence and socio-demographic factors

Results from the Mental Health of Young People Survey 2017 describe the relationship between the prevalence of any mental illness (mental, emotional, behavioural) among children and young people, and demographic factors and wider determinants.

From Table 26, the prevalence of all mental disorder (mental, emotional and behavioural) among 5 to 19-year-olds is higher:

- at ages 17 to 19 years compared to 5 to 10 years
- among boys at ages 5-10 years and girls at 17 to 19 years
- in the White British population
- among children with special educational needs and children with poor physical health
- where parents have a mental health condition and where family functioning is unhealthy
- where household income is low, benefits for income or disability are claimed
- in areas of deprivation and in the England

Table 26: Any mental, emotional or behavioural disorder

Any mental, emotional or behavioural disorder

		Relationship to:				
Illness/ presentation	**Prevalence 5 to 19 years**	**Age**	**Sex**	**Ethnicity**	**Special educational needs**	**Child/ young person's health**
Any disorder	12.8%	**Prevalence increases with age** 9.5% at ages 5 to 10 years to 16.9% at ages 17 to 19 years	Prevalence is **higher in boys aged 5 to 10 years, 12.2% vs. 6.6%, similar aged 11 to 16 years, c.14%** and **higher in girls 17 to 19 years,** 23.9% vs 10.3% boys	**Highest among White British** 14.9%, lowest among Asian/Asian British, 5.2%	**Higher among children with special educational needs**, 39.1% vs. 9.8% without	**Clear gradient: highest where health is fair/poor/very bad**, 41.8% compared to very good health, 6.4%

	Relationship to:					
Illness/ presentation	**Parental mental health issues**	**Family functioning**	**Household income**	**Benefits status**	**Deprivation**	**Region**
Any disorder	**Higher where parent indicated to have a common mental health disorder**, 27.9% vs. 9.4% where no disorder	**Higher where unhealthy family functioning**, 22.2% vs. 8.9% where healthy functioning	**Prevalence increases the lower household income**, however 4th lowest income quintile: Highest income (1st quintile), 6.8%, Lowest income, 14.1% (4th quintile 16.2%)	**Higher where family receives low income benefits** 18.2% vs. 9.8% without **and where disability benefits are claimed** 31.8% vs. 9.8% without	**Unclear: Lowest in least deprived two quintiles (Q1 and Q2)**, 11.8 -11.9%, **highest in Q3, 14.4%** and in between for the most deprived (Q4 and Q5), 12.8% to- 13.1%.	**Highest in the East of England**,15.6%, Lowest in London 9.0%

Demographics

The Mental Health of Young People Survey reports that, overall, the prevalence of all disorders, behavioural disorders, hyperkinetic disorders and other less common disorders are more prevalent in boys aged 5 to 15 years compared to girls, while the prevalence of emotional disorders is higher in among girls. Table 27 provides a more detailed breakdown of the relationship between specific disorders and age and sex.

Table 27: Relationships between prevalence of mental disorders and age and sex, 2017. London

Emotional disorders

	Relationship to:		
Illness/ presentation	**Prevalence 5 to 19 years**	**Age**	**Sex**
Emotional disorders	8.1%	**Prevalence increases with age** 4.1% at age 5 to 10 years to 14.9% at ages 17 to 19 years	**Higher among boys at 5 to 10 years** 4.6% vs. 3.6%, **higher among girls otherwise: 11 to 16 years** (10.9% vs. 7.1%) **and 17 to 19 years** (22.4% vs. 7.9%)

Anxiety disorders

	Relationship to:		
Illness/ presentation	**Prevalence 5 to 19 years**	**Age**	**Sex**
Anxiety disorders	7.2%	**Prevalence increases with age** 3.9% at ages 5 to 10 years and 13.1% at ages 17 to 19 years	**Higher for boys aged 5 to 10 years**, 4.6% vs. 3.6%, **higher for girls otherwise**: 11 to 16 years, 10.9% vs. 7.1% and17 to 19 years 22.4% vs. 7.9%
Separation anxiety	0.7%	**Prevalence is highest at 5 to 10 years**, 1.0% than 11 to 16 years,0.6%. **Not recorded at 17 to 19 years**	**Higher for girls aged 5 to 10 years**, 1.1% vs. 1.0%, **higher for boys otherwise**: 11 to 16 years, 0.8% vs. 0.4%
Generalised anxiety disorder	1.5%	**Prevalence increases with age** 0.7% at ages 5 to 10 years and 3.2% at ages 17 to 19 years	**Higher for boys aged 5 to 10 years**, 1.2% vs. 0.2%, **higher for girls otherwise**: 11 to 16 years, 2.2% vs. 1.0% and 17 to 19 years 4.6% vs. 1.9%
Obsessive compulsive disorder	0.4%	**Prevalence lowest aged 5 to 10 years**, 0.1% and the **same at ages 11 to 19 years**, 0.7%	**Does not vary**: at ages 5 to 10 years, 0.1%. Similar at ages 11 to 19, 0.7%
Specific phobia	0.8%	**Parabolic: Increasing from** ages 5 to 10 years to 11 to 16 years 0.8% to 0.9%, **falls at ages 17 to 19 years** to 0.6%	

	Relationship to:		
Illness/ presentation	**Prevalence 5 to 19 years**	**Age**	**Sex**
Social phobia	0.8%	**Prevalence increases with age** 0.2% at 5 to 10 years and 1.8% at 17 to 19 years	**Same at 5 to 10 years**, 0.2% **higher in girls 11 to 16 years,** 1.3% vs. 0.8% **and 17 to 19 years**, 2.6% vs. 1.0%
Agoraphobia	0.5%	**Not recorded at ages 5 to 10 years**, **Highest at ages 11 to 16 years**, 1.7%, vs. 17 to 19 years, 0.8%	**Higher in girls 11 to 19 years,** 0.8% vs. 0.2%
Panic disorder	1.1%	**Not recorded at ages 5 to 10 years**, **Increases with age 11 to 16 years**, 1.1%, to 3.4% at ages 17 to 19 years	**Higher among girls** aged 5 to 19 years, 1.7% vs. 0.5%
Post-traumatic stress disorder	0.6%	**Prevalence increases with age** 0.2% at ages 5 to 10 years and 1.3% at ages 17 to 19 years	**Same at age 5 to 10 years**, 0.2%, **higher in girls at ages 11 to 16 years, 0.8% vs. 0.3% and at 17 to 19 years**, 2.4% vs. 0.3%
Other anxiety disorders	1.6%	**Prevalence increases with age** 1.2% at ages 5 to 10 years and 2.3% at ages 17 to 19 years	**Higher in boys 5 to 10 years**, 1.5% vs. 0.9%, **higher in girls at ages 11 to 16 years, 2.2% vs. 1.2% and at 17 to 19 years**, 3.4% vs. 1.2%

Depressive disorders

	Relationship to:		
Illness/ presentation	**Prevalence 5 to 19 years**	**Age**	**Sex**
Depressive disorders	2.1%	**Prevalence increases with age** 0.3% at age 5 to 10 years to 4.8% at ages 17 to 19 years	**Higher in boys aged 5 to 10 years**, 0.4% vs. 0.2%, **higher in girls at ages 11 to 16 years, 3.8% vs. 1.6% and at 17 to 19 years**, 6.5% vs.3.2%
Major	1.5%	**Prevalence increases with age** 0.2% at age 5 to 10 years to 3.5% at ages 17 to 19 years	**Higher in boys aged 5 to 10 years**, 0.2% vs. 0.1%, **higher in girls at ages 11 to 16 years, 2.8% vs. 1.0% and at 17 to 19 years**, 4.7% vs.2.4%
Other	0.6%	**Prevalence increases with age** 0.1% at age 5 to 10 years to 0.8% at ages 17 to 19 years	**Same at age 5 to 10 years**, 0.1%, **higher in girls at ages 11 to 16 years, 1.1% vs. 0.6% and at 17 to 19 years**, 1.8% vs. 0.8%

Bipolar affective disorder

	Relationship to:		
Illness/ presentation	**Prevalence 5 to 19 years**	**Age**	**Sex**
Bipolar affective disorder	0.0%	**Not recorded at ages** 5 to 10 years, **Increases from** <0.0% at ages 11 to 16 years to 0.1% at ages 17 to 19 years	**Higher among girls** 0.1% at ages 11 to 19 years, vs. <0.1% for boys

Table 27 continues on the next page

Table 27 continued…

Behavioural disorders

Illness/ presentation	Relationship to: Prevalence 5 to 19 years	Age	Sex
Behavioural disorders	4.6%	**Parabolic: Increasing from** ages 5 to 10 years to 11 to 16 years 5.0% to 6.2%, **falls at ages 17 to 19 years** to 0.8%	**Higher among boys at all ages** (5 to 19 years) 5.8% vs. 3.4%
Oppositional defiant disorder	2.9%	**Prevalence decreases with age: 3.6% at ages 5 to 10 years,** to 0.4% at ages 17 to 19 years	**Higher among boys at all ages** (5 to 19 years) 3.6% vs. 2.2%
Conduct disorder confided to the family	0.1%	**Prevalence decreases with age: 0.2% at ages 5 to 10 years,** to 0.1% at 11 to 16 years, not recorded at ages 17 to 19 years	**Higher among boys at all ages** 5 to 10 years, not recorded for girls 11-16 years or for both sexes at ages 17 to 19 years

Illness/ presentation	Relationship to: Prevalence 5 to 19 years	Age	Sex
Socialised contact disorder	0.4%	**Parabolic: Increasing from 0.3% at ages 5 to 10 years,** to 0.6% at 11 to 16 years, not recorded at ages 17 to 19 years	**Higher among boys**, 0.4 vs. 0.3 at ages 5 to 16 years. **No data on boys at ages 17 to 19 years**
Socialised conduct disorder	0.7%	**Prevalence increases with age: 0.3% at ages 5 to 10 years,** to 1.5% at 11 to 16 years, falls at ages 17 to 19 years to 0.2%	**Higher among boys**, 0.9 vs. 0.3 at all ages 5 to 19 years.
Other conduct disorder	0.5%	**Prevalence is the same for ages 5 to 16 years,** falls at ages 17 to 19 years to 0.2%	**Higher among boys**, 0.9 vs. 0.3 at ages 5 to 16 years. **No data on boys at ages 17 to 19 years**

Other less common disorders

Illness/ presentation	Relationship to: Prevalence 5 to 19 years	Age	Sex
Other less common disorders	2.1%	**Prevalence is the same for ages 5 to 16 years**, 2.2%, then **falls to 1.8% for ages 17 to 19 years**	**Higher among boys at ages 5 to 10 year 3.4% vs. 1.0% and at 11 to 16 years**, 2.4% vs. 2.0%, **higher in girls at 17 to 19 years**, 2.2% vs. 1.4%
Pervasive developmental disorders/ Autistic spectrum disorders	1.2%	**Prevalence declines with age** 1.5% at 5 to 10 years to 0.5% at ages 17 to 19 years	**Higher among boys at all ages** 1.9% vs. 0.4%
Eating disorders	0.4%	**Prevalence increases with age** 0.1% at 5 to 10 years to 0.8% at ages 17 to 19 years	**Same at ages 5 to 10 years, higher among girls at other ages:** 11 to 16 years , 1.0% vs. 0.2% and at 17 to 19 years 1.6% vs. 0%
Tic/ Other less common disorders	0.8%	**Prevalence declines with age** from 1.1% at ages 5 to 10 years to 0.6% for ages 11 to 19 years	**Higher among boys at ages 5 to 10 year 1.6% vs. 0.6% and at 11 to 16 years**, 0.8% vs. 0.4%, **higher in girls at 17 to 19 years**, 0.8% vs. 0.4%

Hyperkinetic disorders

Illness/ presentation	Relationship to: Prevalence 5 to 19 years	Age	Sex
Hyperkinetic disorders	1.6%	**Parabolic: Prevalence is highest at 11 to 16 years**, 2.0%; Prevalence at 5-10 years is 1.7% and at 17 to 19 years 0.8%	**Higher in boys at all ages** (5 to 19 years), 2.6% vs. 0.6%
Hyperkinesis	1.4%	**Parabolic: Prevalence is highest at 11 to 16 years**, 1.7%; Prevalence at 5-10 years is 1.6% and at 17 to 19 years 0.4%	**Higher in boys at all ages** (5 to 19 years), 2.2% vs. 0.6%
Other hyperkinetic disorders	0.3%	**Prevalence increases with age** 0.1% at 5 to 10 years to 0.4% at 17 to 19 years	**Higher in boys at all ages** (5 to 19 years), 0.4% vs. 0.0%

Source: Mental Health of Children and Young People Survey, NHS Digital, data published 2018

Other estimates

Comparative analysis of the prevalence of mental illness in children aged 5 to 16 years performed by PHE suggests that rates are lower than the London and England average in Kensington and Chelsea 8.2%, but higher than the England average in Westminster, 9.6% (England 9.2%, London 9.3%). Trend analysis is not available.

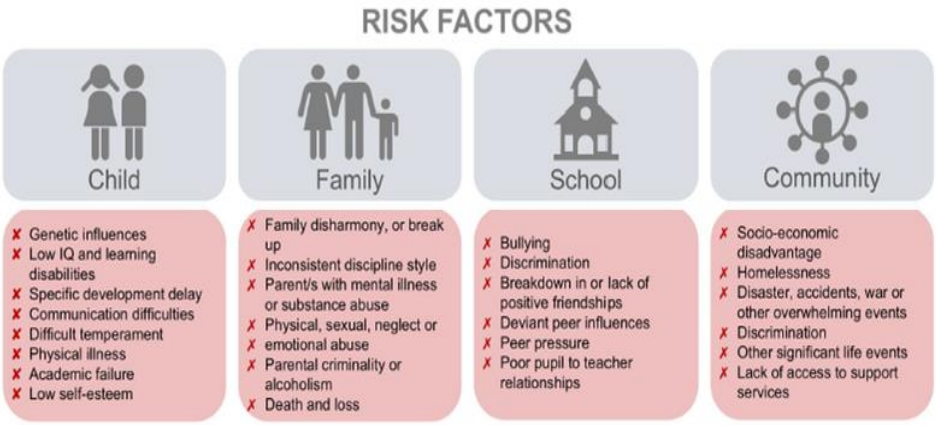
7.4 Risk factors

As discussed in Chapter 4, the primary predictor of mental health and wellbeing in children and young people is the quality of the parent-child relationship and parenting more broadly.

Children also spend a high proportion of their waking life in schools and so this is an age where the school environment is key to wellbeing. The school ethos, mental wellbeing of teachers, relationships with peers and prevalence of bullying all matter. The importance of the school environment was also recognised in recent consultation with young people for the annual report of the Director of Public Health.

Recently, attention has been given to adverse childhood experiences (ACE) and the impact these events have on an individual's health and wellbeing into adulthood. The term is used to describe the occurrence of abusive or neglectful parenting, drug and alcohol misuse, parental mental illness, divorce or bereavement. Where risks are identified and problems addressed early, a virtuous cycle of accessing the right support and recovery can be established.

Figure 2: Risk factors associated with children and young people developing mental illness.



Source: Adapted from the mental health of children and young people in London (PHE, December 2016)

Comparative data

The following section reviews comparative data from the PHE fingertips profiles relating to children and young people. The indicators are RAG (red, amber, green) rated to indicate where rates are worse, the same or better than the London region.

Child excess weight is not included in Figure 2 however it is included in the PHE JSNA profile as a risk factor and has therefore been included.

Child level risk factors

Table 28 summaries comparative data from the PHE fingertips profiles relating to the child level risk factors identified in Figure 2. The following key points are noted:

- There is a clear contrast between the child level risk factors between boroughs: in general children in Kensington and Chelsea demonstrate lower rates of child level risk factors compared to London, while children in Westminster experience higher rates.
- Exceptions include the rate of Learning Disabilities, children aged 15 years with a diagnosed illness, disability or medical condition, GCSE performance and looked after children's average difficulties score – both boroughs perform better than London on these indicators, but both boroughs perform worse than the London average on school readiness.

Table 28: Comparative data, child level risk factors

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Children with learning disabilities known to schools/ 1,000	2018	11.4	18.2	23.0	33.9	291	580
School Readiness: % achieving expected level – All	2017/18	86.4%	86.3%	85.0%	82.5%	842	120
School Readiness: % achieving expected level – Free school meals	2017/18	78.0%	81.0%	76.7%	70.1%	130	200
GCSEs 5A*-C incl. English & Maths: % pupils	2015/16	65.0%	63.6%	61.3%	57.8%	362	700
5 or more GCSEs % of children in care	2015	-	-	16.8%	13.8%	-	-
Special Educational Needs % School age	2018	13.5%	15.3%	14.4%	14.4%	1,732	3,427
Special Educational Needs % Primary	2018	10.3%	15.0%	12.4%	12.3%	550	1,730
Special Educational Needs % Secondary	2018	14.6%	13.9%	13.9%	13.8%	1,079	1,471
Children in need: child disability or illness/ 100,000 u18	2018	19.3	48.5	38.5	29.7	55	219
Diagnosed long-term illness/disability/condition (15yrs)	2014/15	11.3%	11.6%	12.6%	14.1%	-	-
Mental health disorders % 5-16yrs	2015	8.2%	9.6%	9.3%	9.2%	1,491	2,571
Hyperkinetic disorders: % 5-16yrs	2015	1.3%	1.6%	1.5%	1.5%	237	423
Conduct disorders: % 5-16yrs	2015	4.9%	5.9%	5.7%	5.6%	881	1576

Social, emotional and mental health needs % School age	2018	2.1%	3.2%	2.4%	2.4%	274	713
Social, emotional and mental health needs % Primary	2018	2.3%	2.0%	2.2%	2.2%	169	207
Social, emotional and mental health needs % Secondary	2018	1.9%	4.3%	2.5%	2.3%	103	500
Looked after children: average difficulties score 5-16yrs	2016/17	10.5	12.3	13.7	14.1	-	-
Cause for concern - % of looked after children 5-16yrs	2016/17	-	25.0%	35.5%	38.1%	-	20
Children in need: Socially unacceptable behavior/ 10,000	2018	36.5	-	13.3	6.9	104	-
Mean wellbeing (WEMWBS) score at 15 yrs	2014/15	48.6	47.4	47.8	47.6	-	-
Positive satisfaction at 15 yrs: % positive	2014/15	62.8%	50.4%	59.9%	63.8%	-	-
Excess weight Reception yr: % 4-5 yrs	2017/18	20.6%	18.9%	21.8%	22.4%	140	205
Excess weight Year 6: % 10-11 yrs	2017/18	36.7%	40.0%	37.7%	34.3%	261	466

Source: Public Health England Fingertips (2019)

Family

Table 29 shows that, by contrast to child level risk factors, the boroughs present similarly on familial risk factors when compared to London. The following key points are noted:

- Rates of looked after children and children subject to a child protection plan are lower than the London average in both boroughs. In Kensington and Chelsea, the rate of children subject to repeat child protection plan is also lower than the London average (there is no data for Westminster on this indicator).
- Both boroughs have lower rates of children in need and looked after children for abuse or neglect compared to London.
- Both boroughs have higher rates of children in need due to family stress, family dysfunction or absent parenting compared to London. In addition, Westminster, also has a higher rate of looked after children for family stress, family dysfunction or absent parenting

- Both boroughs have higher rates of children in need due to parental disability or illness, however rates of children and young people providing care were lower than the London average in 2011

Table 29: Comparative data, family level risk factors

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Domestic abuse-related incidents & crimes/ 1,000	2017/18	31.7	31.7	31.7	25	-	-
Parents in drug treatment/ 100,000 0-15yrs	2011/12	81.6	137.2	104.1	110.4	20	45
Parents in alcohol treatment/ 100,000 0-15yrs	2011/12	134.7	91.5	108.2	147.2	33	30
Children in need: abuse/neglect / 100,000 u18	2018	92.7	92.3	180.3	181.4	264	417
Looked after: due to abuse/neglect / 100,000 u18	2018	5.3	5.5	13.1	16.4	15	25
Children in need: family stress/dysfunction/absent parenting / 100,000 u18	2017	163.6	145.0	97.9	93.8	467	641
Looked after: family stress/dysfunction/absent parenting / 100,000 u18	2017	8.8	18.5	11.6	9.3	25	82
Children in need: parent disability/illness	2018	18.6	19.9	14.0	8.8	53	90
Families with health problems: % of households	2011	2.6%	3.5%	5.0%	4.6%	2,033	3,726
Young people providing care: % 16-24	2011	4.4%	5.1%	5.4%	4.8%	735	1,330
Children providing care: % <15	2011	0.8%	1.0%	1.1%	1.1%	186	332
Looked after children: rate/ 10,000 < 18	2015/16	37.1	38.7	50.5	60.3	105	165
Child protection plan: rate/ 10,000 < 18 yrs - Neglect	2018	15.8	4.4	16.3	21.8	45	20
Child protection plan: rate/ 10,000 < 18 yrs - Abuse	2018	9.8	12.6	21.3	21.2	28	57
Repeat child protection plan: 2nd/ subsequent time	2018	13.1%	-	15.0%	20.2%	13	-

Source: Public Health England Fingertips (2019)

School

The following indicators relate to the influences that can occur through a child's experiences at school. The following key points are noted:

- Kensington and Chelsea is shown to have higher rates of bullying at age 15.
- Both Kensington and Chelsea and Westminster have a higher proportion of residents of mixed and of other ethnicity compared to the London average.
- Both boroughs have higher rates of secondary school fixed period exclusions and school absences compared to the London average
- Primary school fixed period exclusions in Kensington and Chelsea are higher than the London average, while rates are lower than the London average in Westminster.
- Generally, both boroughs have lower rates of risky behavior at age 15 compared to the London average. The exception is Kensington and Chelsea which has a higher rate of current smokers at age 15 and higher rates of alcohol specific hospital admissions among under 18's, compared to London.

Table 30: Comparative data, school level risk factors

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
15 yr olds bullied in the past couple of months	2014/15	50.2%	49.6%	50.0%	55.0%	-	-
Ethnicity: White	2011	70.6%	61.7%	59.8%	85.4%	112,017	135,330
Ethnicity: Mixed	2011	5.7%	5.2%	5.0%	2.3%	8,986	11,395
Ethnicity: Black	2011	6.5%	7.5%	13.3%	3.5%	10,333	16,472
Ethnicity: Asian	2011	10.0%	14.5%	18.5%	7.8%	15,861	31,862
Ethnicity: Other	2011	7.2%	11.1%	3.4%	1.0%	11,452	24,337
15 yr took drugs (excl. cannabis) in the last month	2014/15	-	0.6%	1.0%	0.9%	-	-
15 yr olds regular drinkers: % of 15 yr olds	2014/15	1.8%	1.5%	3.1%	6.2%	-	-
15 yr olds current smokers: % of 15 yr olds	2014/15	5.3%	6.8%	6.1%	8.2%	-	-
3 or more risky behaviours: % of 15 yr olds	2014/15	8.2%	7.5%	10.1%	15.9%	-	-
Hospital admissions - alcohol-specific u18yrs/ 100,000	15/16-17/18	20.0	15.9	18.0	32.9	17	21
Fixed pd. exclusion: persistent disruptive behaviour/ 100 pupils	2016/17	0.6%	0.7%	0.7%	1.4%	75	147

Primary school fixed period exclusions/ 100 pupils	2016/17	0.9%	0.5%	0.8%	1.4%	63	57
Secondary school fixed period exclusions/ 100 pupils	2016/17	11.8%	9.5%	7.5%	9.4%	597	1,083
School absence: % of half days missed	2016/17	4.6%	4.6%	4.4%	4.7%	173,033	282,314

Source: Public Health England Fingertips (2019)

Community

Table 31 shows how the boroughs compare to London on indicators of community level factors that influence the risk of a child developing a mental illness. The following key points are noted:

- Rates of children and young people in the youth justice system are lower than the London average in both boroughs. However, youth reoffending levels in Kensington and Chelsea are above the London average.
- Both boroughs have a higher percentage of children aged under 16 and under 20 years living in poverty compared to the London average.
- Westminster has a higher percentage of children living in income deprivation compared to the London average, whereas in Kensington and Chelsea has a lower percentage.
- Youth unemployment is higher than the London average in Kensington and Chelsea while in Westminster the rate is below the London average
- Both boroughs have a higher percentage of children receiving free school meals compared to the London average.
- Both boroughs have lower rates of family homelessness, care leavers and out of work households compared to the London average

Table 31:Comparative data, community level risk factors

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
First time entrants - youth justice system/100,000 10-17yrs	2017	231.2	250.3	380.3	292.5	26	43
Children in youth justice system/1,000 10-18yrs	2016/17	5.2	4.8	6.2	4.8	-	-
Youth re-offending levels: % of offenders*	2016	55.3%	38.6%	46.7%	41.9%	126	117
Child poverty: % of children aged 0-15 (IDACI)	2015	17.4%	28.7%	24.4%	19.9%	4,305	9875
Children under 20 in poverty: % children <20	2015	20.1%	28.5%	19.2%	16.6%	3,820	8,325
Children under 16 in poverty: % of children < 16	2015	19.4%	27.3%	18.8%	16.8%	3,195	6,875
16-18 yrs NEET: %	2017	9.3%	2.8%	5.0%	6.0%	130	70
Free school meals: % uptake among all pupils	2018	18.9%	22.0%	15.6%	13.5%	2,468	4,987
Family homelessness: rate per 1,000 households	2016/17	3.1	3.1	4.0	1.9	245	372
Families out of work: % of households with dependent children & no adult in employment	2011	3.6%	5.0%	5.7%	4.2%	2,842	5,251
Children leaving care u18yrs	2015/16	26.5	25.8	30.7	27.2	75	110

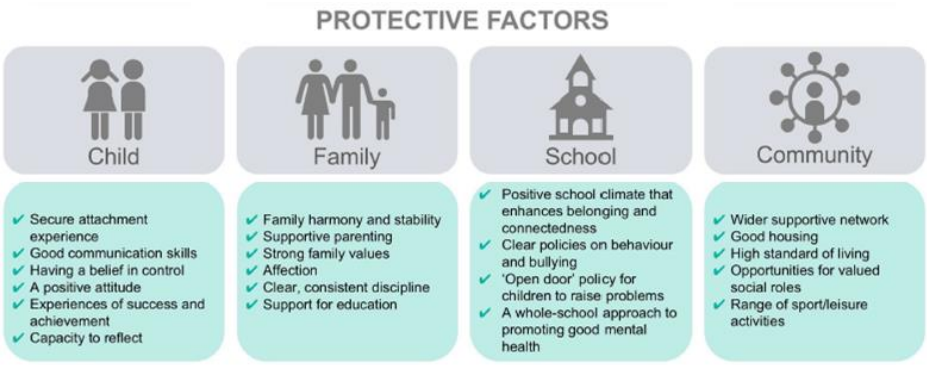
*Source: Public Health England Fingertips (2019). * MOJ p*

7.6 Protective factors

Figure 3 summarises the known protective factors associated with a reduced likelihood of children and young people developing mental illness.

Comparative quantitative data on protective factors for children as described below is currently not available.

Figure 3: Protective factors associated with reduced likelihood of developing mental illness.



Source: Adapted from he mental health of children and young people in London (PHE, December 2016)

7.7 Social Media and online lives

In recent years there have been concerns raised over the impact of social media on the mental health and wellbeing of children and young people.

A growing body of research suggest that social media can have both a positive and negative impact on health and wellbeing. While it can provide a gateway to advice, help or support, and encourage young people to develop social skills and a sense of belonging with an online community, there are also risks associated with excessive internet use. These range from cyberbullying, access to harmful content, such as websites which promote self-harm.

Local young people expressed concerns around social media In the Director of Public Health's Annual Report Our Health Our Wellbeing: young people growing up in Kensington and Chelsea, and Westminster. Young people expressed specific concern around cyberbullying and also the impact of spending too much time on it. Research indicates that around 44% on children and young people spend over 3 hours per say on social media. However, as many described how social media could create opportunities to promote health messages in a targeted way through sites such as YouTube and Instagram.

Case Study: Westminster Academy – safety and social media

Westminster Academy are focusing on safety and social media as their work to achieve the Centre of Excellence Award. The aim of the project is that their pupils will understand the implications of misuse of social media, will self-manage and thereby be able to safeguard themselves and their peers. The school aims to achieve a reduction in fixed term exclusions related to social media use.

Supporting parents is also a critical part of the plan and they aim to help parents become more confident and knowledgeable in managing and monitoring their children's activity on social media. Social media also provides opportunities, so the school will also be looking at how it can be used as a tool for teaching and to raise attainment. Westminster Academy will share its learning with all Westminster schools.

7.8 What works

Shah (2015) found that mental health promotion activities can help children develop positive mental wellbeing and prevent mental illness. Pre-school and early education programmes are highlighted in the Under 5's Healthy Child Programme and result in improvements in cognitive skills, school readiness, academic achievement and family outcomes, including siblings (Woolfenden, Williams & Peat, 2001). They are also effective in preventing emotional and conduct disorder.

More targeted approaches such as home visiting programmes improve child functioning and reduce behavioural problems (Waddell et al., 2007) (being rolled out in the UK as Family Nurse Partnership).

School-based mental health promotion interventions can improve wellbeing, with resulting benefits for academic performance, social and emotional skills and classroom behaviour (NICE, 2008a). They can also result in reductions in anxiety and depression (NICE, 2009b). Targeted Mental Health Support in Schools (TaMHS) is also effective.

Evidence for school-based yoga and mindfulness activities to improve mental health was very low quality.

Better Mental Health For All (2016) reports a number of interventions or programmes to promote mental health and wellbeing among children and young people:

- Parenting under Pressure, a promising programme for supporting parenting in families where parents abuse drugs or alcohol.
- Let's Talk About Children, a manual for a two session discussion with parents who are living with a mental health issue.
- The English Healthy Child Programme (2009) covers five to nineteen-year olds and sets out the recommended framework of universal and progressive services for children and young people in order to promote optimal health and wellbeing.

- A comprehensive 'whole school' approach to promoting the mental wellbeing of children and young people.
- Evidence based bullying prevention programmes in settings in which children and young people learn, live and spend their leisure time.
- Looked after children should have sufficient involvement in decisions to do with their care and have access to nurturing relationships that foster attachment.
- Target wellness services towards clusters of children identified as being at high risk of multiple poor behaviours, rather than providing single issue services only.
- The Early Intervention in Psychosis (EIP) model, which was developed in Melbourne and has been adopted in England and Wales, is an effective intervention.
- A prevention intervention aimed at children at risk of eating disorders is Cognitive Dissonance Activities. This initiative engages young people in conversation on body image.
- The Increasing Access to Psychological Therapies (IAPT) programme

What NICE says…

NICE guidelines (PH20) outline responsibility for all involved professionals to be adequately trained to support children's social and emotional wellbeing through:

- listening and facilitating skills and the ability to be non-judgemental
- how to manage behaviours effectively, based on an understanding of the underlying issues
- identifying and responding to the needs of young people who may be experiencing emotional and behavioural difficulties
- how to access pastoral care based in secondary education or specialist services provided by other agencies, such as child and adolescent mental health services
- the issues in relation to different medical conditions (such as diabetes, asthma and epilepsy) to ensure young people with these conditions are not bullied, inappropriately excluded from school activities or experience any undue emotional distress
- opportunities to reflect upon and develop their own social and emotional skills and awareness.

Their evidence review (2009) concluded:

'This evidence therefore is mixed and it is unclear whether curriculum-based interventions for tackling bullying and disruptive behaviour are effective. However, on balance the evidence suggests that certain interventions can be effective. It is possible that including community elements in these types of interventions may be beneficial'

7.9 Service Activity

Preventative services

Looked after children

Nationally, Public Health England publish comparative data on the services for children. Table 32 below summarises the published indicators on assessment for looked after children and the performance of the boroughs compared to the London average. From this data the following key points are noted:

- In 2014, both boroughs achieved a higher than London average percentage of looked after children receiving their annual assessment and eligible looked after children assessed for emotional and behaviour health.
- Westminster also achieved a higher than the London average percentage of looked after children aged under 5 years with up-to-date development assessments, while data for Kensington and Chelsea were not available.

Table 32: Assessments for looked after children

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Looked after children who had an annual assessment	2014	100%	100%	92.2%	88.4%	55	125
Looked after children assessed for emotional and behavioural health	2014	85.0%	100%	78.0%	68.0%	34	95
Looked after children aged< 5yrs with up-to-date development assessments	2014		100%	93.2%	86.8%		20

Source: Public Health England Fingertips (2019)

Health Visiting

As shown in the Perinatal Mental Health Section (6.7). Table 30 shows the performance of the health visiting service in both boroughs exceeding the London average on all review indicators.

Table 33: Percentage of births and children receiving a health visitor review by age and borough

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Review by 8 weeks: % births	2017/18	72.2%	81.7%	67.1%	84.3%	1,141	1,779
New birth visits <14 days: % births	2017/18	92.5%	93.0%	92.3%	87.7%	1,607	2,318
12 Month review % children	2017/18	74.3%	80.1%	56.2%	75.6%	1,232	1,999

Source: Health visitor service delivery metrics: 2017 to 2018 (2019)

Treatment services

Prescribing

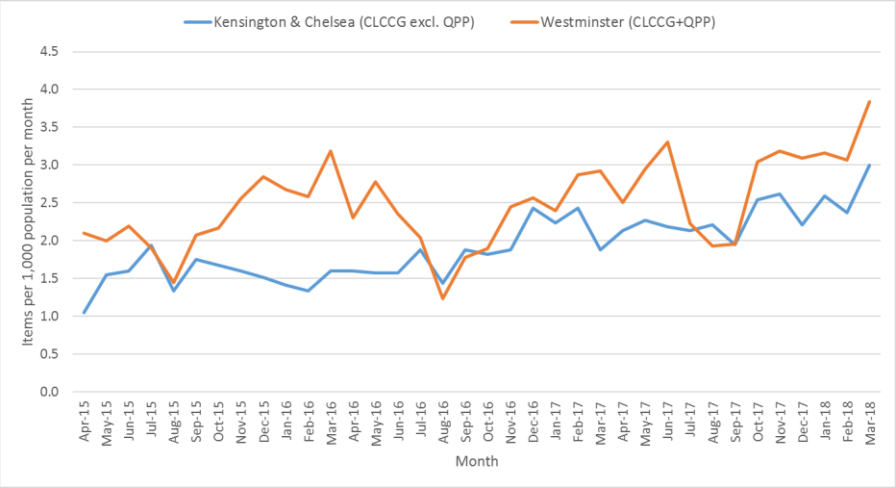
Data on the number of children prescribed antidepressants is not available, only the number of items prescribed (packs of medication).

Chart 22 shows that the crude rate of antidepressant items prescribed to children aged 0 to 19 years per 1,000.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

Chart 22 shows rates of prescribing have been typically higher in Westminster compared to Kensington and Chelsea and rates in both boroughs and have been increasing over the past three financial years.

Chart 22: Antidepressant prescribing, items per 1,000 children aged 0 to 19 years



Source: NHS North West London Medicines Management

Table 34 shows annual numbers of items prescribed per financial year and crude rates per 1,000 GP registered population to enable comparison.

In 2017/18 1,045 items were prescribed to children in Kensington and Chelsea and 1,474 items to children from Westminster.

Table 34: Antidepressant prescribing 0 to 19 years inclusive

Metric	Borough	2015/16	2016/17	2017/18
Items/ 1,000 population	Kensington & Chelsea (WLCCG excl. QPP)	18	23	28
	Westminster (CLCCG + QPP)	28	28	34
Items	Kensington & Chelsea (WLCCG excl. QPP)	701	819	1,045
	Westminster (CLCCG + QPP)	1,105	1,162	1,474

Source: NHS North West London Medicines Management

Specialist mental health services

This section describes the finding from analysis of activity data provided by Central and North West London NHS Foundation Trust (CNWL). In interpreting these findings it should be considered that while CNWL is the largest provider of mental health care services, there are other mental health services, and therefore the numbers presented are likely to be an underestimate of current demand for treatment services.

Referrals

Chart 23 shows referrals to Central and North West London NHS Foundation Trust's (CNWL's) Child and Adolescent Mental Health Services (CAMHS) by Clinical Commissioning Group (CCG).

CCG boundaries map to the Bi-Borough as follows:

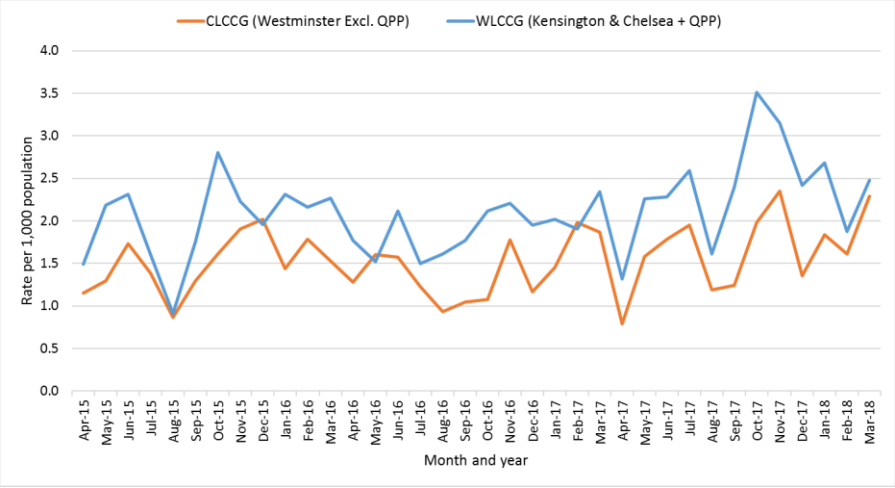
- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen's Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen's Park Paddington

In interpreting referrals data, it should be noted that not all referrals are accepted, and that not all accepted referrals lead positive diagnosis and treatment.

Chart 23 shows the trend in referrals from all sources. Table 35 and Table 36 show annual numbers by referral source for Central London CCG and West London CCG respectively. They show referral volumes by source in rank order and indicate where annual numbers have increased (dark blue) or decreased (light blue) year on year.

The tables list the reasons for referral in rank order. Year on year changes are highlighted as increase (dark blue) or decrease (light blue).

Chart 23: CAMHS referrals to CNWL, all sources of referral, monthly trend



Source: CNWL contract monitoring data

From Table 35 and Table 36 the following key points are made:

- The most common referral routes into CAMHS are via GP, from the Education Service or from A&E in both CCGs
- For most referral routes 2017/18 volumes have been higher than 2016/17 in both CCGs
- Continual year-on-year increases in volumes have been seen in referrals from A&E departments and carers in CLCCG, and from WLCCG from education services, A&E departments and 'other services or agency'
- Numbers of referrals from 'other secondary care specialities' in CLCCG and social services in WLCCG have been continually declining

Table 35: CAMHS: Source of referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

	Referrals					Change	
Source of referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
GP	321	319	329	969	52%	99%	103%
Education Service	70	63	127	260	14%	90%	202%
Accident And Emergency Department	30	72	87	189	10%	240%	121%
Other service or agency	35	23	53	111	6%	66%	230%
Social Services	54	27	28	109	6%	50%	104%
Carer	23	30	33	86	5%	130%	110%
Other secondary care specialty	47	19	15	81	4%	40%	79%
Community-based Paediatrics	9	6	9	24	1%	67%	150%
Other Primary Health Care	15	5	<5	20	1%	33%	-
Hospital-based Paediatrics	9	9	<5	18	1%	100%	-
Self	<5	<5	11	11	1%	-	-
Asylum Services	<5	<5	0	0	0%	-	-
Health Visitor	<5	<5	<5	0	0%	-	-
Independent Sector - Low Secure Inpatients		<5	0	0	0%	-	-
NHS Direct	<5	<5	<5	0	0%	-	-
Other Independent Sector Mental Health Services	<5	<5	<5	0	0%	-	-
Out of Area Agency	<5	<5	<5	0	0%	-	-
Probation Service	<5	<5	<5	0	0%	-	-
Permanent transfer from another Mental Health NHS Trust		<5	0	0	0%	-	-
School Nurse	<5	<5	<5	0	0%	-	-

Source: CNWL contract monitoring data

Table 36: CAMHS: Source of referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

	Referrals					Change	
Source of referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
GP	501	437	510	1448	43%	87%	117%
Education Service	103	126	166	395	12%	122%	132%
Accident And Emergency Department	51	133	156	340	10%	261%	117%
Other service or agency	60	78	184	322	10%	130%	236%
Social Services	114	84	63	261	8%	74%	75%
Other secondary care specialty	100	39	49	188	6%	39%	126%
Carer	43	34	70	147	4%	79%	206%
Community-based Paediatrics	21	17	22	60	2%	81%	129%
Self	9	17	15	41	1%	189%	88%
Hospital-based Paediatrics	13	17	7	37	1%	131%	41%
Other Primary Health Care	31	5	<5	36	1%	16%	-
NHS Direct	<5	<5	19	19	1%	-	-
Health Visitor	16	<5	<5	16	0%	-	-
School Nurse	8	5	<5	13	0%	63%	-
Other Independent Sector Mental Health Services	<5	5	7	12	0%	-	140%
Out of Area Agency	<5	<5	5	5	0%	-	-
Asylum Services	<5	<5	0	0	0%	-	-
Independent Sector - Low Secure Inpatients	0	<5	0	0	0%	-	-
Probation Service	<5	<5	<5	0	0%	-	-
Permanent transfer from another Mental Health NHS Trust	0	<5	0	0	0%	-	-

Source: CNWL contract monitoring data

Emergency non-emergency

From Table 37, the majority of referrals to CAMHS are routine in nature, with over 85% of referrals from each CCG. The remaining 15% are urgent or emergency referrals. In 2017/18 there were 181 urgent or emergency referrals from WLCCG and 81 from CLCCG.

Table 37: Type of referral by CCG

WLCCG (Kensington and Chelsea +QPP)

	Referrals			Percentage of referrals		
Referral type	15/16	16/17	17/18	15/16	16/17	17/18
Emergency	39	83	98	4%	8%	8%
Routine	975	856	1097	91%	85%	86%
Routine Plus	<5	-	-	0%	0%	0%
Urgent	63	66	83	6%	7%	6%

CLCCG (Westminster Excl. QPP)

	Referrals			Percentage of referrals		
Referral type	15/16	16/17	17/18	15/16	16/17	17/18
Emergency	19	36	36	3%	6%	5%
Routine	582	512	623	93%	88%	88%
Routine Plus	<5			-	0%	0%
Urgent	24	35	47	4%	6%	7%

Source: CNWL contract monitoring data

Accepted Referrals

Table 38 shows that the percentage of referrals that are accepted has been increasing in both boroughs over the past three financial years. In 2017/18 the percentage of referrals to CAMHS accepted was 81% for WLCCG registered patients and 88% for CLCCG registered patients.

Table 38: CAMHS: Referrals accepted by CCG

WLCCG (Kensington and Chelsea +QPP)

	Referrals			Percentage of referrals		
Decision	15/16	16/17	17/18	15/16	16/17	17/18
Accepted	859	819	1030	80%	82%	81%
Not Accepted	217	185	247	20%	18%	19%
Not Recorded	<5	<5	<5	-	-	-

CLCCG (Westminster Excl. QPP)

	Referrals			Percentage of referrals		
Decision	15/16	16/17	17/18	15/16	16/17	17/18
Accepted	504	538	618	86%	86%	88%
Not Accepted	79	86	83	14%	14%	12%
Not Recorded	<5	<5	<5	-	-	-

Source: CNWL contract monitoring data

Reason for referral

Table 39 and Table 40 show annual numbers by referral by reason for referral Central London CCG and West London CCG respectively. From these tables the following key points are made:

- Anxiety is the most common reason for referral for both CCGs, followed by 'in crisis'.
- The number of referrals for PTSD for WLCCG have increased over 13 times between 2016/17 and 2017/18. This is expected to be related screening for PTSD following the Grenfell Tower disaster.
- The number of referrals for 'in crisis' in both boroughs and capacity (advice or assessment) in WLCCG have been declining year on year

Table 39: CAMHS: Reason for referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

	Referrals					Change	
Reason for referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
Anxiety	76	207	246	529	28%	272%	119%
In crisis	297	132	65	494	26%	44%	49%
Depression	57	51	86	194	10%	89%	169%
Relationship difficulties	64	50	62	176	9%	78%	124%
Conduct disorders	20	15	61	96	5%	75%	407%
Self harm	27	34	30	91	5%	126%	88%
Suspected ADHD	14	27	38	79	4%	193%	141%
Suspected ASD	8	14	28	50	3%	175%	200%
Post-traumatic stress disorder	<5	8	28	36	2%	-	350%
Neurodevelopmental conditions	11	10	14	35	2%	91%	140%
Unexplained physical symptoms	15	5	5	25	1%	33%	100%
Eating disorders	5	11	7	23	1%	220%	64%
Perinatal mental health issues	12	<5	0	12	1%	-	-
Adjustment to Physical Health Condition	<5	<5	11	11	1%	-	-
Obsessive compulsive disorder	<5	6	5	11	1%	-	83%
Capacity (advice/assessment)	7	<5	<5	7	0%	-	-
Drug and alcohol difficulties	<5	<5	<5	0	0%	-	-
Medication Review	<5	<5	<5	0	0%	-	-
Organic brain disorder	<5	0	<5	0	0%	-	-
Personality disorders	<5	<5	<5	0	0%	-	-
Phobias	<5	<5	<5	0	0%	-	-

Source: CNWL contract monitoring data

Table 40: CAMHS: Reason for referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

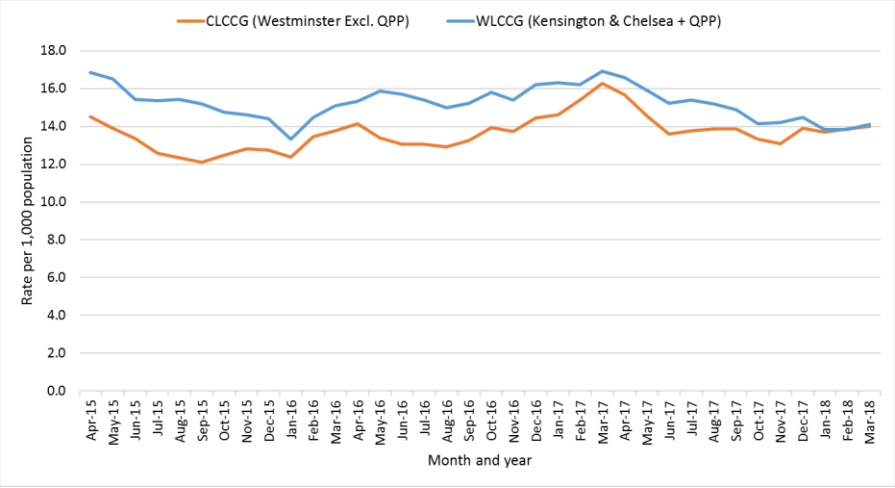
	Referrals					Change	
Reason for referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
Anxiety	193	345	325	863	26%	179%	94%
In crisis	496	171	116	783	24%	34%	68%
Post-traumatic stress disorder	<5	8	272	280	8%	-	3400%
Depression	51	82	117	250	8%	161%	143%
Conduct disorders	34	78	116	228	7%	229%	149%
Self harm	39	67	81	187	6%	172%	121%
Relationship difficulties	53	44	58	155	5%	83%	132%
Suspected ADHD	35	52	53	140	4%	149%	102%
Neurodevelopmental conditions	35	57	41	133	4%	163%	72%
Capacity (advice/assessment)	52	28	8	88	3%	54%	29%
Perinatal mental health issues	48	<5	0	48	1%	-	-
Eating disorders	7	14	19	40	1%	200%	136%
Suspected ASD	7	9	24	40	1%	129%	267%
Unexplained physical symptoms	15	14	9	38	1%	93%	64%
Adjustment to Physical Health Condition	<5	<5	13	13	0%	-	-
Obsessive compulsive disorder	<5	5	7	12	0%	-	140%
Drug and alcohol difficulties	<5	7	<5	7	0%	-	-
Medication Review	<5	<5	<5	0	0%	-	-
Organic brain disorder	<5	0	<5	0	0%	-	-
Personality disorders	<5	<5	<5	0	0%	-	-
Phobias	<5	<5	<5	0	0%	-	-

Source: CNWL contract monitoring data

Caseload

In 2017/18 average caseloads were 663 for WLCCG and 492 for CLCCG. Chart 24 shows the monthly trend in CAMHS caseload by referring CCG. Numbers on caseload are converted into rates per 1,000 population aged 0 to 19 years to enable comparison. Cases per head of population from WLCCG are typically higher compared to CL CCCG.

Chart 24: CAMHS: children and adolescents on caseload per 1,000 population aged 0 to 19 yrs



Source: CNWL contract monitoring data

Hospital admissions

Table 41 presents comparative Public Health England data on the rates of mental health related hospital admission for children and young people. From this table the following key points are made:

- Rates of hospital admissions for mental illness and self-harm among 10 to 24-year olds are lower than the London average in both boroughs.
    - Rates of self-harm in age groups 10-14 and 15 to 19 years are also lower than the London average in Kensington and Chelsea, however is not possible to report on Westminster due to a lack of data
- Rates of hospital admission for substance misuse among young people in Kensington and Chelsea are higher than the London average, while in Westminster they are lower than the London average

Table 41: Mental health related hospital admission rates for children and young people

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Hospital admissions - mental health/ 100,000	2016/17	56.0	47.5	76.8	81.5	16	21
Hospital admissions - Self-harm/ 100,000 10-24yrs	2016/17	98.2	113.7	197.2	404.6	22	43
Hospital admissions - Self-harm/ 100,000 10-14yrs	2016/17		64.6	102.1	211.6	-	7
Hospital admissions - Self-harm/ 100,000 15-19yrs	2016/17		224.5	305.2	619.9		26
Hospital admissions- substance misuse/ 100,000 15-24yrs	2015-17	73.2	51.2	67.2	89.8	36	45

Source: Public Health England Fingertips (2019)

Local data

Analysis of hospital spells for primary and secondary diagnoses of mental health conditions (International Classification of Diseases 10th edition [ICD 10] Chapter F) and self-harm (codes within ICD 10 Chapter X) produced the findings in Table 42. Data presented where more than 5 spells occurred in the pooled 2015/16 and 2016/17 data and for the top 5 diagnoses

Table 42 presents the findings from local analysis of hospital activity data. As mental health and/ or self-harm diagnoses are most commonly coded as a secondary diagnosis, only pooled data from 2015/16 and 2016/17 could be utilised as the 2017/18 spells data does not include secondary diagnosis field.

The table shows the number of hospital admissions are low, fewer than 20 spells over two years. Of recorded spells:

- the most common primary mental health diagnoses are 'mental and behavioural disorders due to the use of alcohol' in Kensington and Chelsea and 'depressive episodes' in Westminster
- the most common primary mental health diagnoses are 'mental and behavioural disorders due to the use of alcohol' in Kensington and Chelsea and 'depressive episodes' in Westminster.

Table 42: Hospital admissions (Spells), children aged 0 to 19 years, with a relevant primary diagnosis Chapter F or X, 2015/16 and 2016/17 pooled data

Primary Diagnosis	Borough	EL	NEL	Secondary Diagnosis	Borough	EL	NEL
Mental and behavioural disorders due to use of alcohol	RBKC	-	5	Mental and behavioural disorders due to use of tobacco	RBKC	7	7
Developmental disorder of speech and language, unspecified	RBKC	5	-	Disturbance of activity and attention	RBKC	8	<5
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics & antirheumatics	RBKC	-	5	Childhood autism	RBKC	8	<5
				Specific (isolated) phobias	RBKC	7	<5
				Developmental disorder of scholastic skills, unspecified	RBKC	6	<5
				Developmental disorder of speech and language, unspecified	RBKC	6	<5
Depressive episode, unspecified	WCC	-	8	Childhood autism	WCC	30	5
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics & antirheumatics	WCC	-	13	Developmental disorder of scholastic skills, unspecified	WCC	17	<5
Exposure to unspecified factor	WCC	-	11	Anxiety disorder, unspecified	WCC	14	<5
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	WCC	-	7	Depressive episode, unspecified	WCC	-	13
Intentional self-harm by sharp object	WCC	-	5	Specific (isolated) phobias	WCC	12	-
				Mental and behavioural disorders due to use of tobacco	WCC	5	<5

Source: Secondary Uses Service spells data 2015/16 and 2016/17 pooled data. EL – Elective, NEL – Non-elective. n – Number

7.10 Local services and asset mapping

Services for Children, Young People and Families that Support Emotional Health and Wellbeing

A joint review of the Emotional Health and Wellbeing Services was carried out in 2018 with a report published in July 2018. The findings of this report are significantly drawn upon in this section.

The range of services across the Bi-Borough is considered to be good with a variety of activities taking place in schools, in partnership with the Local Authority and Clinical Commissioning Groups. Services include face-to-face and online awareness raising / training in schools and early years settings.

Table 43: Services for Children, Young People and Families that Support Emotional Health and Wellbeing

Type / Age	Westminster	Kensington and Chelsea
0-5	Family Nurse Partnership Health Visiting Attachment project 0-5 / CNWL Healthy Early Years Awards Children's Centres/ Family Hubs	Family Nurse Partnership Health Visiting Attachment project 0-5 / CNWL Healthy Early Years Awards Children's Centres
5-11	Early Help Service LA CNWL Early Intervention Workers (EIWs) MIND Mental Health First Aid (MHFA) Kooth online counselling Healthy Schools Awards Domestic Violence Prevention in Schools School Health Service School investment in Emotional Health and Wellbeing from Pupil Premium Funding.	Early Help Service LA CNWL Early Intervention Workers (EIWs) MIND Mental Health First Aid (MHFA) Kooth online counselling Healthy Schools Awards Gap – no DV School Health Service School investment in Emotional Health and Wellbeing from Pupil Premium Funding.

12-16	CNWL Early Intervention Workers MIND MHFA Kooth online counselling Healthy Schools Awards School Health Service	CNWL Early Intervention Workers MIND MHFA Kooth online counselling Healthy Schools Awards School Health Service
16-18	CNWL Early Intervention Workers MIND MHFA Kooth online counselling Adult IAPT Healthy Schools Awards School Health Service	CNWL Early Intervention Workers MIND MHFA Kooth online counselling Adult IAPT Healthy Schools Awards School Health Service
Child Protection Prevention	Early Help - Partners in Practice (social Care systemic working with families)	Early Help -Partners in Practice (social Care systemic working with families)
Looked After Children	LAC Team CNWL (LA commissioned)	Gap – dedicated LAC therapeutic specialist team X1 Clinical Psychologist (LA commissioned) – Focus on Practice / Nick Pembry's team
Sexual Abuse	NWL CSA Hub	NWL CSA Hub
Children with Disabilities	Gap – therapeutic specialist team	Behaviour Family Support Team (BFST)
Youth Offending Service	CNWL CAMHS Worker	CNWL CAMHS Worker
Transition from Children's to Adults Services	NWL Young Minds Project Transition worker – being recruited	NWL Young Minds Project Transition worker – being recruited

Children's Centres/Hubs

Children's Centres in RBKC are a one-stop shop for families living in the boroughs with a child under the age of five. Their aim is to provide families with information, advice, guidance and support to help them be school ready, healthy adults, healthy children, confident parents, and provide skills and opportunities to support them back to work or training.

There are two children's centre hubs in Westminster and one family hub, with plans for the other two to become family hubs. The family hubs provide additional services to children's hubs such as birth registrations on site, housing advice, parenting courses, Child & Adolescent Mental Health Services and are for families with children up to the age of nineteen.

Early Help

Early Help Practitioners use systemic skills to help families identify patterns in how they relate to each other and the problems they are facing and then enables them to take different positions and see other opportunities for action. This process builds new possibilities for change and mobilises the resources within the family to function in a different way, thus reducing or diminishing problematic symptoms (such as poor behaviour, family arguments mental wellbeing, school attendance etc..).

They look at the whole family and work to build on the strengths of that family. They follow a team around the family (TAF) approach so that support is coordinated across a number of agencies and ensure that the voice the child is heard. They provide both support to individual families and also group work in schools. Support available to families includes:

- Parenting Techniques
- Wellbeing support
- Support to increase school attendance
- Support with a child behaviour concern
- Accessing local networks and activities
- Building parent's confidence
- Supporting school transition
- Identifying and supporting young carers

They also offer group work in schools on the above areas to both parents and students as well as topics such as bullying, personal safety and increasing aspirations.

Health Visiting and Family Nurse Partnership (FNP)

Health Visitors are trained and skilled in assessing mental health including the use of assessment tools WHOOLEY and the Edinburgh Postnatal Depression Scale, which are both recommended by NICE. Their role is prevention, early identification of risk and early intervention. The health visiting services have the opportunity to assess maternal mental health at the antenatal contact, the new birth visit and at the 6-8 week visit. These contacts are for all mothers. The 1 year assessment and the two – two-and-a-half year review are key for addressing the development of the child.

FNP is a licensed intensive home visiting service for first time young mothers commencing 16 weeks of pregnancy until child aged two-teenage often have higher rates of poor mental health up to three years post birth. They use perinatal assessment tools and the Ages and Stages Social Emotional questionnaires to assess the parent: child-interaction, attunement, attachment and bonding.

Midwives work closely with both groups to share risk factors.

It is a concern that currently not all mothers and their babies are getting these mandated checks locally and with the potential to miss identifying concerns with maternal or paternal mental health.

Family Hubs with the integration of Health (MWs, HVs, School Health) with Social Care (Social workers, Early Help staff, Children's Centre Staff, housing), 'One Front Door' and 'Tell It Once' - reduce duplication, and may reduce referrals, waiting times and access.

School Health Service

School Health Service work in teams to supervise and lead the delivery of universal and mandated elements of the Healthy Child Programme 5-19 which includes health screening; health needs assessment and the National Child Measurement Programme. In addition, they input into the school health care plans of children with long term conditions and play a key role in safeguarding. The service also incorporates an offer of provision of relationships and sex education. A Registered Mental Health Nurse will provides specialist advice, CAMHS liaison and integrated training based on school needs assessments. School Nurses trained in Tier 1 interventions provide dedicated support for each school and referral to CAMHS.

Healthy Schools and Healthy Early Years

Emotional Health and Wellbeing is one of the four theme areas of the Healthy Schools Awards and Health Early Years Awards. Both programmes support schools and early years setting to put in place:

- Senior leadership team for Emotional Wellbeing and Mental Health.
- Emotional health and wellbeing policy which is reflected in practice and through ethos, culture and the environment and review by consultation at least every three years.
- The curriculum includes emotional wellbeing and mental health including anti-bullying, social and emotional learning and risk. T.
- Playground provision – playgrounds need to be safe, supportive, encourage physical active and include quiet areas
- Pupil voice – the school has mechanisms in place to ensure that the views of all children and young people including those hard to reach are reflected in the school's decision making
- The school provide opportunities for child and young people to build confidence and self-esteem; develop responsibility, independence and resilience and learn how to assess risk and stay safe

- The school has systems to identify and meet the needs of vulnerable children and young people and has arrangements to provide appropriate and relevant support. All children and young people and parent/carers can confidentially, access advice, support and services (within and beyond school)
- The school identifies staff CPD needs for health and wellbeing and provides appropriate training and development opportunities
- The school provide opportunism for parents/carers to access information, support and advice on health and wellbeing

Silver and Gold Awards

All schools or early years setting once they have their Bronze Award are encouraged to work towards a Silver and Gold Award. Whether they choose an explicitly mental health priority or another area, working towards these awards will improve the wellbeing of pupils.

To achieve the Silver the awards the school identifies a health priority for the school by carrying out a needs analysis. They may choose mental health as their priority. They then use this needs analysis to identify at least one universal and one targeted health priority. They then develop planned outcomes and an action plan to achieve these priorities.

To achieve the Gold award they implement their plan over about a year or so and evaluate its impact.

Examples of health priorities in relationship to EWMH:

<u>Secondary School</u>

•Universal: Improve the physical and mental wellbeing of the pupils through an increase in understanding and engagement with physical activity.

•Targeted: Supporting the physical and mental wellbeing of year 11 students in connection with exam stress and body image.

<u>Primary School</u>

1. Universal: To improve resilience, self-regulation and healthy relationships of all pupils across the whole school.

2. Targeted: To improve behaviour for learning and emotional wellbeing in identified group of Year 5 boys

Examples of measurable outcomes include:

• Increase the number of pupils reporting they feel safe in school

• Increase the number of pupils reporting “I know what to do if I feel worried or upset at school”

• Increase the number of pupils reporting the school does enough about bullying

• Increase the number of pupils reporting they are confident to be peer mediators following training

• Increase the number of pupils reporting they know where to access support for their mental wellbeing

• Increase the number of pupils reporting they have strategies in place to deal with exam stress

•Increase the number of pupils reporting they can work well in groups

To support schools working towards the Healthy Schools Awards, there is guidance, advice and training provided by the Health Education Partnership.

Pupil premium

In addition to services commissioned by local authorities and the CCGs, some schools also pay for services to support their pupil's emotional health and wellbeing out of pupil premium funding.

Pupil premium is additional funding for publicly funded schools in England. It is designed to help disadvantaged pupils of all abilities perform better, and close the gap between them and their peers.

A review of pupil premium spend for 2017/18 indicates that for RBKC schools approximately £900k was spent on emotional health and wellbeing and for WCC schools £600k was spent.

The activity provided is wide ranging, examples include family therapy, family support workers, pastoral support, psychotherapy; staff training on emotional literacy; art therapy, drama therapy; play therapy; Place2B and speech and language therapy.

Areas for improvement or development

In recent years, Early Intervention Worker capacity has been utilised to deal with perceived capacity challenges within Specialist CAMHS. A shift is needed to an Early Intervention focus out into school.

Behaviour Family Support Team is a highly specialised and resource intensive service commissioned for RBKC residents only. Service could be adapted to incorporate less expensive clinical staff and provider greater coverage for Westminster.

Specialist Community Child and Adolescent Mental Health Services (CAMHS))

The specialist CAMHS contract is part of the adult mental health contract, which is shared with 5 other CCGs. The service is provided by Central and North West London NHS Foundation Trust.

Referral to the specialist community CAMHs service can be via the general practitioner (GP) or teacher. A few clinics will also accept self-referrals. Following assessment, the CAMHs service designs a package of care around a child, which links in with the support currently being provided to the family by other agencies and professionals.

Some of the services provided by the community CAMHS are as follows:

Art therapy

Art therapy helps people to express what they are thinking and how they are feeling through the use of art. Art therapy may help you find out more about yourself, which can lead to positive changes. Art therapy is open to all, and does require being skilled in art.

Child and adolescent psychotherapy

Child and adolescent psychotherapy involves meeting with a specially trained therapist. Seeing a child and adolescent psychotherapist individually can help people to think about their personal difficulties, by exploring how their feelings and thoughts are connected to their relationships and behaviour, and how past experiences can affect their current relationships.

Child psychotherapists work with children and young people on an individual basis, usually in a weekly session, but they also do short-term work with parents or carers and their children together.

Cognitive behavioural therapy (CBT)

CBT is a 'talking therapy' that focuses on the links between thoughts, feelings and behaviour. It aims to help the young person to manage your feelings and change any thinking or behaviour patterns which might be unhelpful and/ or making their problems worse.

Family therapy

Family therapy involves working with the CYP and the people who are important to them. The CYP and the people who come with them are encouraged to consider each other's points of view, experiences and beliefs and find ways to make positive changes that work for everyone involved.

Medication

If CAMHS doctors (psychiatrists) think that you can be helped by medication they will discuss this with you and your parents or carers. They will explain why they think medication could help, any possible side-effects, and your other options.

Eating Disorder Service

The specialist Eating Disorders Service is provided by Central and North West London NHS Foundation Trust (CNWL).

Crisis and Liaison Service

A CYP 24 hour crisis service is currently being set up. The current arrangement for access to services is via accident and emergency departments.

Performance of Specialist CAMHS

Overall, performance is good for each of the CAMHS providers operating in the bi-borough. This is in accordance with the KPIs agreed with commissioners and reported monthly.

Outcomes – evidencing the difference that makes a difference

CAMHS providers are on the whole achieving their targets for systematic use of clinical outcome measures and reporting the effectiveness of therapeutic interventions.

Table 44: CAMHS Key Performance Indicators

CAMHS KPI measurement for end of year 2017/18	West London	Central London	Target
% of CYPIAPT/ CAMHS Outcome Research Consortium (CORC) measures completed for patients accepted into the service	87.6%	91%	85%
% of appropriate CYPIAPT/ CORC measure completed for patients discharged from the service	81.4%	87.5%	80%
% of young people discharged with CYPIAPT/ CAMHS CORC measure showing improvement between acceptance and discharge	67.5%	72.1%	>60%

Improving access to CAMHS[2]

In relation to national access targets for NHS consultant led services, both CAMHS services are achieving targets for enabling access within mandatory timescales, and are performing better overall than neighbouring CCG areas in North West London. However, the target is set low at 85% of children and young people seen within 18 weeks. A new access standard of 4 weeks to assessment is anticipated for 19/20 as indicated in the Schools Green Paper.

Table 45: CAMHS: Percentage of CYP seen within 18 weeks

CCG	% CYP seen within 18 weeks	Target
West London	91.9%	85%
Central London	95.1%	85%
NWL Average	88.6%	-

Increasing numbers of children and young people accessing CAMHS

Nationally, CCGs have been set the target of increasing access to support for children and young people to emotional wellbeing mental health services. The ambitious target is to meet 35% of mental health prevalence by 2020/21. The target set for 2018/19 is for each CCG area to support 30% of local prevalence, which is being met successfully by both CCGs in the Bi-borough. The particularly high figure reported for West London CCG relates to additional activity being picked up as a result of post-Grenfell support.

Table 46: Percentage of local prevalence (CYP) accessing CAMHS, 2017-18

CCG	% Access rate (annual)	Target
West London	78.1%	30%
Central London	31.0%	30%
NWL average	36%	30%

Staffing within Specialist CAMHS

During the EWMH review carried out in 2018 by the CAMHs commissioners, Central and North West London NHS Foundation Trust (CNWL) agreed to share staffing numbers and description as well as for the commissioner to meet with service teams to listen to clinicians' assessment of strengths, areas for development.

Table 47: CNWL CAMHS staffing levels in comparison with neighbouring CCGs

CAMHS Service	Total Clinical / Medical	EIW (recommended 25%)	Psychiatry (recommended 15-25%)
Westminster	40.5	36% (inc. CWPs)	20%
RBKC	44	24% (inc. CWPs)	11%

Key points:

- Level of staffing allocated to early intervention in each service is sufficient for an effective primary mental health model in each area of Bi-Borough.
- Level of psychiatry is lower than recommended levels for RBKC. However, there are higher levels of clinical psychology in RBKC capable of some diagnostic work.
- Banding is relatively high for both Westminster and RBKC CAMHS. It is worth reviewing the introduction of lower-banded staff for development as part of a cost effective and sustainable workforce development strategy.

High Level Findings from the Children's Emotional and Mental Wellbeing Report

1. **Early intervention strategy –** to develop an effective Primary Mental Health Worker model with a clear allocated offer for every school and GP Practice in each borough by 1st April 2019. Enhanced development / promotion of guided self-help[7] online counselling, positive parenting interventions and 0-5 attachment project. Consider PMHW management of Single Point of Access in each borough. Strategic aim to reduce demand / escalation to Specialist CAMHS by intervening early.
2. **MCP integration and alignment (focus autism and LD) –** consider opportunity for integrated / aligned models to increase quality and achieve efficiencies for families within the context of Managed Care Partnership (MCP) development. The main area of focus to address is pre-diagnostic, diagnostic and post-diagnostic support for CYP with autism. Develop effective **autism strategy** and action plan in each borough (combined with clinician commissioned to deliver **proactive CETRs** for CYP at risk of admission / high need / complex, integration / alignment of CAMHS / Community Paediatrics processes, support for young adults below AMHS threshold).
3. **Behavioural support service** – recommission BFST service to see more clients and value support equitably across RBKC and Westminster. Consider co-locating with special schools or children with disabilities team with Local Authority and behavioural support service with schools. Children with complex / severe physical health needs (including Continuing Health Care patients) require access to a paediatric behaviour specialist, who can carry out assessments for those children and young people with challenging behaviour issues.
4. **Focus productivity assurance** – in recent years, great gains have been made by CAMHS to report on outcomes and improving access in terms of numbers and waiting times. The key focus to sustain these gains is a new focus by commissioners and providers on optimising best use of clinical capacity, which requires significant improvement based on the current data picture.

7.11 Quality and outcomes

Waiting times

The following section summarises the latest available data on waiting time performance by service. The data presented refer only to the performance of Central and North West London NHS Foundation Trust (CNWL).

Table 48 shows percentage of children referred to Child and Adolescent and Mental Health services (CAMHS) within 18 weeks and to the CAMHS eating disorder service, within 4 weeks.

The following key points are noted:

- Referrals from West London CCG are less likely to be seen within threshold waiting times than Central London CCG referrals
- Eating disorder referral to treatment targets are met more frequently by the eating disorder service

Table 48: Monthly waiting times to first treatment, CAMHS, CNWL 2017/18

West London CCG	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Av. Referrals
CAMHS (18wks)	9.9%	19.2%	23.6%	11.8%	38.6%	26.7%	12.3%	26.0%	36.5%	8.3%	44.0%	10.7%	71
CAMHS Eating Disorders (4wks)			86%			75%	50%	100%	0%	0%	0%	0%	<5

Central London CCG	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Av. Referrals
CAMHS (18wks)	8%	10%	11%	10%	11%	8%	8%	8%	10%	8%	11%	11%	48
CAMHS Eating Disorders (4wks)			100%			33%	100%	100%	67%	100%	0%	100%	<5

Source: CNWL

Transition from Children's Mental Health Services to Adult Mental Health Services

Research indicates that many young adults find statutory services inaccessible or unresponsive to their specific needs and fall through the gaps between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS). Differences in service thresholds and age appropriateness of services mean that it is at this point young people previously receiving services may fall out of the mental health system. There has been a suggestion at a national level around the redirection of funding from Adult services into CAMHS to allow CAMHS provision to continue until the young person is 25 when they would then transition to AMHS. Contrary to concerns that such a model would merely delay transition, evidence suggests it could prevent premature disengagement and more serious problems developing later on.

Case Study: Cardinal Hume Centre Experience – Transition

Our experience at Cardinal Hume Centre is that unfortunately we have seen that the transition from CAMHs to adult services is often problematic, with young people in need of support seeming to fall 'between the cracks'. We have had the experience of receiving referrals of young people into our residential services who have a history of mental health issues and of receiving care from CAMHs or Looked After Children's nurse and yet when they turn 18, there is insufficient communication between children's and adult mental health services and no 'handover' or continuity and a lack of information sharing between the two services. This necessitates 'starting from scratch' in terms of putting support in place and inevitably these 'gaps' have a negative impact on the young person involved.

7.12 Service User Views

In 2017/18, the charity Rethink was commissioned by CAMHs commissioners to conduct number of reviews to assess the quality and accessibility of services from the perspective of young people and their parents.

Accessibility report

67% of parents and carers felt that access to appointments needed improvement. Of these 54% (13) responded that the waiting time to be accepted by the service and/or to receive treatment was too long. Many also complained that once inside the service, the time between appointments was too long. 13% specifically thought out-of-hours appointments were needed.

Young people welcomed the possibility to attend via 'drop in' sessions and the possibility to attend sessions in early evening.

63% of users said that the environment and staff made CAMHS offices accessible for them.

"The staff here. I can talk about my feelings. It's a friendly environment" - A young person who took part in the review

Parents and carers were asked 'in your experience, what works well about accessing CAMHS'. 43% said that the staff themselves made the service accessible through their friendly and supportive approach.

"The people we have had contact with have all been amazingly supportive and knowledgeable" - A parent who took part in the review.

Youth Offending Team (YOT) Review

Rethink Mental Illness (RMI) were commissioned to carry out a review of the effectiveness of the CAMHS worker role in the Youth Offending Team (YOT) in the tri-borough area. The review only evaluated the CAMHS delivery service in Westminster YOT, as in RBKC there had not been a CAMHS worker to apply the service model specifically and consistently over the last two years. The report indicated that overall the service is good. 67% of users rated it good, very good or excellent. Both parents/ carers and young people are satisfied with accessibility, time and location of service. The report did however note a need to improve the consistency of the service including coordination between YOT staff and CAMHs staff.

Typical comments given by service users:

"Easy to talk to" – Westminster

"It is good to have a neutral person to talk to" – Westminster

Eating Disorders Service review

RMI were commissioned to evaluate the newly established (April 2016) Community Eating Disorder Service for Children and Young People in the tri-borough area. Staff are considered to be compassionate and competent while some points were noted such the environment being unwelcoming, cold and clinical with no waiting room. Another criticism was need for soundproofing of therapeutic spaces required to ensure confidentiality. A prominent concern from the service users was a lack of integration of the dietician and meal plans into the broader scope of their treatment plan.

Out of Hours Service for Under 18s

An RMI review was undertaken into the extent to which the CAMHS Out of Hours (OOH) service is meeting the needs of children and young people in the Tri-Borough area in providing crisis care.

Feedback indicated a strong level of support for the service as a highly valuable and important way to meet the mental health needs of young people in times of crisis. However, there was a clear need for the service to improve on its provision of advice/signposting.

There were important differences in the service users and parents/carers experience of dealing with hospital accident and emergency (A&E) staff in contrast with CAMHS staff, with many feeling more listened to and comfortable with CAMHS staff than the former. Particular criticisms of A&E include lack of privacy for support and communication challenges noted with A&E staff. Lastly, long waiting times were repeatedly mentioned by service users and parents as an area for improvement.

Supporting CYP with Disabilities and their Families in Managing Challenging Behaviour

The Behavioural Family Support Team (BFST) seeks to meet the needs of families and children and young people (CYP) with disabilities presenting with challenging behaviour. The service is for children with autism and/or moderate to severe learning disabilities, who have emotional, behavioural or mental health issues and are residents of RBKC.

92% of parents rated the service between seven and ten out of ten, showing high levels of overall satisfaction with respect to their experience, support given and long-term impact. The service was found to be accessible, with most parents being referred in through their social worker or school. Parents also revered the service's specialist knowledge, multi-agency coordination of support and their ability to enhance parents' understanding of diagnoses. For 67% of parents, the service had positively impacted their child's educational placement and 75% felt that the BFST had supported them to cope and manage better as a family, therefore preserving family relationships.

8 Working age adult mental health and wellbeing

8.1 Key Messages

Key messages: Adult mental health and wellbeing

Prevalence

- The estimated prevalence of mental illness in working age adults was taken from the Adult Psychiatric Morbidity Survey (APMS 2014). This survey found common mental health disorders to be the most prevalent. Locally this translates to an estimated 20,529 residents of Kensington and Chelsea and 34,673 residents of Westminster (19% of the population). The most prevalent specified common mental health disorder was generalised anxiety disorder, affecting 7% of the population.
- Personality disorders were found to be the next most prevalent, affecting an estimated 17.5% of the population
- 20.5% of respondents reported having had suicidal thoughts, while 6.1% had attempted suicide and 6.4% had self-harmed
    - Based on local GP register data, the prevalence of mental illness in both boroughs and depression in Kensington and Chelsea is higher than the London average

Risk factors

- Both boroughs have lower rates of people with a learning disability or long-term health problem or disability compared to the London average
- While the employment rate in both boroughs is below the London average, the long-term unemployment rate is lower than the London average
- Rates of marital break-up and persons living alone are higher than the London average
- Both boroughs have comparable rates of Dementia among GP registered patients to the London average
- Both boroughs are expected to have the same rate of alcohol dependence as the London average, however both boroughs have higher rates of hospital admissions for mental and behavioural disorders due to the use of alcohol
- Kensington and Chelsea has a higher rate of substance misuse among young adults, while Westminster has a lower rate, compared the London average. In addition, the prevalence of opiate and/or crack cocaine use among adults is higher than the London average
    - Both boroughs have higher rates of self-reported high satisfaction and high happiness compared to the London average

Protective factors

- Uptake of physical activity is estimated to be better than the London average in both boroughs, however, social isolation among Adult Social Care service users is indicated to be higher with a lower percentage of clients reporting enough social contact compared to the London average.

What Works

- Meeting the housing needs for at-risk adults is an area that supports mental health outcomes. Housing interventions that result in improved mental health outcomes include re-housing interventions; targeted interventions such as supported housing for high-risk groups (including those with mental illness); housing support for high-risk families; and interventions that address fuel poverty.
- There is strong evidence that access to green and open spaces directly improves our health and wellbeing.
    - Physical activity is associated with reductions in depression, improved wellbeing (including people with schizophrenia), better cognitive performance in children and better mental health outcomes in older people.
- Positive psychology interventions and mindfulness interventions promote positive thoughts and emotions
- Secure employment, support for unemployed people and work based mental health and stress management interventions
- There is some evidence that neighbourhood enhancement and regeneration, debt advice and financial capability interventions are effective.
    - The Better Mental Health for All (year) report also identifies key interventions
    - See also relevant NICE guidance PH22 and NICE 2009a

8.2 Background

Adulthood is a time of greater independence and control over life, and is a particularly important point in the life course because of the influence adults have on others through their various roles as partner, co-worker, parent and carer.

Many people become parents and the quality of relationships in the home with partners, if present, and children has a very strong influence on parents' mental health.

Family relationships matter to adults as well as children. Being in a stable relationship is more strongly associated with both physical and mental health benefits, including lower morbidity, lower levels of smoking and drinking, and greater life satisfaction than being single. Unhappy relationships are more strongly predictive of mental health issues than not being in a relationship. Not all adults form families and loneliness can be an issue.

Many adults may also be required to take on the role of caring for a spouse or family member who is ill or has a disability. This can have a negative impact on their mental wellbeing, due to feeling increasingly isolated and unsupported.

Experiencing two or more adverse life events in adulthood is associated with mental health issues and for some this can have a cumulative effect following on from adverse life experiences in childhood. Work, or lack of it, matters greatly as well as the quality of the working environment. People in Great Britain who are unemployed are between four and ten times more likely to develop anxiety and depression.

Access to community resources, such as friendship networks, facilities for children, opportunities for exercise, the quality of the environment and social inequity, stigma and discrimination all impact on adult mental health. The neighbourhood environment is an important factor in the health and functioning of adults.

Mental illness is divided into two main groups, common mental illness and severe mental illness.

Common mental illness, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population of England at any one time. Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental illness but all can be associated with significant long-term disability. For example, depression is estimated to be the second greatest contributor to disability-adjusted life years throughout the developed world. It is also associated with high levels of morbidity and mortality, and is the most common disorder contributing to suicide.

Severe mental illness includes a clinical diagnosis of: schizophrenia, schizotypal and delusional disorders, or bipolar affective disorder, or severe depressive episodes with or without psychotic episodes.

8.3 Prevalence and incidence

Population prevalence

Adult Psychiatric Morbidity Survey (2014)

Table 49 shows the estimated prevalence of mental illness in the working age population are taken from the Adult Psychiatric Morbidity Survey (2014). Estimates are calculated from the **England** age-specific prevalence rates for each illness.

Should the England prevalence of mental illness prevail in the both boroughs and remain constant, and population of each borough grow as projected by the Greater London Authority, the numbers of cases of mental illness shown below could be expected.

Table 49: Estimated prevalence of mental illness by borough 2018 to 2028, 16 to 64 years

Illness/ presentation	Borough	2018	2023	2028
Any CMD	RBKC	20,529	20,837	21,089
	WCC	34,673	36,192	36,728
Unspecified CMD	RBKC	9,266	9,412	9,527
	WCC	15,686	16,366	16,605
GAD	RBKC	7,181	7,284	7,370
	WCC	12,042	12,581	12,781
Depressive episodes	RBKC	4,138	4,198	4,236
	WCC	6,853	7,173	7,278
Phobias	RBKC	3,193	3,235	3,275
	WCC	5,471	5,690	5,761
OCD	RBKC	1,695	1,721	1,745
	WCC	2,854	2,983	3,035
Panic disorder	RBKC	595	611	628
	WCC	1,023	1,073	1,104
PTSD	RBKC	5,554	5,644	5,741
	WCC	9,575	9,972	10,144

Illness/ presentation	Borough	2018	2023	2028
Antisocial personality disorder	RBKC	3,577	3,642	3,701
	WCC	5,690	5,834	5,869
Bipolar disorder	RBKC	2,618	2,653	2,689
	WCC	4,587	4,754	4,804
Borderline personality disorder	RBKC	2,422	2,470	2,535
	WCC	3,874	3,999	4,074
Psychotic disorder	RBKC	702	709	713
	WCC	1,171	1,224	1,234
Suicide thoughts	RBKC	25,235	25,668	26,033
	WCC	42,614	44,544	45,321
Suicide attempts	RBKC	8,542	8,673	8,784
	WCC	14,588	15,204	15,411
Self-harm	RBKC	9,664	9,817	10,000
	WCC	17,284	17,888	18,110

Source: Adult Psychiatric Morbidity Survey (2014). GLA population projections

Other estimates

Public Health England reports the estimated prevalence of long-term mental health issues and of anxiety and depression (in the community and among social care users).

Table 50 shows that based on these estimates, both boroughs are indicated to have a higher percentage of GP registered patients with long-term mental health issues and depression and anxiety compared to the London average. It also shows that in Kensington and Chelsea the percentage of care users with depression and anxiety is higher, while in Westminster the percentage is lower than the London average.

Table 50: Further estimates of long-term mental illness and anxiety and depression

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON**	**ENG.**	**RBKC**	**WCC**
Long-term mental health problems (GP Survey)	2016/17	5.6%	6.1%	4.8%	5.7%	141	202
Depression and anxiety prevalence (GP Survey)	2016/17	14.7%	14.2%	12.4%	13.7%	399	500
Depression and anxiety: social care users	2013/14	56.8%	51.6%	54.4%	52.8%	-	-

Source: Public Health England Fingertips (2019)

Recorded prevalence

Table 51 shows the incidence and prevalence of diagnosed cases of mental illnesses based on GP registers in 2016/17 and claimant data from 2016. The following key points are made:

- The recorded incidence of depression Kensington and Chelsea is the same as the London average, while in Westminster the incidence is below the London average
- The prevalence of severe mental illness in both boroughs and the prevalence of depression in Kensington and Chelsea, are higher than the respective London averages. Rates of depression recorded in Westminster are lower than the London average.
- In 2016/17 the number of new cases of depression were 1,900 and 2,600 for Kensington and Chelsea and Westminster respectively.
- In 2016/17 the number of adults registered with a Serious Mental Illness were 3,851 and 3,215 for Kensington and Chelsea and for Westminster respectively
- over 10,000 residents in each borough are recorded on GP registers as having depression
- In both boroughs the rate of Employment Support Allowance (ESA) for mental and behavioural disorders is above the London average.
- Rates of hospital admission for self-harm in adults and young people are below the London average in both boroughs.
- 2015-17 pooled data show suicide rates in Kensington and Chelsea and Westminster to be comparable to the London average for both genders.

Table 51: GP recorded incidence and prevalence of mental illnesses 2016/17 by borough

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Depression incidence [a]	2017/18	1.2%	1.1%	1.2%	1.6%	1,994	2,636
Depression prevalence[a]	2017/18	8.5%	5.7%	7.1%	9.9%	14,341	13,562
Severe Mental Illness [a]	2017/18	1.5%	1.4%	1.1%	0.9%	3,851	3,215
ESA claimants for mental & behavioural disorders per 1,000 16 to 64 years	2016	26.8	28.1	23.0	27.5	2,930	4,930
Hospital admissions for self-harm, DSR all ages	2016/17	-	64.6	102.1	207.2	-	7
Hospital admissions: Self-harm/ 100,000 15-19 years	2016/17	-	224.5	305.2	619.9	-	26
Hospital admissions: Self-harm/ 100,000 20-24 years	2016/17	75.4	57.2	188.6	393.2	7	10
Suicide rate: Persons	2015-17	9.5	8.3	8.6	9.6	40	49
Suicide rate: Male	2015-17	15.8	12.1	13.1	14.7	32	35
Suicide rate: Female	2015-17	-	4.5	4.4	4.7	8	14

Source: Public Health England Fingertips (2019) [a] Quality and Outcomes Framework data. DSR (Directly Standardised Rate).

8.4 Risk factors

As we grow into adulthood, we start to experience additional challenges to our mental wellbeing. We may experience the loss of loved ones, job or housing insecurity, financial worries and the stresses of everyday life. Building close relationships with friends, family and our communities is incredibly important as is looking after our workplace health.

Table 52 shows comparative data on risk factors for mental illness taken from the Public Health England fingertips profiles for each borough. The first indicator is reported for Clinical Commissioning Group (CCG) registered patients. CCG boundaries map to the Bi-Borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen's Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen's Park Paddington

The following key points are identified:

- Both boroughs have lower rates of people with a learning disability or long-term health problem or disability compared to the London average
- The long-term unemployment rate in both boroughs is also lower than the London average
- Rates of marital break-up and persons living alone are higher than the London average
- Both boroughs have comparable rates of Dementia among GP registered patients to the London average
- Both boroughs are expected to have the same rate of alcohol dependence as the London average, however both boroughs have higher rates of hospital admissions for mental and behavioural disorders due to the use of alcohol
- Kensington and Chelsea has a higher rate of substance misuse among young adults, while Westminster has a lower rate, compared the London average. In addition, the prevalence of opiate and/or crack cocaine use among adults is higher than the London average
- 39.5% of Kensington and Chelsea residents and 27.7% of Westminster residents in touch with specialist alcohol services are also in contact with mental health services (London, 28.1%)
- 24.4% of Kensington and Chelsea residents and 28.9% of Westminster residents in touch with specialist drug services are also in contact with mental health services (London, 28.5%)

Table 52: Risk factors for mental illness. Comparative data

		Rate			Count		
Indicator	**Period**	**WLCCG**	**CLCCG**	**LON.**	**ENG.**	**RBKC**	**WCC**
Learning disability QOF prevalence: people on GP registers 16yrs+	2017/18	0.20%	0.20%	0.40%	0.50%	431	676
		Rate				**Count**	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Long-term health problem (GP survey)	2011	13.1%	13.8%	14.2%	17.6%	28,803	21,645
Long-term unemployment / 1,000 16-64yrs	2016	3.4	3.7	4.1	3.7	371	650
Marital breakup: % of adults	2011	11.4%	11.4%	10.6%	11.6%	15,248	21,208
People living alone: residents in households occupied by a single person	2011	23.4%	22.5%	12.8%	12.8%	36,524	47,893
Adults with dementia known to GPs: % patients	2017/18	0.5%	0.5%	0.5%	0.8%	1,076	1,338
Estimated percentage of adults with alcohol dependence	2014/15	1.4%	1.4%	1.4%	1.4%	1,738	2,728
Admission to hospital for mental and behavioural disorders due to alcohol/ 100,000	2016/17	59.8	60.4	55.8	72.3	93	136
Hospital admissions: substance misuse/ 100,000	14/15 - 16/17	73.2	51.2	67.2	89.8	36	45
No. in treatment at specialist services - Alcohol	2016/17	273	505	11,440	80,454	273	505
Contact with mental health & specialist services: % in treatment -Alcohol	2016/17	39.5%	27.7%	28.1%	22.7%	75	88
Estimated prevalence: opiate and/or crack cocaine	2014/15	11.3	13.2	8.9	8.6	1,250	2249
No. in treatment at specialist services - Drug	2016/17	779	964	30,200	199,339	779	964

Contact mental health & specialist services % in treatment – Drug 18yrs+	2016/17	24.4%	28.9%	28.50%	24.3%	76	118

Source: Public Health England Fingertips (2019)

8.5 Protective factors

The most powerful childhood predictor of adult life satisfaction is a child's emotional health. The most modifiable and important risk factors for mental health issues and the most important determinants of mental wellbeing lie in the family, the environment, the community and the society into which a child is born and raised.

While unemployment is a key risk factor, having stable and secure long term employment can provide feelings of self-worth and efficacy.

Table 53 summarises the available comparative data on protective factors. The following key points are made:

- While Table 52 shows rates of long-term unemployment are lower than the London average, employment rates are lower in both boroughs compared to the London average
- Both boroughs have higher rates of self-reported high satisfaction and high happiness compared to the London average
- In both boroughs a higher percentage residents are estimated to be getting enough exercise compared to the London average
    - sports club membership in also estimated to be higher than the national average in both boroughs
- The estimated percentage of Adult Social Care service users with enough social contact is lower than the London average in both boroughs

Table 53: Comparative data on protective factors, comparison to London

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Employment 16-64yrs	2017/18	65.4%	64.4%	74.2%	75.2%	71,000	113,100
Self-reported -high satisfaction	2015/16	83.9%	81.2%	79.6%	81.2%	-	-
Self-reported -high happiness	2015/16	77.2%	76.3%	74.3%	74.7%	-	-
Enough physical activity 19yrs+	2016/17	68.2%	66.7%	64.6%	66.0%	-	-
Sports club membership 16yrs+	2015/16	30.9%	27.7%	-	22.0%	-	-
Enough social contact: ASC users	2017/18	35.5%	34.3%	41.4%	46.0%	-	-

Public Health England Fingertips (2019)

8.6 What works

For adults, there are a number of interventions that are shown to promote mental wellbeing. Meeting the housing needs for at-risk adults is an area that supports mental health outcomes. Housing interventions that result in improved mental health outcomes include:

- Re-housing interventions (Thomson et al., 2009);
- Targeted interventions such as supported housing for high-risk groups, including those with mental illness (Nelson, Aubrey & Lafrance, 2007);
- Housing support for high-risk families (family intervention projects) associated with reduced eviction rates and improved neighbourhood (National Centre for Social Research, 2010); and
- Interventions that address fuel poverty and ensure adequate heating are associated with improved mental health (Thomson et al., 2009).

There is some evidence that indicates that neighbourhood enhancement and regeneration results in improved mental health. The evidence mainly relates to physical activity with 'walkable neighbourhood' schemes that increase rates of physical activity and provide more opportunities for social interaction (Killoran et al., 2006).

There is strong evidence that access to green and open spaces directly improves our health and wellbeing. Green spaces are associated with a raft of health benefits such as

- improved mental health and wellbeing
- improved cognitive function and stress reduction
- increased self-esteem and improved sleep quality

Physical activity is associated with reductions in depression (NICE, 2009a), improved wellbeing (including people with schizophrenia) (Holley et al., 2011) better cognitive performance in children and better mental health outcomes in older people (NICE, 2008b). Active leisure programmes are associated with improved mental wellbeing. Active travel can be facilitated by a range of interventions including family/school-based active travel promotion schemes, active travel infrastructure (NICE, 2009a).

There is some evidence that debt advice results in improved mental health (Pleasance & Balmer, 2007). Improved financial capability results in improved mental health as well as reduced anxiety and depression (Taylor, Jenkins & Sacker, 2009).

In addition, positive psychology interventions promote positive thoughts and emotions (Sin & Lyumbomirksy, 2009). Mindfulness interventions have been shown to contribute to positive mood, improved quality of life, self-esteem, empathy, optimism, meaning, reduced anxiety and depressive symptoms (Chiesa & Serretti, 2009).

As employment is one of the key risk factors for mental health and wellbeing among adults, secure employment can provide feelings of self-worth and efficacy:

- Work-based mental health promotion results have been shown to deliver increased performance at work and reduced sickness rates as well as reduced anxiety and depression (Kuoppala, Lamminpaa & Husman, 2008);
- Work-based stress management interventions have been shown to deliver reduced work-related stress/sickness absence (Richardson & Rothstein, 2008); and
- Support for unemployed people results in increased employment and reduced distress (Audhoe et al., 2010).

The *Better Mental Health for All* report (2016) points to the following interventions:

- Provide mental health literacy training to frontline housing and advice workers can help individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes
- Use social media and other avenues to disseminate public mental health messages such as those promoted in the 5 Ways to Wellbeing
- Mindfulness has a rapidly expanding evidence base and is increasingly popular in both people with mental health issues and risk factors and in general populations
- Promote body work that both exercises and stills the mind like Yoga and Tai Chi, which are increasingly popular and have a small evidence base to support their effectiveness
- Promote walking and exercise on prescription schemes, books on prescription schemes, social prescribing and wellbeing pledge programmes in primary care
- Promote the use of volunteering, as a way of linking local people who share their time and skills, and enabling them to live well, improve their health and wellbeing, and link them to their community.
- Increasing people's capacity to use psychological treatment methods (such as CBT) can prevent the development of mental health issues, particularly if used during periods of transition and pressure, such as redundancy, after birth or after a bereavement.
- Provide bereavement counselling and relationship support
- Support unemployed working age adults into high quality work and ensure those who are unable to work have access to a reasonable standard of resources and are supported to lead fulfilling lives, moving towards employment as appropriate
- Increase mental health literacy, especially for people with limited financial and social resources, including older people, people with long term health

conditions, refugees, people from Black and Minority Ethnic communities and people living with disabilities.

- People living with serious mental health issues will benefit from regular general physical health assessments and from signposting to information and support that addresses diet, alcohol consumption, exercise, drug misuse and sleep
- Other important interventions include public health intervention that might otherwise be overlooked such as access to smoking cessation, free dental and optical examinations, and flu vaccinations
- Services, facilities and resources should be inspected to ensure they are accessible. This can be done by assessing in collaboration with the local community and making any necessary adjustments.
- Ensure service navigators are available to people with complex needs and advocate for them to have peer experience and be skilled in negotiating the access barriers experienced by minority groups
- Develop trauma informed care, particularly for those who have witnessed or experienced violence, abuse and/or severe neglect either in childhood or adulthood

What NICE says…

NICE guidelines (PH22) outline responsibilities around workplace mental health:

- Adopt an organisation-wide approach to promoting the mental wellbeing of all employees, working in partnership with them. This approach should integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions.
- Ensure that the approach takes account of the nature of the work, the workforce and the characteristics of the organisation.
- Promote a culture of participation, equality and fairness that is based on open communication and inclusion.
- Create an awareness and understanding of mental wellbeing and reduce the potential for discrimination and stigma related to mental health problems.
- Ensure processes for job design, selection, recruitment, training, development and appraisal promote mental wellbeing and reduce the potential for stigma and discrimination. Employees should have the necessary skills and support to meet the demands of a job that is worthwhile and offers opportunities for development and progression. Employees should be fully supported throughout organisational change and situations of uncertainty.
- Ensure that groups of employees who might be exposed to stress but might be less likely to be included in the various approaches for promoting mental

wellbeing have the equity of opportunity to participate. These groups include part-time workers, shift workers and migrant workers.

- Adopt a structured approach to assessing opportunities for promoting employees' mental wellbeing and managing risks.
- Different approaches may be needed by micro, small and medium-sized businesses and organisations for promoting mental wellbeing and managing risks. Smaller businesses and organisations may need to access the support provided by organisations such as the Federation of Small Business and Chambers of Commerce.

Social prescribing: the evidence

Social prescribing has been a key focus of recent strategy and policy to improve wellbeing. Theresa May recently announced plans for social prescribing to be in place by 2023 when announcing the Government's first loneliness strategy.

Social prescribing is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focused on improving mental health and physical well-being. Those who could benefit from social prescribing schemes include people with mild or long-term mental health issues, vulnerable groups, people who are socially isolated, and those who frequently attend either primary or secondary health care.

Evaluation of the impact of social prescribing has proved challenging, as much of the data collected for evaluation is subjective feedback from service users and is difficult to quantify and to analyse. Consequently, results are often inconsistent and difficult to compare between different projects.

However, evidence to support the value of social prescribing can be collated by looking at examples of successful schemes where it has been used to improve patient care. Evaluation of a social prescribing pilot scheme in Rotherham (Voluntary Action Rotherham) has shown impact in various different areas:

- reduction in demand for urgent hospital care (reduction in A&E attendances in those under 80y by 23%)
- improvement in well-being for patients with long-term health conditions (82% of service users experience positive change after 3-4 months of social prescribing)

- estimated economic benefits, a return on investment of £1.98 for each £1 invested, based on NHS costs avoided due to reduction in demand for urgent hospital care

A further report on Social Prescribing in Bristol assessed the Social Return on Investment (SROI), reporting a ratio of £2.90 for every £1 spent.

Social prescribing can benefit a wide section of the population: vulnerable and at-risk groups; lonely, isolated, excluded groups; people with mild to moderate depression/anxiety; frequent attenders in Primary Care.

Many of the perceived benefits around social prescribing are related to improvement in mental health outcomes. Research by the Mental Health Foundation in 2005 found that 78% of GPs had prescribed an antidepressant in the previous 3 years, despite believing that an alternative treatment might have been appropriate, with 60% of GPs saying that they would prescribe antidepressants less frequently if other options were available.

As such, the use of guided self-help and support groups is now suggested in NICE guidelines for management of depression, either in parallel with, or as an alternative to antidepressants. Many of these projects have a focus on Mental illness, with some studies showing 'improvements in anxiety levels and in feelings about general health and quality of life', and another study showing statistically significant improvements in PHQ9 scores for depression, GAD7 scores for anxiety, the Friendship Scale, ONS Wellbeing measures and IPAQ items for moderate exercise, only 3 months after taking part in a social prescribing project. Social prescribing can help increase recovery from mental illness, help patient manage their condition and help social inclusion of people with mental health issues.

In particular, 'green activity', or 'ecotherapy' – improving health and wellbeing through contact with nature – has been shown to have many benefits, including improved self-esteem, positive mood and self-efficacy, as well as reduction in physical and mental health symptoms and improvement in quality of life. The charity, Mind, has produced a leaflet on ecotherapy, to educate potential users about the benefits of this, which include increased activity, social contact and sense of wellbeing.

8.7 Service Activity

Treatment services

This section summarises comparative data on adult mental health services from information published by Public Health England. Indicators data relate to Clinical Commissioning Group (CCG) registered patients. CCG boundaries map to the Bi-Borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen's Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen's Park Paddington

General Practice

Table 54 summarises comparative data on General Practitioner (GP) services. The following key points are made:

- Rates of prescribing for psychosis are lower than the London average in WLCCG, while in CLCCG rates are higher
- Both CCGs have lower rates of patients receiving '1st choice' antidepressants
- Of patients diagnosed with depression a higher percentage of patients for WLCCG received bio psychosocial assessment compared to the London average, while in CLCCG the percentage is lower
- Both CCGs have a higher percentage of patients with a Long Term Condition (LTC) who agree they receive enough support from local services compared to the London average
- Both CCGs have a lower percentage of patients on lithium therapy within a therapeutic range within the past 4 months, and a lower percentage of patients on lithium therapy with a record of serum creatinine, compared to the London average
- Both CCGs have a lower percentage of patients with diagnosed depression review within 10-56 days of diagnosis compared to the London average
- Both CCGs have lower than London average percentages of patients with a Severe Mental Illness (SMI) with a comprehensive care plan
- Both CCGs have a lower than London average percentage of female patients on a mental health register who have received a cervical smear.
- West London CCG have a higher percentage of patients on a mental health register who have received a blood pressure check and alcohol consumption check compared to the London average. By contrast percentages of these checks delivered in Central London CCG are lower than the London average.

Table 54: General practice comparative indicators

		Rate			Count		
Indicator	**Period**	**WLCCG**	**CLCCG**	**LON.**	**ENG.**	**RBKC**	**WCC**
GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1,000 population	2017/18 Q4	47.2	54.7	53.9	62.4	9,628	10,332
Primary care prescribing of '1st choice' antidepressants : % of prescription items	2016/17	66.5%	63.9%	69.0%	68.7%	70,950	68,799
Assessment of depression: % of adults with a new diagnosis of depression who had a bio-psychosocial assessment on diagnosis	2013/14	76.1%	71.9%	72.5%	75.8%	1,575	796
% of people with long-term conditions visiting GP who feel they have had enough support from local services in last 6 months	2017/18	52.7%	52.1%	51.8%	55.3%	717	622
Patients on lithium therapy with levels in therapeutic range: % within preceding 4 months	2016/17	73.5%	77.5%	78.3%	83.0%	164	107
Patients on lithium therapy with record of serum creatinine and TSH: % with record in the preceding 9 months	2017/18	91.5%	91.9%	92.7%	94.2%	193	124

Review of depression: % of newly diagnosed patients with depression who had a review 10-56 days after diagnosis	2017/18	55.9%	52.9%	63.2%	64.2%	1,388	1,124
Patients on MH register who have comprehensive care plan: %	2017/18	83.2%	73.1%	83.3%	78.2%	2,602	1,914
Patients on MH register blood pressure check: % with record in preceding 12 months	2017/18	84.4%	82.8%	84.0%	81.5%	2,639	2,167
Patients on MH register with alcohol consumption check: % with record in preceding 12 months	2017/18	85.5%	81.0%	85.2%	80.6%	2,675	2,121
Female patients on MH register who had cervical screening test: % tested in preceding 5 years	2017/18	67.2%	63.1%	68.4%	69.6%	704	501
Patients with SMI receiving the full list of physical health checks	2014/15	38.2%	34.0%	-	34.8%	1,017	660

Source: Public Health England Fingertips (2019)

Improving Access to Psychological Therapies (IAPT)

IAPT services provide evidence-Based treatments for people with anxiety and depression.

Table 55 provides a summary of IAPT service performance indicators. The data presented relate to Clinical Commissioning Group (CCG) registered patients. CCG boundaries map to the bi-borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen's Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen's Park Paddington

The following key points are made:

- IAPT referral rates and the percentage of referrals that are from BME patients are higher than the London average
- Treatment rates are also higher than the London average in West London CCG, however lower than the London average in Central London CCG
- Average waiting times for first treatment for West London CCG patients are 13.4 days – shorter than the England average, 17.5 days, while average waiting times are 20.7 days for Central London CCG patients – longer than the England average.
- Both CCGs have higher percentages of patients (that have completed treatment) that have been seen for first treatment within 6 weeks and within 18 weeks respectively. This is also true for 'in month referrals' seen in within 6 weeks in West London CCG and seen within 18 weeks in Central London CCG.
    - By contrast, Central London CCG has a lower percentage of 'in month' referrals waiting less than 6 weeks for first treatment and West London CCG has a lower percentage of 'in month' referrals waiting less than 18 weeks for first treatment
- Of referrals, a higher percentage of referrals from West London CCG are estimated to have anxiety or depression compared to the London average, while Central CCG referrals have a lower percentage for these illnesses
- The treatment completion rate is higher than the London average for patients of West London CCG, while the completion rate is lower than the London average for Central London CCG patients
- In both CCGs, average treatment durations are above the England average (6.9 attended appointments), 7.5 and 8.2 attended appointments respectively. However maximum durations of treatment are below the England average (89 attended appointments), 21 and 30 attended appointments respectively.
- 53% of patients from West London CCG and 61% of patients from CL CCG are 'moving towards recovery' at the completion of treatment, compared to the London average is 53.4%
- Both CCGs have higher rates of patients completing treatment who have achieved 'reliable improvement'. This is 78% and 79.7% for West London CCG and Central London CCG respectively, compared to the London average of 72%
- Did not attend (DNA) rates in West London CCG are lower than the London average 8.2% vs. 8.6%, while rates are above the London average for Central London CCG patients at 9.4%

Table 55: IAPT comparative data

		Rate			Count		
Indicator	**Period**	**WLCCG**	**CLCCG**	**LON.**	**ENG.**	**RBKC**	**WCC**
IAPT referrals/ 100,000	2018/19 Q2	1,373	997	892	868	2,485	1,455
Entering IAPT treatment / 100,000	2018/19 Q2	854	696	627	598	1,545	1,015
IAPT referrals for BME patients: % of referrals	2018/19 Q2	51.3%	44.3%	46.2%	16.2%	1,275	645
Waiting < 6 weeks to enter IAPT treatment (supporting measure): % of referrals waiting <6 weeks for first treatment	Sep-18	90.1%	97.1%	94.4%	89.3%	455	340
Waiting < 6 weeks for IAPT treatment (standard measure): % of referrals that have finished course of treatment waiting <6 weeks for first treatment	Sep-18	97.0%	92.0%	93.7%	89.6%	255	160
Waiting < 18 weeks to enter IAPT treatment (supporting measure): % of referrals waiting <18 weeks for first treatment	Sep-18	98.0%	98.6%	99.5%	99.1%	495	345
Waiting < 18 weeks for IAPT treatment (standard measure): % of referrals that have finished course of treatment waiting <18 weeks for first treatment	Sep-18	100.0%	99.0%	99.4%	99.0%	265	170

Average wait to enter IAPT treatment: mean wait for first treatment (days)	Sep-18	19.4	12.6	-	18.9	-	-
Access to IAPT services: people entering IAPT as % of those estimated to have anxiety or depression	Sep-18	17.1%	14.5%	16.1%	16.7%	505	350
Completion of IAPT treatment: rate per 100,000 population aged 18+	2018/19 Q2	412	387	342	334	745	565
Average IAPT treatment dosage: mean number of attended treatment appointments for those referrals finishing course of treatment	Sep-18	7.8	8.2	-	6.9	-	-
Maximum IAPT treatment dosage: maximum number of attended treatment appointments for those referrals finishing course of treatment	Sep-18	27.0	22.0	-	54.0	-	-
IAPT recovery: % of people who have completed IAPT treatment who are "moving to recovery"	Sep-18	54.0%	51.0%	50.3%	51.5%	130	80

IAPT reliable improvement: % of people who have completed IAPT treatment who achieved "reliable improvement"	2018/19 Q2	74.0%	73.3%	71.1%	71.1%	485	370
IAPT DNAs: % of IAPT appointments	Sep-18	8.2%	7.0%	9.6%	10.6%	250	140

Source: Public Health England Fingertips (2019)

Care Programme Approach (CPA)

Table 56 summarises comparative data mental health services users with CPA. The following key points are made:

- The percentage of mental health service users with a CPA is higher than the London average in WLCCG, but lower in CLCCG
- Both CCGs have a higher than London average percentage of people on a CPA in appropriate housing and with a HoNOS assessment
- Of people on a CPA for more than 12 months, WLCCG has a higher than London average percentage who have had a review, while in CLCCG the percentage is lower
- Both CCGs have a higher than London average percentage of people with a CPA followed up after discharge
- Both CCGs have a lower than London average percentage of people with a crisis plan in contact with mental health services

Table 56: CPA comparative data

		Rate			Count		
Indicator	**Period**	**WLCCG**	**CLCCG**	**LON.**	**ENG.**	**RBKC**	**WCC**
People on Care Programme Approach (CPA): rate per 100,000 population aged 18+	2018/19 Q2	508	377	392	362	920	550
Mental health service users on CPA: % of mental health service users	2018/19 Q2	24.1%	16.7%	19.5%	15.7%	920	550
Stable and appropriate accommodation: % of people on CPA (aged 18-69)	2018/19 Q2	85.1%	78.6%	62.0%	57.4%	715	405

CPA users with HoNOS assessment: % of people on CPA with HoNOS recorded	2018/19 Q2	90.8%	85.5%	81.8%	67.5%	835	470
CPA review: % of people on CPA for more than 12 months who have had a review	2018/19 Q2	95.2%	93.2%	93.0%	76.6%	700	410
Follow up after discharge: % of patients on CPA	2018/19 Q2	98.8%	94.2%	94.4%	95.8%	79	49
Service users with crisis plans: % in contact with mental health services	2018/19 Q2	3.1%	2.4%	7.4%	13.6%	140	90
CPA adults in employment. Aged 18-69 yrs	2018/19 Q2	6.5%	8.7%	6.1%	8.4%	55	45

Source: Public Health England Fingertips (2019)

Patient flow

Table 57 below summarises comparative data on the patient flows. The following key points are made:

- Both CCGs have a higher than England average percentage of mental health patients waiting less than 28 days between 1st and 2nd treatments, however waiting times are shorter than the England average
- Both CCGs have higher rates of delayed discharges compared to the London average
- Both boroughs have a lower percentage of mental health service users in hospital compared to the London average

Table 57: Patient flow comparative data

		Rate			Count		
Indicator	**Period**	**WLCCG**	**CLCCG**	**LON.**	**ENG.**	**RBKC**	**WCC**
Percentage waiting < 28 days between 1st & 2nd treatment (annual)	2015/16	34.4%	41.6%	-	35.6%	1,965	2,000
Average waiting time between 1st & 2nd treatment (annual)	2015/16	28.0	24.4	-	31.6	-	-
Delayed discharges: days of delayed discharges in the quarter: rate per 1,000 bed days	2018/19 Q2	1.4	1.3	26.3	3.1	75	50
Service users in hospital: % mental health service users	2018/19 Q2	4.6%	3.6%	3.0%	2.2%	175	120

Source: Public Health England Fingertips (2019)

Local data

This section presents the findings of analysis of local health and care service data

GP prescribing

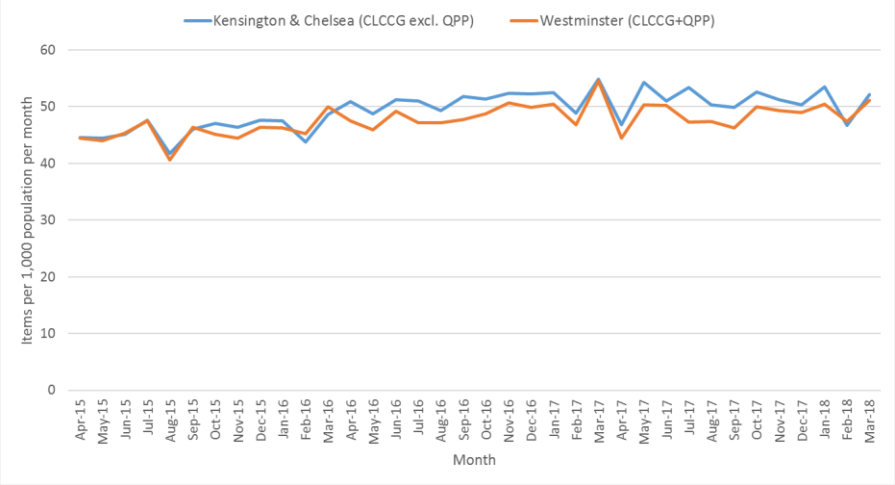
Data on the number of adults prescribed antidepressants is not available, only the number of items (packs of medication).

Chart 25 shows that the crude rate of antidepressant items prescribed to adults aged 20 to 64 years per 1,000 population.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

It can be seen that antidepressant prescribing rates are typically higher in Kensington and Chelsea compared to Westminster. The chart also shows rates in both boroughs and has been increasing slightly over the past three financial years.

Chart 25: Antidepressant prescribing, items per 1,000 adults aged 20 to 64 years



Source: NHS North West London Medicines Management

Table 58 shows annual numbers of items prescribed per financial year and crude rates per 1,000 GP registered population to enable comparison.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

In 2017/18 almost 90,000 antidepressant items were prescribed to working age adults in Kensington and Chelsea and almost 112,000 items in Westminster.

Table 58: Antidepressant prescribing items and rate per 1,000 population aged 20-64 years

Metric	Borough	2015/16	2016/17	2017/18
Items/ 1,000 population	Kensington & Chelsea (WLCCG excl. QPP)	550	615	612
	Westminster (CLCCG + QPP)	546	586	583
Items	Kensington & Chelsea (WLCCG excl. QPP)	81,915	87,256	89,540
	Westminster (CLCCG + QPP)	96,656	106,284	111,847

Source: NHS North West London Medicines Management

Specialist mental health services

Data from the Healthy London Partnership dashboard provides the following comparative information on service activity:

- Community contacts per 100,000 (2015/16): Both CCGs have a higher rate of community contacts compared to the London average, Central London 37,979, West London 39,274 compared to London, 34,000.
- Admissions per 100,000 per 100,000 (2016/17): Both CCGs have a higher rate of admissions compared to the London average, Central London 215.7, West London 227.0 compared to London, 187.4

- Acute admissions per 100,000 (Q2 2018/19): Both CCGs have a lower rate of admissions compared to the London average, Central London 35.4, West London 38.1 compared to London, 39.6
- Acute readmissions within 30 days of discharge (October 2015): In 2015, West London CCG had a higher percentage of readmissions to hospital, 14.0% compared to the London average, 10%
- Psychosis Early intervention caseload per 100,000 (2016): Both CCGs have a lower rate of clients on caseload compared to the London average, Central London 52.8, West London 45.4 compared to London, 53.7

Central and North West London NHS Foundation Trust (CNWL)

This section provides further detailed analysis of activity data using data provided by Central and North West London NHS Foundation Trust (CNWL). In interpreting these findings it should be considered that while CNWL is the largest provider of mental health care services, there are other mental health services. Therefore, the numbers presented are likely to be an underestimate of current demand for treatment services.

Referrals

Chart 26 shows referrals to the Central and North West London NHS Foundation Trust (CNWL) Adult Mental Health Services by Clinical Commissioning Group (CCG).
CCG boundaries map to the Bi-Borough as follows:

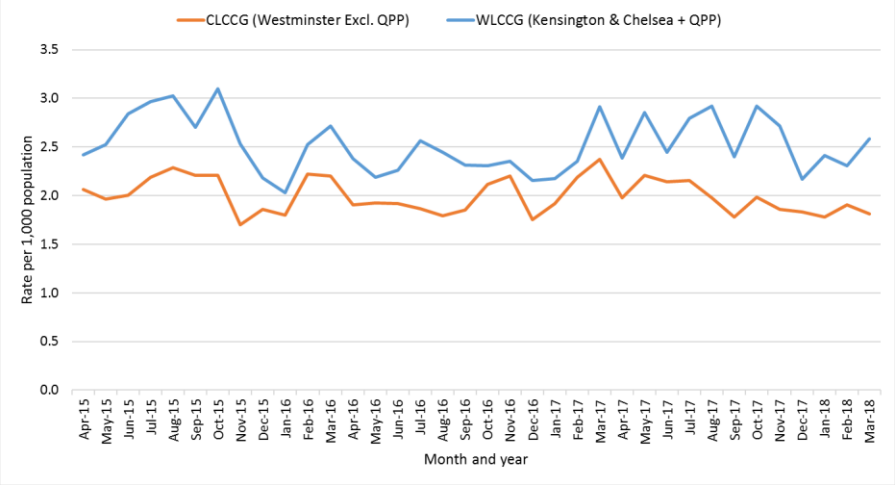
- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen's Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen's Park Paddington

In interpreting referrals data it should be noted that of referrals, not all are accepted (see Table 62 below) and of those accepted not all referrals lead to a positive diagnosis and treatment.

Chart 26 shows the trend in referrals from all sources. Table 59 and Table 60 show annual numbers by referral source for Central London CCG and West London CCG respectively. These show referral volumes by source in rank order and indicate where annual numbers have increased (dark blue) or decreased (light blue) year on year.

Table 63 and Table 64 list the reasons for referral in rank order. Year on year changes are highlighted as increase (dark blue) or decrease (light blue).

Chart 26: Referrals to CNWL, all sources of referral, monthly trend



Source: CNWL contract monitoring data

From Table 59 and Table 60 the following key points are made:

- the most common referral route into Adult services is from A&E in both boroughs. GP is the next most common source of referral from WLCCG, while in CLCCG GP is fourth, following 'other service or agency' and other primary health care.
- For most referral routes 2017/18 volumes have been higher than 2016/17 in both CCGs
- Continual year-on-year increases in volumes have been seen in referrals from A&E departments, other primary health care and Court Liaison Diversion Service in both CCGs and from WLCCG from carers, other independent mental health providers and the probation service
- Numbers of referrals from carers and 'out of areas agencies' in CLCCG and 'other secondary care specialities', 'other service or agency' and 'Permanent transfers from another Mental Health Trust' in WLCCG have been continually declining

Table 59: Adults: Source of referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

	Referrals					Change	
Source of referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
Accident And Emergency Department	895	1027	1296	3218	29%	115%	126%
Other service or agency	639	578	470	1687	15%	90%	81%
Other Primary Health Care	430	530	581	1541	14%	123%	110%
GP	605	330	443	1378	12%	55%	134%
Police	395	473	412	1280	11%	120%	87%
Other secondary care specialty	425	468	353	1246	11%	110%	75%
Self	183	93	104	380	3%	51%	112%
Social Services	84	12	16	112	1%	14%	133%
Court Liaison and Diversion Service	7	29	68	104	1%	414%	234%
Carer	27	24	17	68	1%	89%	71%
Courts	17	26	17	60	1%	153%	65%
Out of Area Agency	27	19	10	56	0%	70%	53%
Other Independent Sector Mental Health Services	16	21	18	55	0%	131%	86%
Permanent transfer from another Mental Health NHS Trust	8	16	9	33	0%	200%	56%
Temporary transfer from another Mental Health NHS Trust	6	13	<5	19	0%	217%	-
NHS Direct	11	<5	7	18	0%	-	-
Drug Action Team / Drug Misuse Agency	10	<5	<5	10	0%	-	-
Health Visitor	<5	<5	8	8	0%	-	-
Prison	8	<5	<5	8	0%	-	-
Voluntary Sector	6	<5	<5	6	0%	-	-
Asylum Services	<5	<5	0	0	0%	-	-
Community-based Paediatrics	<5	<5	<5	0	0%	-	-
Education Service	<5	0	<5	0	0%	-	-
Employer	<5	<5	<5	0	0%	-	-
Improving Access to Psychological therapies Service	0	0	0	0	0%	-	-
Independent Sector - Low Secure Inpatients	<5	<5	<5	0	0%	-	-
Independent sector - Medium Secure Inpatients	<5	<5	<5	0	0%	-	-
Probation Service	<5	<5	<5	0	0%	-	-
School Nurse	<5	<5	0	0	0%	-	-

Source: CNWL contract monitoring data

Table 60: Adults: Source of referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

	Referrals					Change	
Source of referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
Accident And Emergency Department	1691	1721	2129	5541	36%	102%	124%
GP	1113	885	943	2941	19%	80%	107%
Other secondary care specialty	719	636	580	1935	12%	88%	91%
Other service or agency	665	606	545	1816	12%	91%	90%
Police	315	249	303	867	6%	79%	122%
Other Primary Health Care	154	215	256	625	4%	140%	119%
Self	196	169	213	578	4%	86%	126%
Social Services	323	27	39	389	3%	8%	144%
Court Liaison and Diversion Service	17	72	124	213	1%	424%	172%
Courts	80	43	77	200	1%	54%	179%
Out of Area Agency	25	33	33	91	1%	132%	100%
Carer	20	24	28	72	0%	120%	117%
Other Independent Sector Mental Health Services	11	26	27	64	0%	236%	104%
Permanent transfer from another Mental Health NHS Trust	24	19	10	53	0%	79%	53%
NHS Direct	13	7	15	35	0%	54%	214%
Prison	8	13	9	30	0%	163%	69%
Temporary transfer from another Mental Health NHS Trust	17	13	<5	30	0%	76%	-
Health Visitor	5	7	12	24	0%	140%	171%
Probation Service	8	10	6	24	0%	125%	60%
Drug Action Team / Drug Misuse Agency	5	7	5	17	0%	140%	71%
Asylum Services	<5	<5	0	0	0%	-	-
Community-based Paediatrics	<5	<5	<5	0	0%	-	-
Education Service	<5	0	<5	0	0%	-	-
Employer	<5	<5	<5	0	0%	-	-
Improving Access to Psychological therapies Service	0	0	0	0	0%	-	-
Independent Sector - Low Secure Inpatients	<5	<5	<5	0	0%	-	-
Independent sector - Medium Secure Inpatients	<5	<5	<5	0	0%	-	-
School Nurse	<5	<5	0	0	0%	-	-
Voluntary Sector	<5	<5	<5	0	0%	-	-

Source: CNWL contract monitoring data

Referral type

From Table 61, almost of half of referrals to adult mental health services are routine in nature for both CCGs, the remaining half is split almost equally between urgent or emergency referrals. In 2017/18 there were 2,786 urgent or emergency referrals from WLCCG and 1,826 from CLCCG.

Table 61: Adults: Type of referral by CCG

WLCCG (Kensington and Chelsea +QPP)

	Referrals			referrals		
Referral type	15/16	16/17	17/18	15/16	16/17	17/18
Emergency	1363	1364	1584	25%	28%	30%
Routine	2435	2123	2508	45%	44%	47%
Routine Plus	226	237	71	4%	5%	1%
Urgent	1395	1071	1202	26%	22%	22%

CLCCG (Westminster Excl. QPP)

	Referrals			referrals		
Referral type	15/16	16/17	17/18	15/16	16/17	17/18
Emergency	793	788	831	21%	21%	22%
Routine	1939	1823	1909	51%	50%	50%
Routine Plus	238	127	114	6%	3%	3%
Urgent	843	939	995	22%	26%	26%

Source: CNWL contract monitoring data

Accepted

Of referrals, Table 62 shows that the percentage of referrals that are accepted has increased between 2015/16 and 2017/18 in both CCGs. In 2017/18 the percentage of referrals to adult services accepted was 77% for WLCCG registered patients and 81% for CLCCG registered patients.

Table 62: Adults: Referrals accepted by CCG

WLCCG (Kensington and Chelsea +QPP)

	Referrals			referrals		
Decision	15/16	16/17	17/18	15/16	16/17	17/18
Accepted	3736	3689	4114	69%	77%	77%
Not Accepted	1548	904	1225	29%	19%	23%
Not Recorded	135	202	26	2%	4%	0%

CLCCG (Westminster Excl. QPP)

	Referrals			referrals		
Decision	15/16	16/17	17/18	15/16	16/17	17/18
Accepted	2850	2708	3102	78%	71%	81%
Not Accepted	584	972	705	16%	25%	18%
Not Recorded	243	133	42	7%	3%	1%

Source: CNWL contract monitoring data

Reason for referral

Table 63 and Table 64 show annual numbers by referral by reason for referral Central London CCG and West London CCG respectively. The following key points are made:

- For both CCGs 'in crisis' is the most common reason for referral, followed by Depression in CLCCG and HTT gatekeeping in WLCCG
- Continual year on year increases in referrals for depression, anxiety, HTT gatekeeping, perinatal mental health, ongoing or recurrent psychosis and are observed for both CCGs. CLCCG has seen continual increases in capacity (advice/assessment), suspected first episode psychosis and WLCCG in PTSD, bipolar, medication review, obsessive compulsive disorder

- The number of referrals for 'unexplained physical symptoms' in both CCGs have been declining year on year

Table 63: Adults: Reason for referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

	Referrals					Change	
Reason for referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
In crisis	2461	1361	1525	5347	47%	55%	112%
Depression	278	373	418	1069	9%	134%	112%
Capacity (advice/assessment)	184	394	462	1040	9%	214%	117%
Anxiety	151	215	238	604	5%	142%	111%
HTT Gate-keeping	154	218	230	602	5%	142%	106%
Perinatal mental health issues	57	147	185	389	3%	258%	126%
Self harm	113	133	123	369	3%	118%	92%
Ongoing or Recurrent Psychosis	55	124	152	331	3%	225%	123%
Suspected ADHD	63	131	124	318	3%	208%	95%
Relationship difficulties	31	120	100	251	2%	387%	83%
Post-traumatic stress disorder	56	114	59	229	2%	204%	52%
Drug and alcohol difficulties	45	69	43	157	1%	153%	62%
Personality disorders	37	58	43	138	1%	157%	74%
Medication Review	31	45	35	111	1%	145%	78%
Bi polar disorder	23	45	19	87	1%	196%	42%
HTT Discharge Facilitation	12	32	14	58	1%	267%	44%
Adjustment to Physical Health Condition	10	28	16	54	0%	280%	57%
Suspected First Episode Psychosis	6	12	23	41	0%	200%	192%
Obsessive compulsive disorder	8	15	9	32	0%	188%	60%
Unexplained physical symptoms	15	10	6	31	0%	67%	60%
Self - care issues	0	14	8	22	0%	-	57%
Conduct disorders	7	7	<5	14	0%	100%	-
Eating disorders	<5	7	0	7	0%	-	0%
Specific Procedure	7	0	<5	7	0%	0%	-
Gambling Difficulties	<5	<5	7	7	0%	-	-
Neurodevelopmental conditions	<5	<5	<5	0	0%	-	-
Organic brain disorder	<5	<5	<5	0	0%	-	-
Phobias	0	<5	0	0	0%	-	-
Service Redesign	<5	0	0	0	0%	-	-
Suspected ASD	<5	<5	0	0	0%	-	-
Suspected Autism Spectrum Disorder	0	0	<5	0	0%	-	-
(Blank)	<5	0	0	0	0%	-	-

Source: CNWL contract monitoring data

Table 64: Adults: Reason for referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

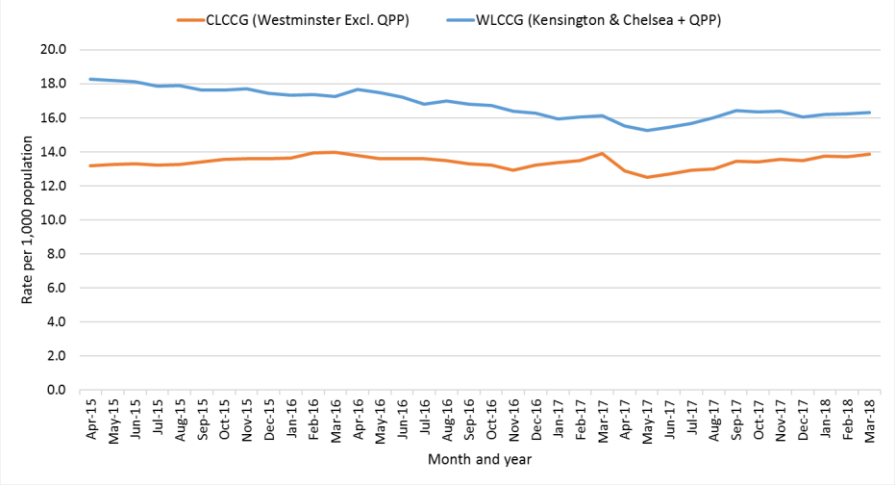
	Referrals					Change	
Reason for referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
In crisis	3254	1642	2079	6975	45%	50%	127%
HTT Gate-keeping	427	457	596	1480	10%	107%	130%
Depression	279	521	619	1419	9%	187%	119%
Capacity (advice/assessment)	519	431	459	1409	9%	83%	106%
Anxiety	138	291	208	637	4%	211%	71%
Self harm	165	231	158	554	4%	140%	68%
Ongoing or Recurrent Psychosis	121	201	228	550	4%	166%	113%
Perinatal mental health issues	59	218	256	533	3%	369%	117%
Suspected ADHD	63	140	137	340	2%	222%	98%
Post-traumatic stress disorder	51	114	142	307	2%	224%	125%
Drug and alcohol difficulties	70	124	93	287	2%	177%	75%
Personality disorders	49	108	77	234	2%	220%	71%
Bi polar disorder	61	73	80	214	1%	120%	110%
Medication Review	22	58	96	176	1%	264%	166%
Adjustment to Physical Health Condition	21	37	36	94	1%	176%	97%
Suspected First Episode Psychosis	26	41	20	87	1%	158%	49%
HTT Discharge Facilitation	18	28	21	67	0%	156%	75%
Unexplained physical symptoms	27	19	13	59	0%	70%	68%
Self - care issues	0	17	15	32	0%	-	88%
Conduct disorders	8	7	11	26	0%	88%	157%
Relationship difficulties	8	16	<5	24	0%	200%	-
Obsessive compulsive disorder	6	7	9	22	0%	117%	129%
Specific Procedure	9	0	0	9	0%	0%	-
Organic brain disorder	<5	<5	<5	0	0%	-	-
Eating disorders	<5	<5	<5	0	0%	-	-
Gambling Difficulties	<5	<5	<5	0	0%	-	-
Neurodevelopmental conditions	<5	<5	<5	0	0%	-	-
Phobias	0	<5	0	0	0%	-	-
Service Redesign	<5	0	0	0	0%	-	-
Suspected ASD	<5	<5	0	0	0%	-	-
Suspected Autism Spectrum Disorder	0	0	<5	0	0%	-	-
(Blank)	<5	0	0	0	0%	-	-

Source: CNWL contract monitoring data

Caseload

In 2017/18 average caseloads were 2,776 for WLCCG and 2,182 for CLCCG. Chart 27 shows the monthly trend in adult caseload by referring CCG. Numbers on caseload are converted into rates per 1,000 population aged 20 to 64 years to enable comparison. Cases per head of population from WLCCG are typically higher than from WLCCG compared to CL CCCG.

Chart 27: Adults: adults on caseload per 1,000 population aged 16 to 64 years



Source: CNWL contract monitoring data

London Ambulance Service

The Healthy London Partnership dashboard provides comparative information on the number of calls and incidents attended by the London Ambulance Service (LAS) for mental health. From the dashboard the following findings were made:

- London Ambulance Service (LAS) Mental Health calls per 100,000 (July 2018): Both CCGs have a higher rate of calls to the LAS compared to the London average, Central London 194.5, West London 147.3 compared to London, 127.7. Time trend data from April 2016 to July 2018 shows monthly rates from Central London to be persistently above the London average, while monthly rates for West London CCG are comparable to the London average.
- London Ambulance Service (LAS) Mental Health incidents per 100,000 (July 2018): Both CCGs have a higher rate of Mental Health incidents attended by the LAS compared to the London average, Central London 132.5, West London 94.0 compared to London, 80.5. Time trend data from April 2016 to July 2018 shows monthly rates from Central London to be persistently above the London average, while monthly rates for West London CCG are comparable to the London average.

Metropolitan Police

According to a recent report by Her Majesty's Inspectorate of Constabulary Services, "the Metropolitan Police Service receives a call about a mental health concern once every four minutes. They send an officer to respond to a mental health-related call every 12 minutes. Officers responding to the call will spend time with the person to understand what they need. Analysis by the Welsh forces showed that on average this took about three hours. They may need more officers to help, and the person might end up being detained under section 136 of the Mental Health Act 1983 and taken to a place of safety. Half the time, the police, and not the ambulance service, transport

people to a place of safety. This can take a few hours, depending on the availability of health agencies and specialist hospital beds. Or it may result in a very long wait in accident and emergency for the person in crisis and the police officers accompanying them."

Hospital spells

Analysis of hospital spells for primary and secondary diagnoses of mental health conditions (International Classification of Diseases 10th edition [ICD 10] Chapter F) and self-harm (codes within ICD 10 Chapter X) produced the findings in Table 65. Data presented where more than 5 spells occurred in the pooled 2015/16 and 2016/17 data and for the top 5 diagnoses.

Table 65 presents the findings from local analysis of hospital activity data. As mental health and/ or self-harm diagnoses are most commonly coded as a secondary diagnosis, only pooled data from 2015/16 and 2016/17 could be utilised as the 2017/18 spells data does not include secondary diagnosis field.

Table 65: Hospital admissions (Spells), adults aged 16-64 years, with a relevant primary diagnosis Chapter F or X, 2015/16 and 2016/17 pooled data

Primary Diagnosis	Borough	EL	NEL	Secondary Diagnosis	Borough	EL	NEL
Mental and behavioural disorders due to use of alcohol	RBKC		78	Mental and behavioural disorders due to use of tobacco	RBKC	264	96
Panic disorder [episodic paroxysmal anxiety]	RBKC	-	9	Mental and behavioural disorders due to use of alcohol	RBKC	17	112
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	RBKC	-	23	Depressive episode, unspecified	RBKC	89	33
Exposure to unspecified factor	RBKC	-	17	Anxiety disorder, unspecified	RBKC	97	17
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics	RBKC	-	13	Specific (isolated) phobias	RBKC	90	<5
Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	RBKC	-	5	Bipolar affective disorder, unspecified	RBKC	14	<5
				Schizophrenia, unspecified	RBKC	9	8
				Mixed anxiety and depressive disorder	RBKC	12	<5
				Developmental disorder of scholastic skills, unspecified	RBKC	10	<5
				Mental and behavioural disorders due to use of opioids	RBKC	<5	11
				Mental and behavioural disorders due to use of cocaine	RBKC	<5	10
				Paranoid schizophrenia	RBKC	5	<5
				Panic disorder [episodic paroxysmal anxiety]	RBKC	<5	6
				Agoraphobia	RBKC	8	-
				Delirium, unspecified	RBKC	-	7
Mental and behavioural disorders due to use of alcohol	WCC	-	158	Mental and behavioural disorders due to use of tobacco	WCC	382	186
Depressive episode, unspecified	WCC	<5	14	Depressive episode, unspecified	WCC	164	85
Unspecified nonorganic psychosis	WCC	-	11	Mental and behavioural disorders due to use of alcohol	WCC	10	205
Anxiety disorder, unspecified	WCC	-	10	Specific (isolated) phobias	WCC	108	<5
Acute and transient psychotic disorder, unspecified	WCC	-	8	Anxiety disorder, unspecified	WCC	46	33
Paranoid schizophrenia	WCC	-	7	Schizophrenia, unspecified	WCC	14	37
Mental and behavioural disorders due to use of opioids	WCC	-	7	Bipolar affective disorder, unspecified	WCC	18	14
Agoraphobia	WCC	6	-	Mental and behavioural disorders due to use of opioids	WCC	<5	20
Mental and behavioural disorders due to use of cannabinoids	WCC	-	5	Developmental disorder of scholastic skills, unspecified	WCC	11	<5
Delusional disorder	WCC	-	5	Paranoid schizophrenia	WCC	<5	12
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	WCC		41	Mental and behavioural disorders due to use of cannabinoids	WCC	<5	9
Exposure to unspecified factor	WCC		36	Mental and behavioural disorders due to use of cocaine	WCC	<5	9

Table 65 continued

Primary Diagnosis	Borough	EL	NEL	Secondary Diagnosis	Borough	EL	NEL
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics	WCC		35	Post-traumatic stress disorder	WCC	<5	6
Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	WCC		22	Failure of genital response	WCC	8	<5
Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances	WCC		9	Mixed anxiety and depressive disorder	WCC	9	<5
Intentional self-harm by sharp object	WCC		6	Unspecified nonorganic psychosis	WCC	9	-
Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system	WCC		5	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	WCC	<5	5
				Delirium, unspecified	WCC	<5	5
				Obsessive-compulsive disorder, unspecified	WCC	<5	5

Source: Secondary Uses Service spells data 2015/16 and 2016/17 pooled data. EL – Elective, NEL – Non-elective. n - Number

Support Services

Adult social care

Comparative data

Table 66 summarises comparative data on social care indicators for both boroughs. The following key points are noted:

- Both boroughs have higher rates of social care assessment for mental health clients compared to the London average
- Kensington and Chelsea have lower rates of mental health clients in residential or nursing care compared to the London average, while rates in Westminster are higher
- Both boroughs have a lower percentage of social care mental health clients receiving self-direct support and Westminster a lower percentage of clients receiving self-direct payments, compared to the London average. Kensington and Chelsea has a comparable percentage of clients receiving self-directed payments
- Both boroughs are highlighted as having lower rates of satisfaction with care, support and protection compared to the London average, however this indicator is not specific to mental health clients

Table 66: Comparative data on personal social care services

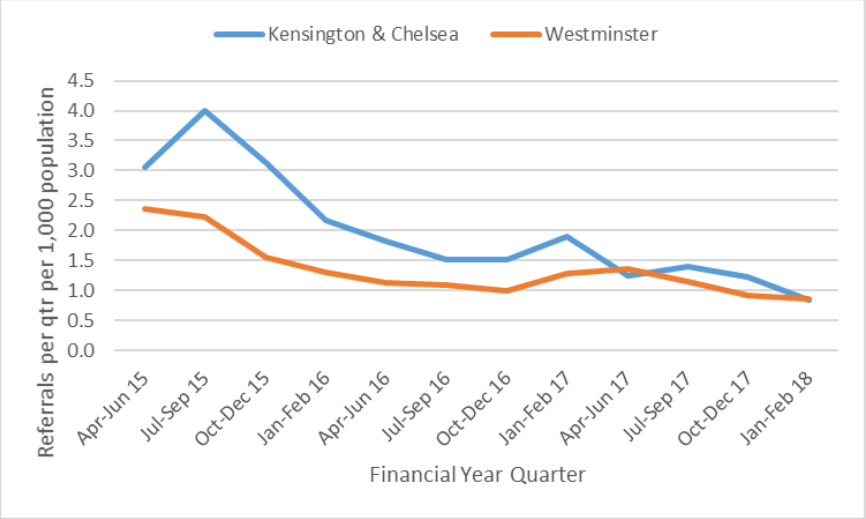
		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Social care assessments for mental health clients 18-64yrs/ 100,000	2013/14	1,917	598	332	265	2,055	965
Social care mental health clients in residential/nursing care 18-64yrs/ 100,000	2013/14	18.7	108.5	29.7	31.9	20	175
Self-directed support: % social care mental health clients	2013/14	12.6%	17.7%	34.5%	28.4%	135	195
Self-directed payments: % social care mental health clients	2013/14	10.7%	9.5%	10.7%	10.7%	115	105
Satisfaction with social care, care support % extremely/very satisfied	2015/16	58.8%	59.5%	60.3%	64.4%	-	-
Satisfaction with social care protection	2015/16	70.8%	76.8%	81.7%	85.4%	-	-

Source: Public Health England Fingertips (2019)

Chart 28 shows the quarterly trend in referrals to Adult Social Care services for Mental Health Support between April 2015 and March 2018.

In interpreting these data it is important to note residents can have more than one referral per period and not all referrals result in a support package being implemented– Table 67 shows the relative numbers of referrals to service users referred and the percentage of referrals that led to a support.

Chart 28: Rate of referrals to Adult Social Care services for Mental Health Support



Source: Adult Social Care client data

Table 67: Adult Social Care referrals for mental health support, adults 16-64 years

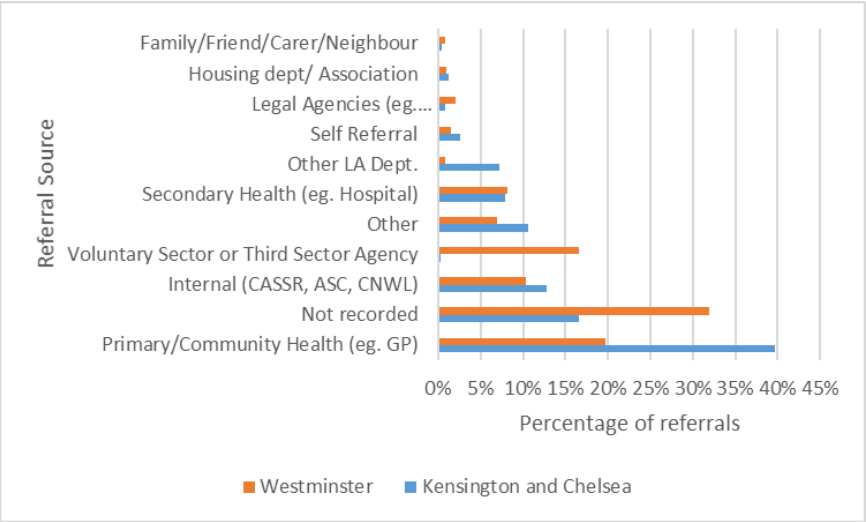
Borough	Mental Health Support	2015/16	2016/17	2017/18
RBKC	Individuals referred	1,252	686	476
WCC	Individuals referred	1,170	759	695
RBKC	% individuals all ASC referrals	64%	56%	45%
WCC	% individuals all ASC referrals	49%	56%	49%
RBKC	Total referrals	1,321	711	497
WCC	Total referrals	1,277	788	758
RBKC	Referrals accepted*	48%	66%	54%
WCC	Referrals accepted*	73%	70%	54%

*Source: Adult Social Care client data. *Remaining referrals either requiring further assessment / no assessment or rejected*

Referral source

Chart 29 shows the distribution of referrals by source. Of referrals with a source recorded, referrals in Kensington and Chelsea are most commonly from Primary/ Community care, while referrals in Westminster a similar percentage of referrals are made by Primary/ Community care and the voluntary/ third sector.

Chart 29: Mental health support referrals percentage by source and borough pooled data 2015/16 to 2017/18



Source: Adult Social Care client data

Table 68 shows the annual numbers of Adult Social Care (ASC) service users receiving care packages for 'mental health support'. As individuals can have more than one care package in place, numbers of service users and the number of care packages is shown. The following key points are made:

- Westminster has almost three times the number of working age service users receiving mental health support compared to Kensington and Chelsea
- numbers of service users and packages for mental health support have declined over the past three financial years
- the percentage of ASC service users with mental health support has declined over the past three financial years

Table 68: Numbers of Service Users and packages for Mental Health Support (excl. Memory and Sensory support)

Borough	Mental Health Support	2015/16	2016/17	2017/18
RBKC	Service users	274	243	231
WCC	Service users	604	603	584
RBKC	% individuals all ASC service users	18%	16%	15%
WCC	% individuals all ASC service users	28%	27%	25%
RBKC	Packages	780	407	443
WCC	Packages	1,872	1,185	1,244

Source: Adult Social Care client data

8.8 Local Services and asset mapping

8.8.1 Primary care

Most often, primary care is the first port of call for health care, with GPs and practice nurses providing person-centred care for both our physical and mental health needs. Primary care settings such as GP practices and community pharmacies are close to people's home and are easily accessible.

Mental health forms a large and growing proportion of primary care presentations, with one in three GP appointments involving significant mental health issues. In London, it is estimated that 90% of people with a common mental health condition are cared for entirely within the primary care sector. There is an overall shift from secondary (hospital) care towards community-based care where there is support from multi-disciplinary teams.

Primary care plays a key role in the prevention and early identification of mental illness, and it is important that GPs and other primary care professionals are aware of factors such as disability, unemployment, debt and loneliness that may present in consultation with patients and indicate increased risk of poor mental health and wellbeing. In particular, patients with long term conditions are at increased risk of common mental illness such as depression and anxiety. People with unexplained physical symptoms may have underlying psychological distress, and good communication skills are key in managing people with mental health issues

The Royal College of GPs have published a Mental Health Toolkit[13] to support practitioners with resources on mental health and wellbeing, and NICE provide evidence-based pathways on a common mental illness in primary care[14]

8.8.2 Employment Support

Work is good for mental health whether it is paid or unpaid. Once in work our mental health can be helped or harmed by the mental health environment within the workplace.

In many cases simple and cost-effective workplace adjustments can make a big difference and can allow people with mental illness to keep in touch with the working world and live healthy and productive lives. The adjustment needed could be a change in practice or workload.

From a regulatory perspective, the Equality Act (2010) outlines an employer's duty to make reasonable adjustments for people with disabilities in order to ensure that they have the same access to everything that involves gaining or keeping employment as a

[13] RCGP. Mental Health Toolkit. https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/mental-health-toolkit.aspx
[14] NICE. Common mental health disorders in primary care. https://pathways.nice.org.uk/pathways/common-mental-health-disorders-in-primary-care

non-disabled person. According to the Act a person is defined as disabled if they have a mental or physical impairment that has a substantial long term (i.e. more than 12 months) effect on their normal day to day activities.

A person is also protected under the Act if they have been affected in this way in the past but have been well for some time. Most adjustments cost nothing and according to The Equality and Human Rights Commission, the average cost is just £752. Despite this The Stevenson / Farmer review of mental health and employers published in 2017 found that 300,000 people with a long-term mental health issue lose their jobs each year in the UK.

In 2013 a JSNA was undertaken which reviewed employment support for people with mental illness, physical or learning disability. The JSNA reported on local needs mapped services of local and national specialist employment support for the tri-borough area. It also provided an overview of evidence of best practice and an outline of vision for an evidence-based service.

Employment Support

Westminster Employment (WE) - Westminster Employment specializes in supporting people with significant barriers to find employment. They work with people with moderate to severe learning or/and physical disabilities to support them into mainstream employment. They are specialists in providing the correct support and work with employers to create a job that fits the persons skills and abilities.

RBKC has a wide employment support service offer from Local Authority, Health and third sector parties. Services specifically able to support those with mental illness include:

- Family and Community Employment Service (FACES)
- Department for Work and Pension's Work and Health Programme
- Community Living Well – Employment Service providing employment advice and support to people with mental health issues managed in primary care, regardless of their diagnosis.
- Third sector organisations commissioned by the local authority such as SMART, Mind and Hestia also provide employment services

The Individual Placement and Support service, run by CNWL, is recognised as the most effective way to support people with mental health illness to gain and maintain paid employment. It is based on 8 evidence-based principles:

1. Competitive employment is the primary goal
2. Everyone who wants to work is eligible for employment support
3. We help you look for work which suits your preferences and strengths
4. We start job search and contact with employers quickly - within four weeks
5. Employment specialists are based within clinical teams, and work with the team to support people to find paid employment

6. Our support is ongoing and arranged to suit both the employee and employer
7. We provide benefits advice as part of your return to work
8. We build relationships with employers to access the 'hidden' labour market

CNWL's IPS services are now one of 14 national Centres of Excellence for IPS, as chosen by the Centre for Mental Health.

Central and North West London NHS Foundation Trust (CNWL) Recovery College

The CNWL Recovery and Wellbeing College is a place where people can learn about recovery and wellbeing in a supportive environment. They provide a range of courses to support people to regain hope, to learn, grow, share and discuss. Included in their offer are courses that are employment and work related.

"I believe that the Recovery and Wellbeing College has played a major part in my own recovery. After I was diagnosed with a mental health condition and detained under the mental health act, I gradually lost everything that had value for me: my career, responsibility for my children; my relationship with my partner, my friends and my sense of identity. It seemed like everyone in my life from then on only focused on what was considered to be wrong with me. It was like everything I had built up in my life before my diagnosis was just wiped away. It was difficult to see myself as anything other than 'a problem'. "

"At the Recovery and Wellbeing College I was able to use my lived experience to help develop a course and for the first time, worked in a truly collaborative way with practitioners and felt that I had something to contribute. "

"I have friends and colleagues and an active role in my community now, and I have gained an understanding of personal recovery and of how to manage my mental health in a positive and effective way. This is turn has enabled me to feel able to return to my previous career and I have just gained a new position as a psychologist."

"With the Recovery and Wellbeing College I came into contact with people who were hope inspiring, focused on my strengths and helped me to rebuild my life." -A Service User Experience

The London Healthy Workplace Charter

Both boroughs provide free support to employers to gain the London Healthy Workplace Charter Awards. The London Healthy Workplace Charter, backed by the Mayor of London, provides clear and easy steps for employers to make their workplaces healthier and happier. Organisations self-assess themselves at meeting standards on:

- health and safety
- mental health
- physical activity
- attendance management

8.8.3 West London CCG Mental Health Services

8.8.3.1 Crises and Urgent Care

Referrals in to the Urgent Mental Health Care Pathway can come from a wide variety of sources including Police, Ambulance Service, Carers, GPs etc as well as self-referral. Calls are made to the Central and North West London NHS Foundation Trust (CNWL) run single point of access (SPA). Their role is to provide advice, support, triage and booking.

Data on the high levels of demand on both the London Ambulance Service and the Metropolitan Police Service to respond to calls about people with mental health concerns are detailed previously.

The Health Based Places of Safety which were established as part of the Crisis Care Concordat and the current site in Kensington and Chelsea is St Charles. There is currently a review underway in North West London with the proposal to reduce the number of sites so that the quality of care can be improved.

8.8.3.2 Routine Care/Community Living Well

Access to NHS mental health services is via the GP, apart from access to the Improving Access to Psychological Therapy (IAPT) services, to which people can self-refer. Where there is an urgent issue there is the Urgent Mental Health Care Pathway which is included in the Appendix.

GPs complete the SPA standard referral form. For non-complex and low risk patients, GPs are prompted to refer to the Community Living Well service. For Drugs, Alcohol and other Addictions, GPs are prompted to refer to drugs and alcohol services which are commissioned by the local authority.

Community Living Well was co-produced with service users, carers, NHS and voluntary sector organisations. It provides a wraparound service which has individuals at the centre of their care and offers support with social wellbeing, mental and physical health needs for those with mild to moderate common mental illness.

The Community Living Well team is made up of a range of professionals. Depending on what support people need they may see one of the following:

- Employment Support Workers
- Navigators
- Mental Health Nurses
- Psychiatrists
- Psychological Therapists or Counsellors
- Peer Support Workers and Coordinators

Community Living Well brings together a range of clinical and wellbeing services to provide coordinated access to mental, physical care and social wellbeing support. Services include:

8.8.3.2.1 Jobs in Mind

Jobs in Mind, in partnership with SMART (see below) provides Employment Support for Community Living Well. Jobs in Mind provide specialist employment support and advice for those struggling with work-related issues caused by stress, anxiety or mental health issues.

8.8.3.2.2 St Mary Abbots Rehabilitation and Training (SMART)

SMART, in partnership with Jobs in Mind provides Navigators for Community Living Well. SMART is a charity that promotes mental health through purposeful activity. They offer a range of supported recovery, work and training opportunities in a friendly and enabling environment. People build both practical and personal skills, gaining experience and confidence. Working one-to-one with individuals they help them people find work and training outside SMART and reconnect with their community through a programme of social events and activities. SMART works closely with the providers of statutory services to develop a more holistic approach to supporting people with mental health needs.

8.8.3.2.3 Kensington and Chelsea Mind

Kensington and Chelsea Mind delivers Peer Support for Community Living Well. Mind offers information, support and training services to support the recovery, growth and wellbeing of people who are experiencing mental health issues to enable them to live full and independent lives.

Central and North West London NHS Foundation Trust (CNWL)

CNWL is the provider for both Psychological Therapy and the Primary Care Liaison Nurse teams within Community Living Well.

Mother Tongue Counselling is delivered Westminster Mind. It aims to integrate Arabic and Farsi (Persian) speaking communities in Kensington and Chelsea, Queen's Park and Paddington into primary care mental health services, by providing effective, accessible and culturally capable one-to-one counselling in their mother tongue languages, along with wellbeing groups and workshops around mental and emotional health, tailored to suit the needs of the group.

8.8.3.2.4 Kensington and Chelsea Social Council

Kensington and Chelsea Social Council in partnership with SMART and Jobs in Mind delivers the Navigator Service within Community Living Well. The Kensington and Chelsea Social Council is the local voluntary and community sector infrastructure body which counts 370 organisations amongst its active members. The organisation works to improve the quality of life for residents of the borough by supporting locally focused voluntary and community organisations

8.8.3 Central London CCG Mental Health Services Adults

8.8.3.1 Crisis and Urgent Care

The crisis care pathway is the same at West London CCG, and is via the Central and North West London NHS Foundation Trust (CNWL) Single Point of Access. The SPA process is valued by GPs. Ideally crisis presentation at accident and emergency departments is avoided however it is considered that there is a good liaison psychiatry service in place when this does occur.

Data on the high level of demand on both the London Ambulance Service and the Metropolitan Police Service to respond to calls about people with mental health concerns is detailed on page 140.

The Health Based Places of Safety which were established as part of the Crisis Care Concordat. The current site in Westminster is the Gordon Hospital. There is currently a review underway in North West London with the proposal to reduce the number of sites so that the quality of care can be improved.

8.8.3.2 Routine Care

GPs make mental health referrals to the Primary Care Plus Service which has been in place for the last 5 years. Patients can also self-refer. Primary Care Plus provide the triage function for routine care. The mental health practitioner will see the patient at their own GP surgery and carry out a full assessment. This process taking place in the GP surgery has the benefit of reducing stigma and seeing people closer to home.

Care Navigators within the Primary Care Plus Service will help patients access other services for such those provided by Westminster MIND, Abbey Centre, Beethoven Centre and floating housing support.

Primary Care Plus will refer on to Community Mental Health Teams if required.

If patients wish to, they can bypass Primary Care Plus and self-refer to the IAPT service.

The primary IAPT service the provision is considered reasonable with 8 week waits, a choice of service and good recovery rates.

GPs report that secondary talking therapies are experiencing high demand resulting in 6 to 9 month waits.

"It is hard to get the right people to have the right therapy at the right time". *GP*

This is despite a large provision of psychologists, psychotherapy and some unique service such as migration trauma service.

The Primary Care Plus Service is currently being reviewed to look at how transition between services can be improved, providing better continuity of care and reduction in silo working.

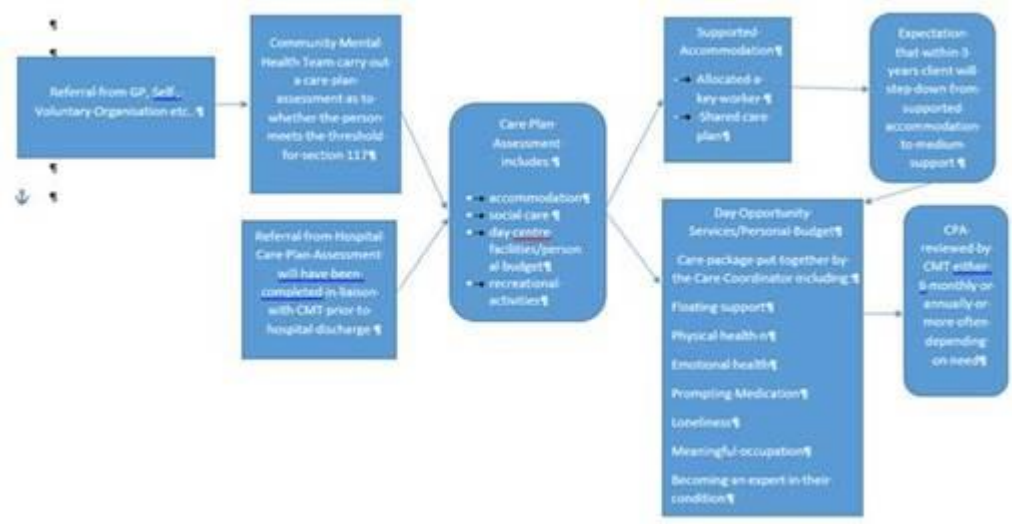
Issues with secondary care are the extended times that people spend there. Some of this may be due to some GPs not be equipped to deliver DEPO injections. Another factor may be that the care of those under a section117 has to be provided by community mental health teams. There is also concern at the length of time people are staying in supported housing for years and not moving on to living independently.

8.8.4 Local Authority Commissioned Services

8.8.4.1 Statutory Provision

The local authority commissions statutory provision which includes supported accommodation; day opportunity services; and spot purchase services for working age adults with severe and enduring mental illness. Day opportunity services in RBKC are commissioned via block contracts. A review of these services is being currently being carried out. Day opportunities services in WCC are paid for via personal budgets.

Figure 4: Adult Mental Health Care Pathway



Section 117 of the Mental Health 2007 requires Health and Local Authorities to provide, in co-operation with relevant voluntary agencies, aftercare services, until they are satisfied that this is no longer necessary, for:

- Service users who are or have been detained under Section 3. Service users who are or have been admitted to a hospital in pursuance of a hospital order made under Section 37 (whether or not with restrictions under Section 41)
- Service users transferred to a hospital in pursuance of a hospital direction made under Section 45A.
- Service users subject to a transfer direction made under Section 47 or 48.

- Service users, as set out above, on leave of absence authorised by the Responsible Clinician

8.8.4.2 Supported Accommodation

Supported housing

Supported housing is an essential part of the system for enabling vulnerable people to be as independent as possible and maintain or improve their wellbeing. It is key to reducing the need for people to access higher supported housing/care packages or be hospitalised if needs are not met sufficiently early.

Supported housing is most effective where it can be sufficiently flexible to respond to client's changing needs, house mixed communities to provide positive environments, where sufficient move-on accommodation is available, and residents' transition supported.

Although the volume of supported housing across the pathway in both RBKC and WCC is relatively high, demand is also high. The broader supported housing pathway comprises of 426 units in WCC and 502 in RBKC. This broader pathway includes a "generic" pathway of step-down accommodation, which includes service users with a variety of needs including serious mental illness.

Mental Health Supported accommodation

Residential and hospital placements are utilised to meet people's needs, support recovery goals and enable move-on where appropriate. Intensive services include NHS acute (inpatient) and Psychiatric Intensive Care Units, independent hospital provision and specialist placements for complex care. Residential and nursing placements are usually out of the local area.

The purpose of local authority mental health supported accommodation is to both reduce relapse and hospital readmission but also to support individuals to improve their health and wellbeing, develop confidence, improve daily living skills and engage with services enabling them to move on with their recovery. This includes re-engaging with the world of work paid or unpaid. To avoid long-term living in an institutional setting with all its attendant problems (such as deskilling; social exclusion; limited horizons; lack of personal space; institutionalised behaviours etc.) the supported accommodation pathway has a focus on recovery to move individuals from high support services, to step down services, floating support and ultimately to living in the community.

There are a range of registered social landlords providing the supported accommodation. The local authority works closely with both the landlords and those providing the support to ensure that residents are receiving the right package of support. Registered Social Landlords (RSL) are also used as one of the resources used as part of the planning for moving on from supported accommodation. Providers of supported accommodation are required to map the environment around their setting for day opportunities / universal assets. They also need to report on how they are signposting to these.

A JSNA on Housing Support and Care was published in August 2016[15] and a review of supported accommodation across the Bi-borough was carried out in 2018 involving a range of stakeholders and service users. These reports have supported the development of the remodeled services and the procurement process commenced late 2018. The current stock of buildings where services are delivered from across both boroughs, and in particular RBKC, do not all lend themselves well to those with more challenging physical disabilities as many are not purpose built and therefore have constraining factors.

There is consistent demand for mental health supported accommodation in both boroughs, greater than the available void places. Spot purchased registered care placements and delayed transfer of care from hospital, are very expensive compared to the cost of mental health high supported accommodation and indicate the potential unmet need for mental health supported accommodation.

The RBKC has 60 bed spaces (50 in high support accommodation and 10 in registered care) which is equivalent to 1.9% of the population with serious mental illness. In addition, there are 1oo people in generic medium support accommodation who had a serious mental illness on entering services.

Westminster has capacity for 426 bed spaces (239 high support, 95 medium support and 92 low support) which is equivalent to 14% of the population with serious mental illness.

Services face a high level of complex need including dual diagnosis and physical health needs. Older people in particular with mental health issues may have physical health issues, particularly due to the correlation between alcohol/substance use and mental health.

In the high support and step-down service, although there is move on, vacancies across the pathway can be challenging as there is need for additional high support units and general needs move on accommodation through both the social housing register as well as the private rented sector.

Peer Support Volunteer Programme in RBKC

The RBKC Housing Commissioning Team in partnership with Look Ahead Care and Support delivers the peer support volunteer programme which is an integral part of the 'co-productive environment' in which staff, customers, peer volunteers and organisation develop and deliver the services through equal partnership. The programme improves the well-being of clients and peer supporters, as well as increases the capacity and capability of services to support and empower them in their journey to independence and employment.

The benefits of the programme range from customers stating that working with peer support volunteers improved their confidence and motivation, particularly in accessing appropriate support services, training and education. Staff state they informally learned from peer support volunteers on issues facing their clients. The

[15] Housing and Care JSNA https://www.jsna.info/housingandcare

peer support volunteers themselves reported that their volunteering in a service has contributed to improving their employability through relevant experience and skills.

8.8.4.3 Spot Purchasing

Spot purchasing from small organisations is managed through care coordinators. All day opportunities services in WCC are spot purchased from personal budgets

Historically services have planned and been maintained on the basis of the provision of block payments. The move to personal budgets for those with severe and enduring mental illness has the following challenges:

- Capacity of the person to take control of their personal budget
- The challenge of finding an appropriate person to take responsibility for the personal budget, in many cases people with severe and enduring mental illness are no longer in contact with their family
- Market readiness
- Considerable resource required in the form of communication, time, energy and infrastructure

Clients will have a Care Plan Assessment review annually. This should be a multidisciplinary process and cover both mental and physical health. It will include a review as to whether a client is taking their medication.

8.8.4.3 Challenges

The perceived need from people with serious mental illness are very high in both boroughs but it feels like there is limited capacity to get in to the mental health care system.

Particular demand for adult social care supported is generated by:

- levels of rough sleepers in Westminster,
- levels of deprivation and poverty;
- levels of alcohol and substance misuse. – are we picking people up earlier enough?
- Aging population, more complex needs
- Half of those in supported accommodation have substance misuse issues.

There is a perception that high caseloads are resulting in high staff turnover, as staff feel overwhelmed by their caseload.

The expectation is that clients will move on from supported accommodation within 3 years if not sooner. They are stepped down to being supported by floating support. But it is considered unlikely that this cohort of patients, particularly those with a history of substance misuse, will be able to move on to independent living due their complex needs.

However, there is a recovery focused journey expected which providers report in their month returns on progress being made. Data on improvements in the quality of life of individuals in supported accommodation is case study based rather than data of performance against outcomes.

The day opportunity services are asked to report on where they have referred people on to the universal offer e.g. healthy eating, physical activity, social prescribing.

8.8.5 Community Mental Health Service

The organizational structure of the community mental health service provided by Central and North West London NHS Foundation Trust (CNWL) in each borough is unique to each borough (see Figure 5 and Figure 6). The adult mental health contract is shared with 5 other CCGs in North West London.

Figure 5: Kensington and Chelsea Service – CMHT in Blue

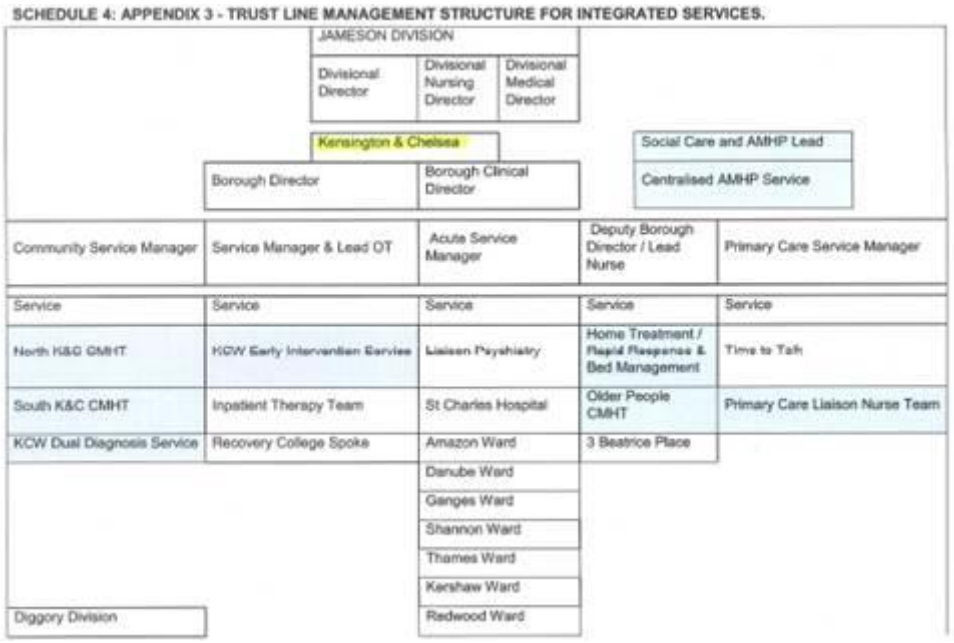
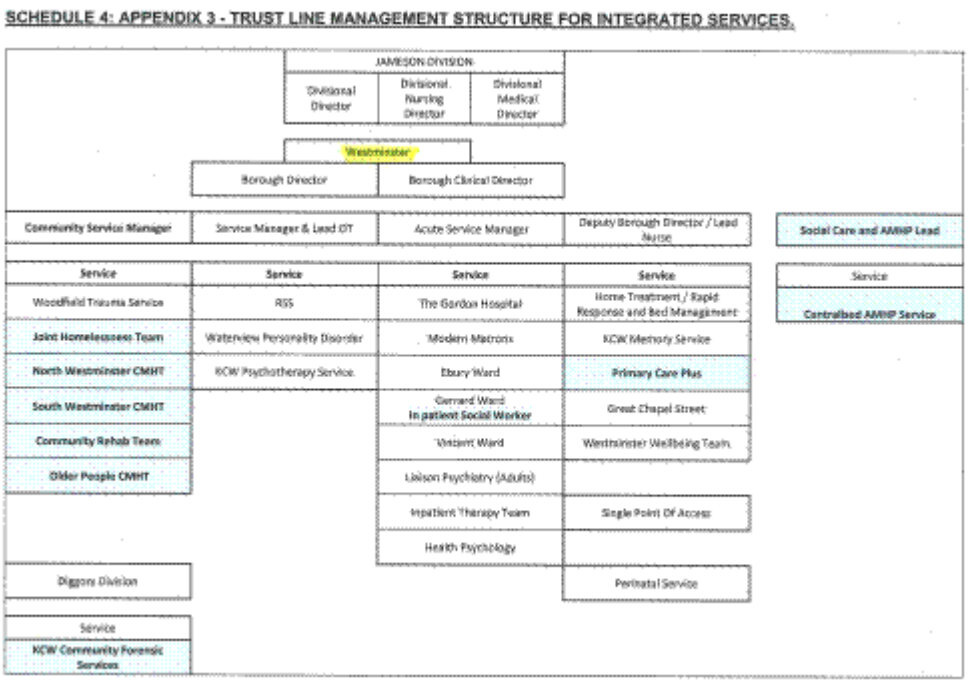


Figure 6: Westminster Service – CMHT in Blue



Community mental health services have recently strengthened their focus on physical health care, ensuring weight gain due to medication is minimised, and make referrals to smoking cessation services, drugs and alcohol services as well as healthy lifestyle services.

Community mental health teams have recently put in a new process to review their caseloads in workshops to see which patients are ready to move on back to the care of their GP. This development has been supported through a greater understanding by clinicians of the support available in the community and in primary care.

Early Intervention Psychosis Service (Central and North West London NHS Foundation Trust)

Early intervention in psychosis services are multidisciplinary Community Mental Health Teams that assess and treat people with a first episode of psychosis without delay (within 2 weeks). Most patients present between the age of 15 and 25 years. Treating symptoms and preventing symptoms from coming back, helps to reduce the number of people who need to be admitted to hospital.

Referral of the young person to this service can sometimes be delayed due to late recognition by schools and parents that behaviours are outside of what can be explained as "being a difficult teenager". Referral on from the GP can also be delayed by different clinical judgments by the GP as to what is the best next step due to the potential connotations for the young person of having a diagnosis. Referral can also come via the CAMHs. The main aim of the service is to be welcoming, challenge concerns that the young person and family may have and get the young person on the way to recovery as soon as possible and return to work/school/university. Support for the parents so that the whole family can support recovery is crucial. Some schools and

universities are particularly supportive at re-establishing and supporting students back into education.

Future Challenges

Feedback from the service is that it there is still a long journey to be made in the health and social care system to treat those who need treatment but empower those with capacity to manage their own conditions with the support of their family. The Central and North West London NHS Foundation Trust (CNWL) Recovery College referred to earlier is one asset to enable this process.

The numbers of young people coming in to the psychosis service after substance misuse poses a future challenge. This suggests the question - has substance misuse of new drugs become normalised amongst some groups? This is potentially an area for investigation.

Those patients most at risk of poor outcomes are those who do not have intact social networks are at risk of acute loneliness. They need somewhere to go and people to talk to.

Can resident's association and communities be empowered to be more supportive of those living amongst them with a mental health condition?

8.8.6. Support for those with a Dual Diagnosis of Mental Illness and Substance Misuse

Dual diagnosis, or co morbidity, is the presence and interaction of two conditions. This can often complicate the treatment of either or both conditions. Treatment frequently requires specialist knowledge in meeting the presenting needs, which can vary depending on the presentation of either or both conditions.

The term dual diagnosis encompasses a broad range of conditions which interact within the mental health and substance use context. People may experience them concurrently or sequentially, with the possible combinations including:

- A primary psychiatric or enduring mental illness which leads to substance use
- Substance use which negatively impacts the presentation of a psychiatric illness
- Intoxication and/or the effects of substance use or dependence which leads to psychological symptoms
- Substance use and/or withdrawals which lead to psychiatric symptoms or illness

(*DOH: 2002*)

Recent literature and polices, define dual diagnosis more narrowly as a severe and enduring mental illness characterised by features of psychosis. These illnesses are schizophrenic type disorders, bipolar affective disorder and other delusional and affective disorders. These illnesses are experienced alongside substance use which includes the use of legal or illicit drugs, including alcohol, which could be harmful with or without dependence.

The Local Authorities' Dual Diagnosis team is set up to provide a service to service users who are open to secondary mental health, either as Out Patient appointments under Lead Professional Care or care co-ordinated under Care Programme Approach, who also have substance use needs. The team will focus on supporting service users regarding their substance use needs. Team members do not act as Care Co-ordinators, but work in joint partnership.

Referrals are screened by the team manager/members and allocated to a dual diagnosis worker within 28 days from the point of referral. Engagement can often be delayed if someone is referred from hospital and still requires treatment. Significant delays in discharge can also occur due to social care needs such as housing.

Ongoing work with the service user may include –

a) One-to-one sessions either at home or at another suitable venue.

b) Referral to structured day time activities through mental health services through Personalisation/Personal Budgets

c) Engagement with Drop In groups run by Substance Use Services

d) Support to attend for assessment for a detox from alcohol or opiates where appropriate

e) Referral for a substance use/ dual diagnosis day programme

f) Referral to a substance use residential rehabilitation programme

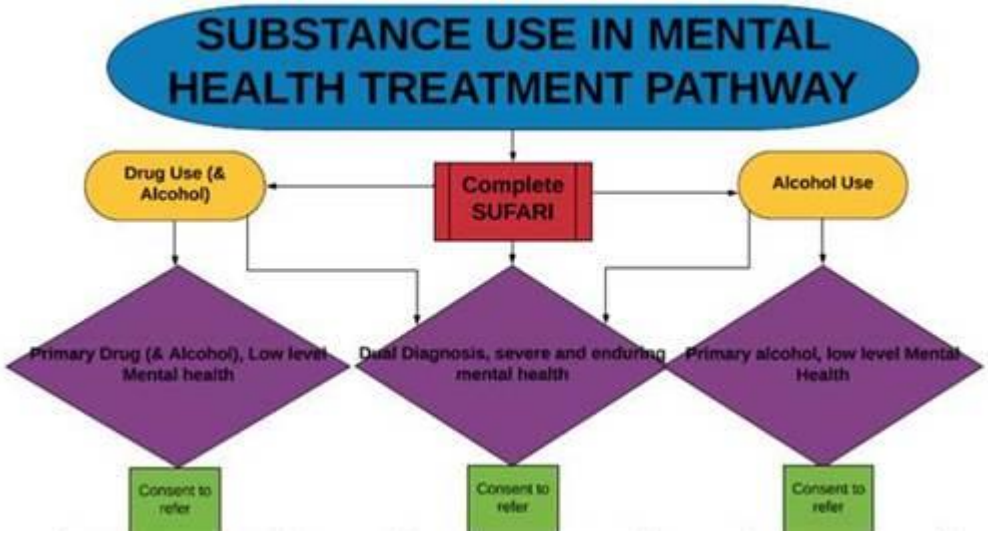
g) Other suitable work to support the service user to make changes to their substance use.

h) Contributing to the assessment by care co-ordinators for Personal Budgets and other packages of care for the service user.

i) Motivational Interviewing, psycho-social education, promoting engagement in community activities to promote general well-being.

This will be reviewed with the service user and in professional and clinical supervision.

Figure 7: Substance use in mental health treatment pathway



This care pathway is in place concurrently with a draft Bi Borough Dual Diagnosis Joint Working process (K&C & WCC). There are particular complex issues with the care and treatment of this cohort of patients in relation to poor outcomes, particularly social isolation and housing. These complex issues can impact on their ability to access services including the mental health service.

Patients with the dual diagnosis team are linked into drugs and alcohol services successfully. Those who do not meet the dual diagnosis remit can be jointly assessed by mental health services and the dual diagnosis team, access drug or alcohol services directly or seek treatment via primary care mental health workers via their GP. As substance misuse and mental illness can frequently be an interrelated matter, a whole person approach needs to be considered.

The strengths of the existing dual diagnosis service lie in working within an assertive outreach approach, ensuring that they build trusting relationships; safeguard and engage service users with harm minimisation; change talk and explore the impact of substance use on their mental illness and other areas of their lives. The service supports well-being and engagement with mental and physical health care, and access to housing, financial, social and psychological support.

It has been recognised that the treatment of dual diagnosis can be lengthy and once those individuals are closed to mental health services, they are no longer able to access support from dual diagnosis. This leaves a gap in provision, which can create some dependency on services, particularly for individuals who lack social support and vocation. Specific groups that benefit from the input of the dual diagnosis service are:

- Arabic speakers – this group are hard to engage with other services, perhaps due to stigma,
- Women
- LGBTQ

The dual diagnosis team are aiming to strengthen their impact on the overall health improvement of patients and improve community integration to reduce dependency on the service and promote independence.

Mental Health Services working with Patients with Dual Diagnosis

It is essential that dual diagnosis service users are able to access the right combination of mental health and substance misuse services in a timely way which meets their individual needs.

It is important that dual diagnosis service users are not discharged prematurely and that an outreach approach is adopted to prevent them from falling through the gaps. If a patient with dual diagnosis does not continue with treatment, the financial costs for the health and social care system are considerable including the cost of crisis admissions.

Areas for improvement of care that have been identified for this cohort include:

- Training for inpatient staff on how to deal with substance misuse on the ward
- Training for community mental health staff on working with clients with Dual Diagnosis
- Address barriers to access to talking therapies for those with Dual Diagnosis
- Support clients to become experts in managing their condition both mental health and substance misuse
- Improve access/use of the voluntary sector by building relationships with those organisations, give clients more information but also support them when needed when they initially access new activities by taking clients there, and introducing them.
- Develop a Bi-borough Group Programme which is not stigmatising, helps people grow emotionally, have a safe place, (Colleen has funding for this)
- Training Strategy – for drugs and alcohol services and for mental health services so they are better equipped to look after those with dual diagnosis. The recommendation is a condensed version of the 2-day Drugs and alcohol and mental health training; training the needs to challenge the stigma of substance misuse.
- Improve the pathway from Mental Health Services into Substance Misuse Services – mental health staff to complete SUFARI screening tool, increased presence of drug and alcohol workers in mental health services,
- Need to analyse trends on the use of services better by systematic collection of data
- People falling through the cracks – stop disengagement by asking the right questions and meeting their needs
- People stopping their medication
- Address barriers to services and treatment for vulnerable cohorts, such as rough sleepers or homeless people. This should be addressed through user engagement and engagement with other services who work with these vulnerable cohorts such as the Homeless Intervention Team.

8.8.7 Substance Misuse Services and Wellbeing

The local drug and alcohol treatment system have bedded an asset-based model, where the services are built around people and communities, their needs, aspirations, capacities, skills and to work to build up their autonomy and resilience.

As part of their recovery Service users are to be assisted to develop potential by:

- Working productively and creatively
- Building strong relationships with others
- Contributing to their community
- Strengthening and actively supporting health initiatives within services and recovery communities as well as in the wider community.

Examples of this include:

- Roads to Wellbeing website- The map provided information about regular opportunities in the local areas for activities that were low cost or free.
- Innovation fund to spark new ideas and includes a panel of service users and members of local communities. Successful bids have included:
  1. the creation of a drama piece created and performed by volunteers in the Queens Park area and attended by 100 members of the local community.
  2. Community gardening and a cooking space is being developed with the Chelsea Physic Gardens with people in recovery and other socially isolated local residents.

Case Study – Billie

The first application to the Big Ideas Fund came from Billie. Billie applied to the fund to run jewelry making and macramé workshops for other service users. Billie has taken these workshops to a variety of service user groups, running stalls at community events and was even featured in the most recent DDN magazine.

8.8.8 Support for those affected by Grenfell

There are services in place in addition to the standard NHS and Council offer which have been developed to meet the needs of those affected by Grenfell. The development of these services has been informed by the health needs assessment The Journey to Recovery and through detailed consultation with the local community.

Grenfell Health and Wellbeing Service

The Grenfell Health and Wellbeing service provided by the NHS, provides a range of psychological therapies and support for both adults and children. The talking therapies on offer include: trauma therapy; cognitive behaviour therapy; arts psychotherapy; bereavement counselling and therapy; family therapy; workshops and group therapy.

People can self-refer and there is also a presence at The Curve. In addition, the outreach wellbeing team visits people in temporary accommodation, at community events and goes door-to-door to check if people need NHS help.

Dedicated service for survivors and bereaved

The local authority has been working closely with survivors and the bereaved to co-design the new dedicated service for this group. The service will be available at two sites co-located with NHS staff, one in the north of the borough and one in the south.

The service will continue to provide:

Resettlement support - working to help people feel more comfortable and settled in their new homes and environments, supporting them to build partnerships and links as well as managing practical issues as they move towards independence in their new properties.

Emotional Support- to help people recover and work with community and health partners to offer sustainable peer support provision. Importantly, they will be integrated with the specialist provision provided by NHS partners.

And in addition will provide:

Educational Offer - A wide-reaching educational offer will be developed in collaboration with representatives of the survivors and the bereaved in the new year. The current proposal is that a new post of Education Lead will be created within the dedicated service. They will be an education specialist and monitor and track individual children's education progress, advocating with schools and arranging additional support where necessary.

The education lead will be linked to the Council's Children's Service and will work with parents, carers and schools to ensure a tailored approach to education for all the survivor and bereaved children eligible for the service. Children and their families will be offered an individual plan setting out clear educational outcomes with the aim of enabling every child to reach their full potential. This provision will be supplemented by a dedicated location-based tuition offer, additional homework clubs and other commissioned activities.

Support with training and employment - managed by focused digital and employment co-ordinators, this will include:

- Digital inclusion and building confidence in digital skills
- Building aspiration and opportunities for young people
- Supporting adults to be able to move into tech or digital careers.
- Setting up a website and app for the dedicated service itself which is led by the bereaved and survivors

This offer will be supplemented by an existing offer provided by Clement James which includes general employment support to help people re-enter the job market and look forwards towards their futures.

Community Contact Team

The Community Contact Team is an outreach service for the wider community affected by the tragedy. The service works with the lower level needs of those who have previously received a key work service and signposting anyone else who seeks help or advice. Based at The Curve, they provide support around getting into new homes, returning home, accessing GPs and schools and other support among other things.

Malton Road

The Malton Road Team works with families from the wider community who have previously been in receipt of a key work service. The Council's Children and Family Services will continue to operate from Malton Road.

8.9 Quality and outcomes

Table 69 summarises comparative data on the quality and outcomes of local services by borough, while Table 70 summarises comparative data on the quality and outcomes of local services by CCG.

From Table 69 the following key points are made:

- In both boroughs the employment rate of those in contact with a secondary mental health service is below the London average. However, the gap between this employment rate and the general employment, in both boroughs, is narrower than the London average, for males and females
- There is no local data on the proportion of people with a learning disability or mental illness in employment
- In both boroughs the percentage of social care mental health clients receiving home care is higher than the London average
- The percentage of patients with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period within 2 weeks of referral. Table 74 shows variable monthly performance for patients of both CCGs.

Table 69: Comparative data on outcomes for adults by borough

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Gap in employment rate - in contact with secondary mental health services vs. overall employment rate %pt difference - Persons	2017/18	58.4	58.4	68.2	68.2	-	-

Employment of people with mental illness or learning disability: % with mental illness or learning disability	2018 Q1	43.3%	35.4%	43.6%	45.7%	5,700	7,900
Social care mental health clients 18-64 receiving home care during the year/100,000	2013/14	60.6	133.2	46.1	42.2	65	-

Source: Public Health England Fingertips (2019)

Table 70: Comparative data on outcomes for adults by CCG

		Rate			Count		
Indicator	**Period**	**WLCCG**	**CLCCG**	**LON.**	**ENG.**	**RBKC**	**WCC**
Smokers on GP registers (certain conditions) offered cessation support and treatment: %	2017/18	96.4%	92.3%	96.2%	94.9%	6,947	5,103
Mental health admissions to hospital: rate per 100,000 population	2018/19 Q2	430.9	466.1	318.9	273.5	195	170
Gate kept admissions: % (quarterly) admissions to acute wards that were gate kept by the CRHT teams	2018/19 Q2	100.0%	100%	98.40%	98.40%	95	77
CPA adults in employment: % of people on CPA (aged 18-69) (end of quarter snapshot)	2017/18 Q4	6.5%	7.2%	6.2%	7.7%	60	40

Source: Public Health England Fingertips (2019)

From Table 70 the following key points are made:

- A higher than London average percentage of WLCCG registered patients are offered smoking cessation support, while the percentage is lower for CLCCG. However, the indicator refers to certain condition and not specifically individuals with a mental illness
- Both CCGs have a higher rate of mental health admissions to hospital compared to the London average
- In both CCGs 100% of acute mental health admissions were gate kept by CHRT teams
- Both CCGs have a higher percentage of adults on a CPA in employment compared to the London average

Waiting times

The following section summarises the latest available data on waiting time performance by service. The data presented refer only to the performance of Central and North West London NHS Foundation Trust (CNWL). The following services are covered:

- Psychiatric Liaison services
- Crisis teams (urgent and emergency referrals) and for routine referrals to Community Mental Health Teams (CMHT)
- IAPT
- Early Intervention Service (EIS)

From these tables the following key points are made:

- On average, 71% of patients are seen by Kensington and Chelsea Psychiatric Liaison service within waiting time thresholds. For Westminster Psychiatric Liaison service, the percentage is 81%.
- On average, 93% of West London CCG patients are seen by CNWL Crisis or CMHT teams within waiting time thresholds. For Central London CCG the percentage is 96%.
- IAPT services to both CCGs consistently meet the 18 week target 100% of the time. For 4 week waits the performance is lower but met for over 90% of patients each month.

Table 71: Psychiatric Liaison: Percentage of referrals seen within threshold waiting times, by service

Kensington & Chelsea Psychiatric Liaison

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Emergency < 1 hour	64%	68%	63%	63%	73%	82%	76%	82%	87%	78%	74%	67%	73%
Routine < 24hours	57%	50%	57%	50%	57%	83%	63%	86%	92%	80%	64%	75%	70%

Westminster Psychiatric Liaison

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Emergency < 1 hour	81%	82%	71%	70%	82%	82%	75%	80%	85%	84%	87%	86%	80%
Routine < 24hours	81%	56%	78%	77%	78%	89%	93%	94%	93%	77%	86%	84%	83%

Source: CNWL contract monitoring data

Table 72: Crisis Team and CMHT: Percentage of referrals seen within threshold waiting times, by CCG

West London CCG	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Av. Referrals
Emergency referrals (4hrs)	100%		100%	100%	50%	100%	100%	100%	100%	100%	100%		<5
Urgent referrals (24 hrs)	100%	95%	95%	96%	89%	96%	97%	100%	94%	86%	79%	86%	29
Routine referrals (4 wks)	85%	89%	90%	93%	95%	95%	97%	94%	92%	95%	90%	96%	75

Central London CCG	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Av. Referrals
Emergency referrals (4hrs)	100%		100%	100%	100%	100%		100%	100%	100%	100%		<5
Urgent referrals (24 hrs)	97%	100%	91%	94%	92%	96%	92%	95%	97%	96%	100%	95%	33
Routine referrals (4 wks)	93%	90%	95%	89%	94%	96%	95%	97%	93%	94%	93%	91%	41

Source: CNWL contract monitoring data

Table 73: Percentage of referrals seen within threshold waiting times, by CCG

West London CCG	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Av. Referrals
IAPT (18 wks)	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	494
IAPT (6 wks)	95%	95%	95%	96%	95%	96%	95%	95%	95%	91%	96%	97%	470

Central London CCG	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Av. Referrals
IAPT (18 wks)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	281
IAPT (6 wks)	97%	99%	98%	98%	98%	99%	97%	96%	96%	96%	98%	96%	274

Source: CNWL

Table 74: Early Intervention Service (EIS): Percentage of patients with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period within 2 weeks of referral

West London CCG	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Av. Referrals
EIS care package (2wks)	33%	er	100%	0%	er	67%	100%	100%	83%	100%	75%	50%	<5

Central London CCG	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Av. Referrals
EIS care package (2wks)	0%	0%	100%	100%	100%	100%	100%	0%	100%	50%	100%	100%	<5

Source: CNWL

8.10 Voluntary and Third Sector Assets in Mental Health and Wellbeing

The voluntary and third sector play a rich and vital role in providing assets for mental health and wellbeing. Listed below are just a flavour of the organisations that contribute to mental wellbeing, including two based in Camden that our residents are known to use.

Table 75: Examples of community and voluntary sector organisations contributing to mental health and wellbeing

Westminster	Both boroughs	RBKC
ETAT – Encouragement through art and talking	Bump Start	Solidarity Sports – Supporting local families
Abbey Centre	Listening Place	Talking Theatre
Westbourne Park Family Centre	MIND	Pepperpot – older afro-Caribbean activities, day centre
Womens' Trust	OPEN AGE	Migrants organise
Beethoven Centre	Volunteer Centres	MIDAYE
St Vincent's Family Project	Community Champions	MUSAWA – BME consortium
Family Lives	Befriending Project	Dalgarno Trust Community Centre (
Neighbourcare- St Johns Wood and Maida Vale	Resonate Arts	Meanwhile Gardens
Café Maida Vale Gallery	BME Health Forum	Men's Sheds- CAMDEN
PIP- Learning Disability		Hestia - Oremi Centre
SHAK Camden		SMART – St Mary Abbots Rehabilitation and Training

The third sector provides opportunities for making friends, to learn, to contribute to society and to be physically active which are key aspects of the five ways to wellbeing as outlined in the Director of Public Health's Report Roads to Wellbeing.

They provide services across the life course from Bump Start where through a network volunteers they support parents and children who are experiencing difficulties of one kind or another to Age UK providing opportunities to socialise and befriending. One example is that St Mungo's Well-being and Recovery college which provides a supportive educational environment in which staff, clients and volunteers, have the opportunity to sample a range of subjects and wellbeing activities alongside a diverse group of peer learners.

The third sector are also commissioned as providers of services for those with a mental health condition. For example, RBKC commissions community mental health day services from MIND, Hestia and SMART whilst Westminster spot purchases services from personal budgets.

The CCGs as part of their care planning whether as part of their Community Living Well service, My Care My Way Service or as part of the Primary Care Plus service are sign-posting to open access services provided by the third sector as well as paying for particular services. Examples of services funded by the CCGs are that Westminster MIND are an IAPT provider and also provide mother tongue counselling for patients of West London CCG.

Reflections from the community mental health service from working with the third sector after the Grenfell Fire are that the circumstance of dealing with the tragedy meant that relationships were built with the third sector beyond the business and usual ones with SMART, MIND and HESTIA. There was greater recognition of what groups can and wish to contribute to wellbeing of their community both faith groups such as Al Manaar, and the Methodist Church as well are other community organisations such are Rugby Portobello, Harrow Club and Midaye.

At a time of focus on limited budgets there is a complexity of funding streams for the third sector i.e. spot purchasing, social prescribing, commissioned block payments There is potential risk for the economic sustainability of some services provided by the third sector which may be reliant on a number of these if this is not understood. There may also be a competition for access to services that the third sector may be providing free access to for the general population but are also being drawn upon by the health and social care system for those with an identified mental health need.

8.11 Service User Views

What is the national picture?

In August 2018, Healthwatch England produced a service user feedback report on Mental Health Services. Over 34,000 people shared their views and experiences of mental health services over more than 2 years. Six common issues were identified across different adult mental health services;

1) *People struggle to find the information and support they need*, due in turn to difficulties navigating the services, and not wanting to access services via their GP

2) *Physical and Mental health needs are treated in isolation*- Many people have both physical and mental symptoms, so services need to consider the individuals full needs. A lack of co-ordination between hospital services and social care or mental health services results in some patients being discharged without the care they need. This is a particular issue for people with drug or alcohol problems, and those with learning disabilities.

3) *Varying levels of support between areas or services*, along with inconsistent care and lack of communication between different services or areas can prolong recovery.

Moving areas can lead to unnecessary reassessments and a change in mental health professional, which can distress people with mental health issues and time and trust must be re-invested to build a relationship with the professional.

4) *Long delays in accessing services and crisis care* results in delays to receiving a diagnosis and treatment. A lack of timely support can result in conditions worsening.

5) *Lack of Mental health training and understanding* in non- MH health and care settings means that concerns go can unaddressed.

6) *Lack of involvement or power over decisions affecting them*- many people are concerned that there is a lack of empathy and respect from professional staff, which further pressured but short appointment slots.

What is the local picture?

A number of surveys have been undertaken locally among services users on particular aspects of the care that they receive. Some of the findings reflect some of the themes highlighted in the national research.

Care planning

A recent (2017) evaluation of 27 adults accessing the community mental health teams at Pall Mall and Woodfield Road found:

- Some people still don't know what care plans are, what format they might take, and state they do not have one. Since 2010 awareness has gone up by 2% to 75% in Westminster and down by 18% to 58% in Kensington and Chelsea.
- Since 2010 there has been a decrease in people feeling like they have a choice about who attends the CPA or care review meeting (down 30% in Westminster; down 8% in RBKC)
- A marked reduction in people reporting they knew when their next CPA/Care Review meeting would take place (down 32% to 13% in Westminster; down 29% in K&C to 21%)
- There was an increase in the percentage of interviewees with a Crisis Plan (up 13% to 63% in Westminster; up 13% to 50% in K&C)

A number of recommendations are made in the report to address these gaps, increase awareness of care plans and how they can support patients to track their recovery.

Community Treatment Orders (CTO)[16]

A survey of 17 recipients of CTOs identified a number of themes:

Communication – although nearly all had been told what the CTO was and the reason for it, in a way that they could understand there were a very small number of instances where language or literacy were a barrier. Most people (59%) were not told how long a CTO would last, with no clear dates for review.

Involvement – almost half of the interviewees (46%) had not had their care plan changed since the start of the CTO or even knew they had a care plan.

Relationship with professionals – people tended to see their CPN during the course of the CTO and the frequency of appointments met their needs. The nature of the relationship did not usually change because of the CTO, although there were some cases where it did (for better and for worse equally). Interviewees valued having a professional who really listened to them.

Independent Mental Health advocacy – although access to an Independent Mental Health Advocate (IMHA) is a statutory right for people on a CTO 41% (7 people) were not told about the advocacy service or how to access an advocate.

The majority of the interviewees were white British, male and/or in the 36-45 age group. A number of recommendations were highlighted to address these issues.

The Single Point of Access Service (SPA)

A recent User Focused Monitoring project (May 2017) looked at the knowledge of the SPA as a service, and service user feedback.

The majority of Mental Health service users have not heard of the SPA. In community mental health team waiting rooms, 42 of 64 people approached (65%) had not heard of the service. In Gordon and St Charles mental health hospitals, 85% of people asked had not heard of the service.

What can the SPA offer? There was lots of confusion about the remit and abilities of the SPA from both service users interviewed (15 people) and by professionals (4 people). It was felt that the service was not explained clearly enough in the introduction to the service.

[16] 'A CTO is the legislative power by which patients with mental health difficulties who are treated involuntarily in hospital can be discharged into the community but still remain subject to compulsory treatment. The CTO thus extends the setting for involuntary treatment from being exclusively confined to the hospital ward to the community.' (Stroud, J., Doughty, K., and Banks, L., School of Applied Social Science, University of Brighton May 2013)

Access to Service. Service user and professionals appreciated the 24 hour availability of the service. Voluntary sector managers found that fast access to information that would help speed up the process of getting support for the client.

14 out of 17 respondents called for help to manage a crisis, though other reasons for calling included signposting to other services and advice.

Half of people interviewed felt that they had not been given enough time to discuss their issues. Participants' suggestions for improvements included lengthening the time available to talk, reducing waiting times, the availability of face to face contact and follow up services, as well as creating alternative routes to access the service.

Primary Care Plus

GPs can refer to the Primary Care Plus service which coordinates referrals into mental health services and offers patients an assessment by a mental health practitioner in their own GP surgery. The service can refer to the community mental health team if required, as well as other local services which support wellbeing. It can also help those discharged from hospital back into the community.

In 2014 an evaluation of the service interviewed 12 services users who had been 'stepped up' into the service found that:

- 50% saw their GP more than once a month, and 75% felt that the amount of times they saw their GP about mental health was enough for their needs
- Although booking appointments with the Primary Care Liaison Nurse was considered easy for most, 2 people mentioned communication as a barrier to making an appointment
- Most (9 out of 12) found the PCLN helpful in some way, for example to be referred, feeling needed and not judged, getting medication or advice, and felling supported. A small number did not find PCLN appointments helpful with reasons such as finding the PCLN confrontational.
- Just over half (7 out of 12) found that they had their needs met by the PCLN for reasons such as getting quick appointments, helpful to talk to, being referred, and getting medication. However, 5 of the 12 reported that they had not had their needs met, citing reasons such as lack of expertise, having to organise their own care due to lack of knowledge, and not getting on with the PCLN.
- The majority of the interviewees (8) felt that their GP practice did not have the skills or knowledge to manage their mental health condition. While they valued the GP for their physical health, they did not feel the GP understood their mental health issues and that they needed specialist help.
- Respondents did value the proximity of their GP practice and some did have good relationships with their GP.

The report puts forward some recommendations on training for GPs and their staff, communicating information about the role of the PCLN (in ways that tackle language and other communication barriers), and administration of appointments.

It should be noted that the study involved a small sample size, with the majority of interviewees being of a white ethnic background (75%) and within the 26-65 age bracket (10 out of 12).

9 Older adults mental health and wellbeing

9.1 Key Messages

Key messages: Older Adult Mental Health

Prevalence

- The estimated prevalence of mental illness in older adults was taken from the Adult Psychiatric Morbidity Survey (APMS 2014). Not including dementia, national estimates applied to the local population of older adults suggest that 2,527 older adult residents of Kensington and Chelsea and 3,170 older adult residents in Westminster experience a common mental health disorder. The most common of specified disorders was general anxiety disorder, affecting 819 older residents in Kensington and Chelsea, and 1025 in Westminster

- Should the England prevalence of mental illness prevail in the both boroughs and remain constant, and population of each borough grow as projected by the Greater London Authority, the number of cases of mental illness in older adults (not including dementia) in 2028 will grow to 3162 in Kensington and Chelsea and 4071 in Westminster.

Risk factors

- Levels of discrimination, presence of meaningful activities and relationships, physical health condition and poverty are key factors that affect the mental health and wellbeing of older people. In addition factors such as recent bereavement, caring responsibilities, family breakdown, loss of mobility and loss of independence (giving up driving, unemployment, age-related disability) all present risk factors

- Some groups of older people are at increased risk of mental health issues. Those who are lonely have a higher risk of developing dementia and depression and older people in a caring role may struggle to get the support they need

Comparative data on prevalence of risk factors shows

- The rate of diagnosed dementia among the GP registered population is lower than the London average in West London CCG (Kensington and Chelsea and Queen's Park and Paddington), while rates in Central London CCG (Westminster) are similar London average
- Both boroughs have a higher percentage of residents aged 60 years and over living in income deprivation compared to the national average

- In both boroughs the percentage of older people living alone is above the London average and the percentage of social care users with enough social contact is lower than the London average

What Works

There is evidence that the following interventions can have a beneficial effect on mental health and wellbeing:

- befriending programmes along with psychosocial interventions can promote wellbeing and prevent depression
- volunteering opportunities are associated with improved mental wellbeing, self-reported health and reduced depression
- addressing hearing loss is associated
- physical activity programmes can improve mental wellbeing and reduce mental illness.
- interventions to promote household warmth are associated with improved mental health and reduced depression
- Interventions to prevent social isolation have also been shown to improve wellbeing
- The Better Mental Health for All report highlights the following areas for consideration:
- The Campaign to End Loneliness provides guidance on developing strategies to address loneliness amongst older people in their local populations.

- NICE recommend a range of activities for older people including support sessions to assist with daily routines and self-care, community based physical activity programmes, walking schemes and training for practitioners. (See also relevant NICE guidance PH16)

9.2 Background

Our mental health and wellbeing can be challenged as we grow older by events outside of our control, such as the loss of a loved one and reduced mobility. The Mental Health Foundation and Age Concern said “promoting mental health and well-being in later life will benefit the whole of society by maintaining older people’s social and economic contributions, minimising the costs of care and improving quality of life” (Mental Health Foundation & Age Concern, 2006).

Life satisfaction, the feeling of being worthwhile, and happiness all increase in the years leading up to and during the first few years of retirement, however so do feelings of anxiety. It is in the later years of retirement, 74 and older, that anxiety stays continuously high, but happiness, life satisfaction and feeling worthwhile decrease.

Mental health issues in later life are under-identified by health professionals and by older people themselves, this can be when the impacts of poor mental health and adversity throughout life become evident. To promote mental wellbeing for all it is vital to prevent, identify and effectively treat mental health issues in later life.

Good relationships and connecting with others is important for a mentally healthy later life. Loneliness can lead to deterioration in health and wellbeing and is also a symptom of common mental illness. Although recent research has shown us that young people often report being lonely more often than older adults, nearly half of all people over the age of 75 live alone.

Many older adults will suffer from physical ill health and this can lead to mental health issues. The risk of developing depression is over 7 times higher in those with two or more chronic physical problems.

9.3 Prevalence and incidence

Population prevalence

Table 76 shows the estimated prevalence of mental illness excluding dementia in the older age population are taken from the Adult Psychiatric Morbidity Survey (2014). Estimates are calculated from the England age-specific prevalence rates for each illness.

Should the England prevalence of mental illness prevail in the both boroughs and remain constant, and population of each borough grow as projected by the Greater London Authority, the numbers of cases of mental illness shown below could be expected.

Table 76: Estimated prevalence of mental illness by borough 2018 to 2028

Illness/ presentation	Borough	2018	2023	2028
Any CMD	RBKC	2,527	2,799	3,162
	WCC	3,170	3,566	4,071
Unspecified CMD	RBKC	1,242	1,391	1,577
	WCC	1,560	1,764	2,016
GAD	RBKC	819	897	1,010
	WCC	1,025	1,148	1,310
Depressive episodes	RBKC	428	469	528
	WCC	537	601	685
Phobias	RBKC	136	152	172
	WCC	171	193	220
OCD	RBKC	74	83	94
	WCC	92	105	120
Panic disorder	RBKC	161	179	203
	WCC	202	228	260
PTSD	RBKC	289	309	346
	WCC	361	400	455

Illness/ presentation	Borough	2018	2023	2028
Antisocial personality disorder	RBKC	-	-	-
	WCC	-	-	-
Bipolar disorder	RBKC	55	55	61
	WCC	68	73	83
Borderline personality disorder	RBKC	-	-	-
	WCC	-	-	-
Psychotic disorder	RBKC	41	45	50
	WCC	52	58	66
Suicide thoughts	RBKC	2,488	2,738	3,088
	WCC	3,118	3,499	3,992
Suicide attempts	RBKC	676	730	818
	WCC	846	941	1,071
Self-harm	RBKC	300	313	346
	WCC	374	410	465

Source: Adult Psychiatric Morbidity Survey (2014). Greater London Authority population projections

9.4 Risk factors

As with other age groups there are many risk factors associated with the mental health of older adults. Levels of discrimination, presence of meaningful activities and relationships, physical health condition and poverty are key factors that affect the mental health and wellbeing of older people.

Older people who have experienced any of the following are at a greater risk of a decline in their independence and wellbeing[8] if:

- their partner died in the past 2 years
- they are a carer
- they live alone and have little opportunity to socialise
- recently separated or divorced
- recently retired (particularly if involuntarily)
- unemployed in later life
- on low income
- have recently experienced or developed a health problem
- have had to give up driving
- have an age-related disability
- are aged 80 or older

Some groups of older people are at increased risk of mental health issues. Those who are lonely have a higher risk of developing dementia and depression and older people in a caring role may struggle to get the support they need.

Table 77 shows summarise comparative data on mental health risk factors for older adults. The following key points are made:

- The rate of diagnosed dementia among the GP registered population is lower than the London average in Kensington and Chelsea, while rates in Westminster are above the London average
- Both boroughs have a higher percentage of residents aged 60 years and over living in income deprivation compared to the national average
- In both boroughs the percentage of older people living alone is above the London average and the percentage of social care users with enough social contact is lower than the London average

Table 77: Comparative data on mental health risk factors for older adults

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Dementia recorded prevalence (aged 65+): % of practice register	Sep-17	4.3%	4.9%	4.5%	4.3%	1,050	1,303
Older people living in poverty: % of population aged 60+ (IDAOPI)	2015	21.6%	24.9%	-	16.2%	-	-
Older people living alone: % of households occupied by a single person aged 65 & over	2011	10.5%	10.4%	9.6%	12.4%	8,240	11035
Enough social contact in adult social care users: % of adult social care users	2017/18	35.8%	34.3%	41.4%	46.0%	-	-

Source: Public Health England Fingertips (2019)

9.5 Protective factors

There is limited comparative data specifically focused on protective factors in older adults, therefore this section therefore presents the available data. Some data is already included in risk factors and most relate to adults rather than older ages. Table 78 summarises the available comparative data. The following key points are made:

- Levels of life satisfaction and happiness in the boroughs is higher than the London average, as are physical activity levels
- Health related quality of life for residents aged 65 years and over is higher than the London average in Kensington and Chelsea and similar to the London average in Westminster
- Levels of social isolation among carers and care users, as well as care users' and carer's quality of life measures are below the London average.

Table 78: Comparative data on protective factors for mental health for older adults

		Rate				Count	
Indicator	**Period**	**RBKC**	**WCC**	**LON.**	**ENG.**	**RBKC**	**WCC**
Self-reported wellbeing – high satisfaction	2015/16	83.9%	81.2%	79.6%	81.2%	-	-
Self-reported wellbeing – high happiness	2015/16	77.2%	76.3%	74.3%	74.7%	-	-
Health related quality of life (65yrs+)	2016/17	0.764	0.731	0.728	0.735	-	-
Carer-reported quality of life (Dementia carers) 18yrs+	2014/15	6.7	7.0	7.6	7.9	-	-
Social care related quality of life (18yrs+)	2015/16	18.1	18.5	18.6	19.1	-	-
Enough physical activity (19yrs+)	2016/17	68.2%	66.7%	64.6%	66.0%	-	-
Older people living alone (65yrs+)	2011	10.5%	10.4%	9.6%	12.4%	8,240	11,035
Social isolation: Social care users as much social contact as they would like	2017/18	35.8%	34.3%	41.4%	46.0%	-	-
Social isolation: Adult carers as much social contact as they would like	2016/17	30.1%	29.0%	35.6%	35.5%	126	110

Source: Public Health England Fingertips (2019)

9.6 What works

There is evidence that:

- befriending programmes along with psychosocial interventions can promote wellbeing and prevent depression (Cattan et al., 2005).
- volunteering opportunities are associated with improved mental wellbeing, self-reported health and reduced depression.
- addressing hearing loss is associated with improved quality of life.
- physical activity programmes can improve mental wellbeing and reduce mental illness.
- interventions to promote household warmth are associated with improved mental health and reduced depression (Thomson et al., 2009).
- Interventions to prevent social isolation have also been shown to improve wellbeing (Deacon et al., 2009). This is discussed in more depth elsewhere in the JSNA.

The *Better Mental Health for All* report (2016) highlights the following areas for consideration:

- The Campaign to End Loneliness provides guidance on developing strategies to address loneliness amongst older people in their local populations. Their Loneliness Framework set out interventions across the healthcare system and the wider community
- Community approaches to reduce isolation in older people that have been found to be effective include:
    - Befriending and mentoring
    - Social group schemes which incorporate self-help support and peer involvement
- Identifying and supporting carers with a focus on carers aged eighty-five and over.
- Dementia Friendly Communities is an Alzheimer's Society programme which enables the creation of dementia-friendly communities across the UK and ensures everyone understands that they have a shared responsibility for ensuring people with dementia feel understood, valued and able to contribute to their community.
- The Dementia Friends initiative aims to change people's perceptions of dementia and to change the way the nation thinks, talks and acts about the condition
- Peer support groups for people with early stage dementia living in extra care, retirement housing and their families have had promising outcomes in the areas of wellbeing, social support and practical coping strategies, with improvements in communication abilities, managing memory and managing lives all linked to peer support

- Reminiscence therapy for older people has a range of therapeutic and preventative effects, including reduction in symptoms of depression and improved feelings of self-esteem
- NICE recommend a range of activities for older people including support sessions to assist with daily routines and self-care, community based physical activity programmes, walking schemes and training for practitioners.

What NICE says…

NICE Guidelines (PH16) outline recommendations around the wellbeing of older people:

- Involve occupational therapists in the design and development of locally relevant training schemes for those working with older people. Training schemes should include:
  - essential knowledge (and application) of the principles and methods of occupational therapy and health and wellbeing promotion
  - effective communication skills to engage with older people and their carers (including group facilitation skills or a person-centred approach)
- Ensure practitioners have the skills to:
  - communicate effectively with older people to encourage an exchange of ideas and foster peer support
  - encourage older people to identify, construct, rehearse and carry out daily routines and promote activities that help to maintain or improve health and wellbeing
  - improve, maintain and support older people's ability to carry out daily routines and promote independence
- Collect and use regular feedback from participants.
- Advise older people and their carers how to exercise safely for 30 minutes a day (which can be broken down into 10-minute bursts) on 5 days each week or more. Provide useful examples of activities in daily life that would help achieve this (for example, shopping, housework, gardening, cycling).
- Invite regular feedback from participants and use it to inform the content of the service and to gauge levels of motivation.

In collaboration with older people and their carers, offer a range of walking schemes of low to moderate intensity with a choice of local routes to suit different abilities; and tailored physical activity and exercise schemes

9.7 Services

Treatment services

Prescribing

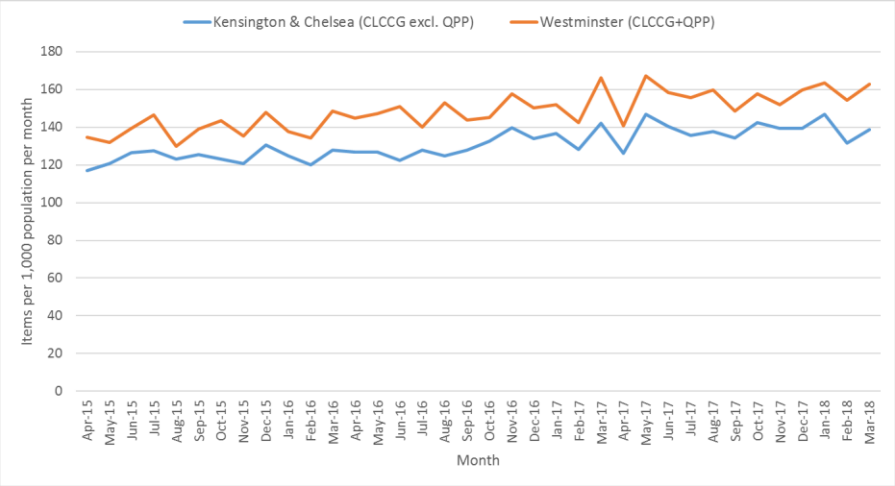
Data on the number of older adults prescribed antidepressants is not available, only the number of items (packs of medication).

Chart 30 shows that the crude rate of antidepressant items prescribed to older adults aged 65 years and over per 1,000 population.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

Antidepressant prescribing rates are typically higher in Westminster compared to Kensington and Chelsea. The chart also shows rates in both boroughs and has been increasing slightly over the past three financial years.

Chart 30: Antidepressant prescribing, items per 1,000 adults aged 65 years and over



Source: NHS North West London Medicines Management

Table 79 shows annual numbers of items prescribed per financial year and crude rates per 1,000 GP registered population to enable comparison.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

In 2017/18 around 40,000 antidepressant items were prescribed to older adults in Kensington and Chelsea and almost 50,000 items in Westminster.

Table 79: Antidepressant prescribing items and rate per 1,000 population aged 65 years and over

Metric	Borough	2015/16	2016/17	2017/18
Items/1,000 population	Kensington & Chelsea (WLCCG excl. QPP)	1,487	1,569	1,659
	Westminster (CLCCG + QPP)	1,668	1,793	1,880
Items	Kensington & Chelsea (WLCCG excl. QPP)	36,353	38,530	42,165
	Westminster (CLCCG + QPP)	41,406	45,964	49,698

Source: NHS North West London Medicines Management

Specialist mental health services

This section describes the finding from analysis of activity data provided by Central and North West London NHS Foundation Trust (CNWL). In interpreting these findings it should be considered that, while CNWL is the largest provider of mental health care services, there are other mental health services, therefore the numbers presented are likely to be an underestimate of current demand for treatment services.

Referrals

Chart 31 shows referrals to Central and North West London NHS Foundation Trust's (CNWL) Older Adult Mental Health services for registered patients aged 65 years and over, by Clinical Commissioning Group (CCG).

CCG boundaries map to the Bi-Borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen's Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen's Park Paddington

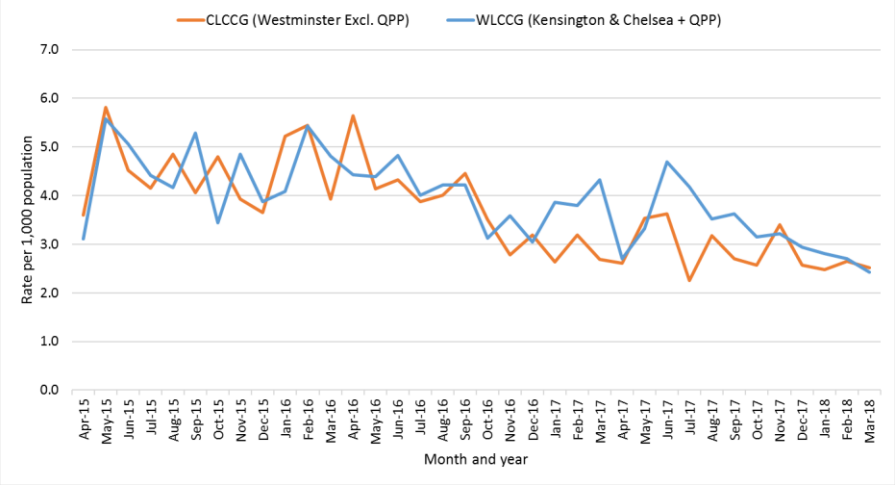
In interpreting referrals data it should be noted that of referrals, not all are accepted (see Table 83 below) and of those accepted not all referrals lead to a positive diagnosis and treatment.

Chart 31 shows the trend in referrals from all sources. Table 80 and Table 81 show annual numbers by referral source for Central London CCG and West London CCG respectively. The tables show referral volumes by source in rank order and indicate where annual numbers have increased (dark blue) or decreased (light blue) year on year.

Table 82 and Table 83 list the reasons for referral in rank order. Year on year changes are highlighted as increase (dark blue) or decrease (light blue).

Chart 31 shows that monthly referral rates for CCG registered patients have declined in 2017/18. It also shows that prior to 2017/18, monthly rates of referral from both CCGs have been similar, but in 2017/18 rates for WLCCG exceed those from CLCCG.

Chart 31: Older Adults: Referrals to CNWL, all sources of referral, monthly trend



Source: CNWL contract monitoring data

From Table 80 and Table 81 the following key points are made:

- the most common referral route into Older Adult services is from GPs followed by 'other secondary care specialty'
- No continual year on year increase in referral volumes from any source is observed for either CCG, but there have been continual year on year reductions in the number of referrals from GPs and 'other service or agency'

Table 80: Older Adults: Source of referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

	Referrals					Change	
Source of referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
GP	680	658	552	1890	66%	97%	84%
Other secondary care specialty	213	178	131	522	18%	84%	74%
Other service or agency	133	34	29	196	7%	26%	85%
Social Services	78	44	24	146	5%	56%	55%
Other Primary Health Care	30	25	<5	55	2%	83%	-
Self	9	12	7	28	1%	133%	58%
Accident And Emergency Department	7	7	10	24	1%	100%	143%
Carer	5	8	5	18	1%	160%	63%
Voluntary Sector	5	<5	0	5	0%	-	-
Drug Action Team / Drug Misuse Agency	<5	0	0	0	0%	-	-
Health Visitor	<5	0	0	0	0%	-	-
Improving Access to Psychological therapies Service	0	0	0	0	0%	-	-
Independent sector - Medium Secure Inpatients	0	0	<5	0	0%	-	-
NHS Direct	<5	0	<5	0	0%	-	-
Other Independent Sector Mental Health Services	<5	<5	<5	0	0%	-	-
Out of Area Agency	<5	<5	<5	0	0%	-	-
Permanent transfer from another Mental Health NHS Trust	<5	<5	<5	0	0%	-	-
Police	<5	<5	<5	0	0%	-	-
Temporary transfer from another Mental Health NHS Trust	<5	<5	0	0	0%	-	-

Source: CNWL contract monitoring data

Table 81: Older Adults: Source of referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

	Referrals					Change	
Source of referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
GP	921	868	815	2604	66%	94%	94%
Other secondary care specialty	311	342	200	853	21%	110%	58%
Other service or agency	132	45	28	205	5%	34%	62%
Social Services	39	31	32	102	3%	79%	103%
Other Primary Health Care	33	31	32	96	2%	94%	103%
Accident And Emergency Department	12	7	16	35	1%	58%	229%
Self	18	7	8	33	1%	39%	114%
Police	7	5	5	17	0%	71%	100%
Carer	5	5	5	15	0%	100%	100%
Voluntary Sector	12	<5	0	12	0%	-	-
Drug Action Team / Drug Misuse Agency	<5	0	0	0	0%	-	-
Health Visitor	<5	0	0	0	0%	-	-
Improving Access to Psychological therapies Service	0	0	0	0	0%	-	-
Independent sector - Medium Secure Inpatients	0	0	<5	0	0%	-	-
NHS Direct	<5	0	<5	0	0%	-	-
Other Independent Sector Mental Health Services	<5	<5	<5	0	0%	-	-
Out of Area Agency	<5	<5	<5	0	0%	-	-
Permanent transfer from another Mental Health NHS Trust	<5	<5	<5	0	0%	-	-
Temporary transfer from another Mental Health NHS Trust	<5	<5	0	0	0%	-	-

Source: CNWL contract monitoring data

Emergency and non-emergency

From Table 82, the majority of referrals to older adult mental health services are routine in nature, over 80% in both CCGs, the remaining are predominantly urgent, but not emergency referrals. In 2017/18 there were 128 urgent referrals from WLCCG and 67 from CLCCG, while numbers of emergency referrals were fewer than 5 per month.

Table 82: Older Adults: Type of referral by CCG

WLCCG (Kensington and Chelsea +QPP)

	Referrals			referrals		
Referral type	15/16	16/17	17/18	15/16	16/17	17/18
Emergency	<5	6	<5	-	0%	-
Routine	1291	1087	965	87%	81%	84%
Routine Plus	21	63	52	1%	5%	5%
Urgent	179	193	128	12%	14%	11%

CLCCG (Westminster Excl. QPP)

	Referrals			referrals		
Referral type	15/16	16/17	17/18	15/16	16/17	17/18
Emergency	<5	<5	<5	-	-	-
Routine	1056	889	696	90%	91%	91%
Routine Plus	<5	6	5	-	1%	1%
Urgent	111	80	67	10%	8%	9%

Accepted

Of referrals Table 83 show that the percentage of that are accepted has not changed substantially between 2015/16 and 2017/18 in both CCGs. Around one-third of referrals are not accepted. In 2017/18 the percentage of referrals to adult services accepted was 70% for WLCCG registered patients and 67% for CLCCG registered patients.

Table 83: Older Adults: Referrals accepted by CCG

WLCCG (Kensington and Chelsea +QPP)

	Referrals			referrals		
Decision	15/16	16/17	17/18	15/16	16/17	17/18
Accepted	1051	995	806	70%	74%	70%
Not Accepted	438	349	340	29%	26%	30%
Not Recorded	6	5	<5	0%	0%	-

CLCCG (Westminster Excl. QPP)

	Referrals			referrals		
Decision	15/16	16/17	17/18	15/16	16/17	17/18
Accepted	787	662	519	67%	68%	67%
Not Accepted	380	314	253	33%	32%	33%
Not Recorded	<5	<5	<5	-	-	-

Reason for referral

Table 84 and Table 85 show annual numbers by referral by reason for referral Central London CCG and West London CCG respectively. From these tables the following key points are made:

- For both CCGs 'in crisis' is the most common reason for referral, followed by Capacity (advice/ assessment) in CLCCG and Depression in WLCCG
- Continual year on year increases are only seen in capacity (advice/assessment) referrals from WLCCG
- The number of referrals for 'in crisis' in both CCGs have been declining year on year, as have referrals for 'unexplained physical symptoms' from WLCCG

Table 84: Older Adults: Reason for referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

	Referrals					Change	
Reason for referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
In crisis	958	656	545	2159	75%	68%	83%
Capacity (advice/assessment)	48	96	75	219	8%	200%	78%
Depression	49	87	80	216	8%	178%	92%
Anxiety	39	66	48	153	5%	169%	73%
Ongoing or Recurrent Psychosis	9	24	10	43	1%	267%	42%
Unexplained physical symptoms	30	10	0	40	1%	33%	0%
Medication Review	8	11	<5	19	1%	138%	-
Personality disorders	8	<5	<5	8	0%	-	-
Organic brain disorder	7	<5	<5	7	0%	-	-
Self - care issues	0	5	<5	5	0%	-	-
Self harm	<5	5	<5	5	0%	-	-
Adjustment to Physical Health Condition	<5	<5	<5	0	0%	-	-
Bi polar disorder	<5	<5	<5	0	0%	-	-
Conduct disorders	<5	<5	0	0	0%	-	-
Drug and alcohol difficulties	<5	<5	<5	0	0%	-	-
Eating disorders	<5	0	0	0	0%	-	-
Neurodevelopmental conditions	<5	0	0	0	0%	-	-
Obsessive compulsive disorder	<5	0	0	0	0%	-	-
Post-traumatic stress disorder	<5	<5	<5	0	0%	-	-
Relationship difficulties	<5	<5	<5	0	0%	-	-
(blank)	<5	0	0	0	0%	-	-
	<5	0	0	0	0%	-	-

Source: CNWL contract monitoring data

Table 85: Older Adults: Reason for referral and year on year change in volumes CLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

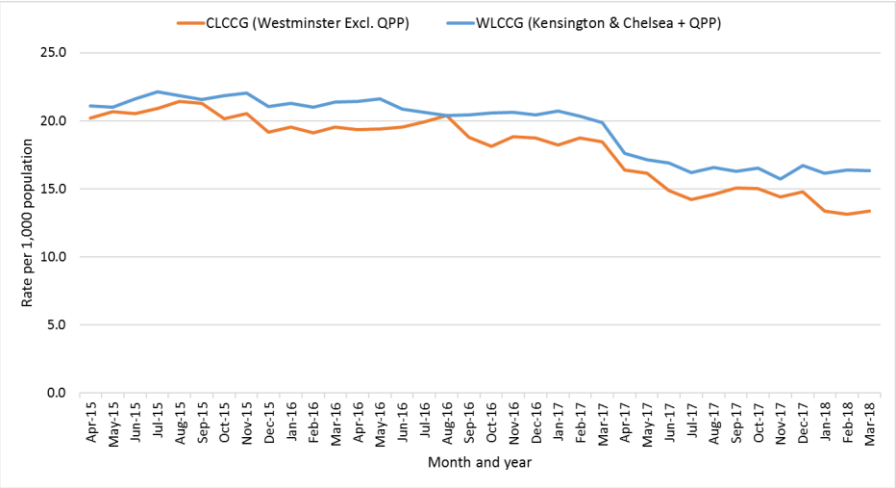
	Referrals					Change	
Reason for referral	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
In crisis	1235	968	830	3033	77%	78%	86%
Depression	89	180	152	421	11%	202%	84%
Ongoing or Recurrent Psychosis	35	52	33	120	3%	149%	63%
Capacity (advice/assessment)	33	39	41	113	3%	118%	105%
Anxiety	28	41	35	104	3%	146%	85%
Medication Review	24	14	23	61	2%	58%	164%
Bi polar disorder	9	7	11	27	1%	78%	157%
Organic brain disorder	<5	11	8	19	0%	-	73%
Self harm	9	8	<5	17	0%	89%	-
Drug and alcohol difficulties	<5	15	<5	15	0%	-	-
Conduct disorders	13	<5	0	13	0%	-	-
Adjustment to Physical Health Condition	<5	6	<5	6	0%	-	-
Eating disorders	<5	0	0	0	0%	-	-
Neurodevelopmental conditions	<5	0	0	0	0%	-	-
Obsessive compulsive disorder	<5	0	0	0	0%	-	-
Personality disorders	<5	<5	<5	0	0%	-	-
Post-traumatic stress disorder	<5	<5	<5	0	0%	-	-
Relationship difficulties	<5	<5	<5	0	0%	-	-
Self - care issues	0	<5	<5	0	0%	-	-
Unexplained physical symptoms	<5	<5	0	0	0%	-	-
(blank)	<5	0	0	0	0%	-	-
(blank)	<5	0	0	0	0%	-	-

Source: CNWL contract monitoring data

Caseload

In 2017/18 average caseloads were 484 for WLCCG and 331 for CLCCG. Chart 26 shows the monthly trend in older adults caseload by referring CCG. Numbers on caseload are converted into rates per 1,000 population aged 65 years to enable comparison. From Chart 26 cases per head of population from WLCCG are typically higher compared to CL CCCG

Chart 32: Older Adults: older adults on caseload per 1,000 population aged 65 years and over



Source: CNWL contract monitoring data

Hospital admissions

Analysis of hospital spells for primary and secondary diagnoses of mental health conditions (International Classification of Diseases 10th edition [ICD 10] Chapter F) produced the findings in Table 86. Data presented where more than 5 spells occurred in the pooled 2015/16 and 2016/17 data and for the top 5 diagnoses

Table 86 presents the findings from local analysis of hospital activity data. As mental health and/ or self harm diagnoses are most commonly coded as a secondary diagnosis, only pooled data from 2015/16 and 2016/17 could be utilised as the 2017/18 spells data does not include secondary diagnosis field.

Table 86: Hospital admissions (Spells), adults aged 65years and over, with a relevant primary diagnosis Chapter F or X, 2015/16 and 2016/17 pooled data

Primary Diagnosis	Borough	EL	NEL
Mental and behavioural disorders due to use of alcohol	RBKC	-	19
Vascular dementia, unspecified	RBKC	<5	11
Unspecified dementia	RBKC	-	12
Delirium, unspecified	RBKC	<5	11
Severe depressive episode with psychotic symptoms	RBKC	-	9
Anxiety disorder, unspecified	RBKC	-	7
Depressive episode, unspecified	RBKC	-	5
Unspecified dementia	WCC	-	32
Delirium, unspecified	WCC	-	25
Mental and behavioural disorders due to use of alcohol	WCC	-	17
Anxiety disorder, unspecified	WCC	-	9
Vascular dementia, unspecified	WCC	-	9
Delirium superimposed on dementia	WCC	-	8

Secondary Diagnosis	Borough	EL	NEL
Exposure to unspecified factor	RBKC	-	10
Exposure to unspecified factor	WCC	-	19
Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	WCC	-	10
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics & antirheumatics	WCC	-	6
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism & psychotropic drugs, not elsewhere classified	WCC	-	5

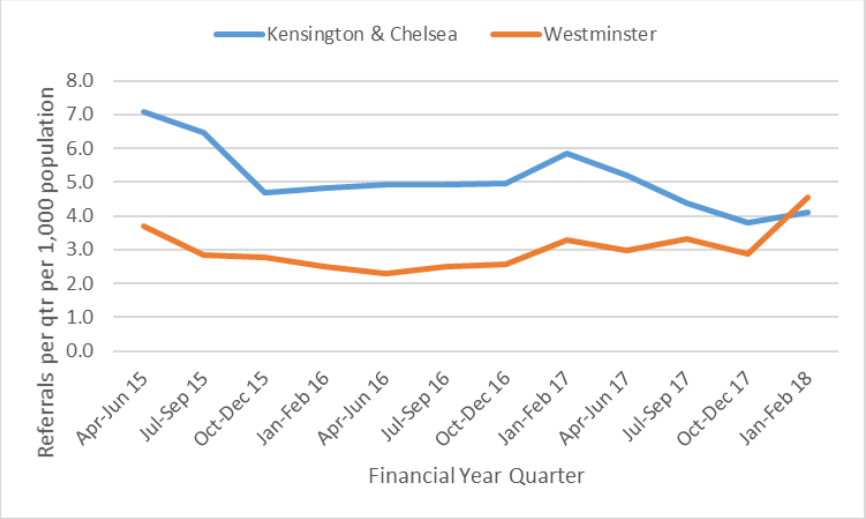
Source: Secondary Uses Service spells data 2015/16 and 2016/17 pooled data. EL – Elective, NEL – Non-elective. n - Number

Support Services

Chart 33 shows the quarterly trend in referrals to Adult Social Care services for Mental Health Support between April 2015 and March 2018.

In interpreting these data it is important to note residents can have more than one referral per period and not all referrals result in a support package being implemented. Table 87 shows the relative numbers of referrals to service users referred and the percentage of referrals that led to a support.

Chart 33: Rate of referrals to Adult Social Care services for Mental Health Support



Source: Adult Social Care client data

Table 87: Referrals to ASC Mental Health Support

Borough	Mental Health Support	2015/16	2016/17	2017/18
RBKC	Individuals referred	462	412	343
WCC	Individuals referred	296	272	351
RBKC	% Individuals all ASC referrals	19%	18%	14%
WCC	% Individuals all ASC referrals	10%	10%	13%
RBKC	Referrals	521	482	418
WCC	Referrals	336	311	412
RBKC	Referrals accepted*	7%	4%	1%
WCC	Referrals accepted*	25%	10%	8%

Source: Adult Social Care client data

Table 88 shows the current numbers of Adult Social Care Clients with 'Mental Health Support' primary reason for support. This table also shows the number packages assigned to ASC clients.

Table 88: Numbers of Service Users and packages for Mental Health Support (excl. Memory and Sensory support)

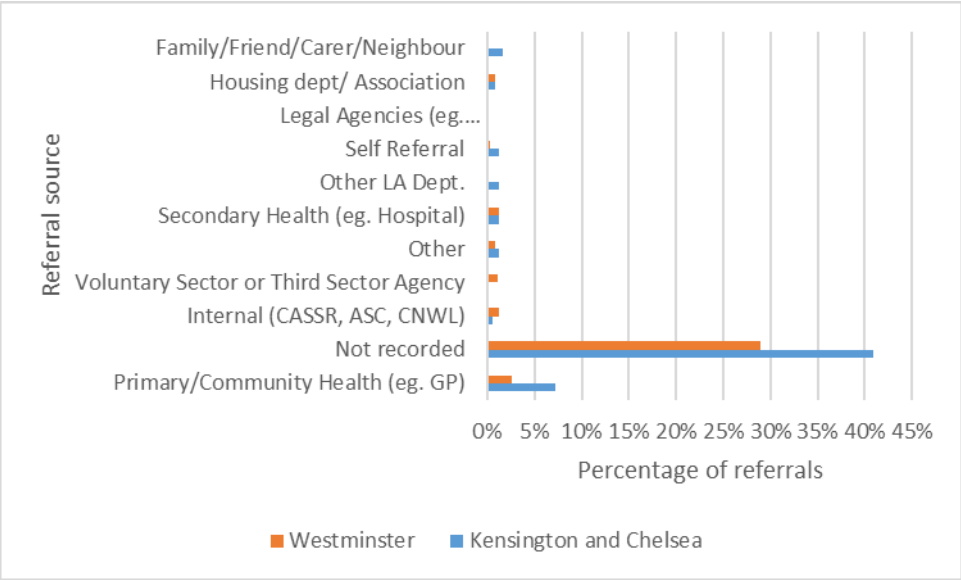
Borough	Mental Health Support	2015/16	2016/17	2017/18
RBKC	Service Users	142	148	141
WCC	Service Users	306	307	328
RBKC	% Individuals all ASC referrals	7%	7%	7%
WCC	% Individuals all ASC referrals	8%	8%	9%
RBKC	Packages	574	321	334
WCC	Packages	1,286	853	874

Source: Adult Social Care client data

Referral source

The chart below shows the distribution of referrals by source.

Chart 34: Referrals for mental health support by source and borough, pooled data 2015-18



Source: Adult Social Care client data

9.8 Local services and asset mapping

9.8.1 Central London CCG

Older adults are triaged by Primary Care Plus and then may be referred on to the Older People's Community Mental Health Team, the Home Treatment Team or to the Kensington & Chelsea and Westminster Memory Service.

Wait times for the Memory Service are considered to be too long (insert how long). Options are being considered for more assessments to be carried out by GPs, and make more use of the Primary Care Plus Navigators to provide post diagnosis support and sign–posting to services such as those provided by OpenAge and to ensure integration of mental health care and physical health care.

9.8.2 West London CCG

There are a number of services looking after the health care of older adults.

- The My Care My Way service provides integrated health and social care for those over the age of 65. The organisations included are GP surgeries, NHS hospitals, local community and social care services as well as many local charities and voluntary organisations.
- Memory Service and post diagnostic support
- Older people's Community Mental Health Teams
- The Community Living Well service

Like Central London CCG, long waits for the memory service are being addressed by developing proposals for more diagnosis to be done by the GP.

The current structure which keeps mental health services and physical health separate has a potential for some duplication.

9.8.3 Older Adults Wellbeing Services Commissioned by Local Authorities including Dementia Services

9.8.3.1 All Older Adults

Adult Social Care commission a range of services that contribute to the mental wellbeing of older adults which include hubs, carer's services, befriending, residential and nursing.

The Royal Borough of Kensington and Chelsea –Community Hubs

<u>New Horizons</u>

New Horizons offers over 80 sessions per week, including art, keep fit and IT classes, various discussion groups, a 10-week life stories programme and massage/reflexology sessions, amongst others.

Second Half Centre

The centre holds over 60 hours of activities and classes each week: Zumba Classes, Pilates, Yoga, Art, and International Cooking Classes. IT skills, from basic emailing to Excel, are also taught in the dedicated IT room. The centre also has a café onsite, where members can drop by and catch up with friends.

City of Westminster – Community Hubs

Older Peoples' Hubs in Westminster aim to ensure residents enjoy a good quality of life in their local community by having access to a range of services, relevant information, learning and recreational opportunities and to promote opportunities for social inclusion in order to maintain their physical, mental health and wellbeing and prevent early admission to either hospitals or long-term care. City of Westminster hubs are:

- Westbourne Hub
- Queens Park, Harrow RoaMotherd
- Churchill Hub
- Penfold Hub

The above hubs are currently under commissioning review.

Leonora Hub

The Leonora group, for people aged 50 and above, meets on Tuesdays and Wednesdays. Members choose which activities they want to take part in during the morning. Examples of activities on offer include bingo, dominoes, word games and reminiscence sessions. In the afternoon, the hub offers chair exercises or gentle yoga classes with a trained instructor. The centre also organise parties to mark special occasions throughout the year.

9.8.3.2 Services for those living with Dementia

The following services are specifically commissioned by ASC for those with dementia.

WCC

- London Care - Integrated Dementia Service. This currently consists of a dementia day centre at Westbourne Park, dementia advisor who runs dementia cafes, and dementia nurse.
- London Care - Pullen Day Centre. This is a day centre supporting those with cognitive and physical impairment needs most days and has a day dedicated for those with a dementia diagnosis.
- Carers Network - Carers Hub. They have dedicated support sessions for those caring for someone with a dementia diagnosis.
- Notting Hill Genesis - Penfold Extra Care Housing. Service generally supports residents with physical and or cognitive impairments and has 8 dedicated units for those with dementia.

- Octavia - Leonora Extra Care Housing. Service generally supports residents with physical and or cognitive impairments and has 5 dedicated units for those with dementia.

RBKC

- Age UK Dementia Services. 1) Dementia advisor who runs the dementia cafes. 2) Volunteer co-ordinator. 3) Dementia one to one support. 4) Exercise for the mind sessions.
- Chamberlain House dementia day centre.
- Octavia – High Lever Extra Care Housing. All the 81 ECH housing units within RBKC supports residents with physical and or cognitive impairments. High Lever is a 5 unit scheme dedicated for those with dementia.

9.8.3.3 Support for Carers

The support for carers is crucial for their own mental health and wellbeing as well as enabling them to continue to care for their loved ones. It is important to note that carers can be of any age, and providing care for family, friends or neighbours of all ages. Support available encompasses information and advice; carers assessments and reviews; outreach and partnership

Information and Advice (4 hours per day, 5 days per week)

The service delivers specialist advice to all carer cohorts in the following priority areas:

- Carers related information, advice, guidance and support;
- Health- maintenance, improvement, self-management and recovery
- Welfare Rights;
- Legal Advice;
- Financial Advice including debt and money advice;
- Community Care – Care Act 2014;
- Education / Employment / Training advice.

Carers Assessments and Reviews (195 per quarter in WCC, 65 per quarter in RBKC)

The service delivers carers assessments, reviews, and support planning, and indicative carers personal budget allocations to the full range of carer cohorts within our communities. This review of the needs of each carer includes the following:

- An individual's caring role and how it affects their life and wellbeing;
- The carer's health and wellbeing – physical, mental and emotional issues;
- The carer's emotional wellbeing and feelings and choices about caring;
- The carer's capacity regarding work, study, training and leisure;
- The relationships, social activities and goals that the carer wants to achieve;
- Housing issues that may be affecting the carer;

- Planning for emergencies (such as a Carer Emergency Scheme) with the carer;
- Eligibility and access to Personal Health Budgets.

Support, Outreach and Partnership

- A dedicated Carers' telephone helpline for Carers' enquiries (8 hours per day, 5 days per week)
- Wrap around service including out of office hours – carers support provision (4 hours per day, 5 days per week)
- Targeted information and advice surgeries within identified community settings throughout the borough (3 co-located sessions x 42 weeks per year in WCC, 1 x 42 weeks in RBKC)
- Work with GP Surgeries, prioritising surgeries who have participated within the Primary Care Carers Navigator Scheme (1 practice per week in both WCC and RBKC)
- Carer identification, accessing new carers via primary care facilities, pharmacies, clinics, primary and community health facilities (1 organisation per week in both WCC and RBKC)
- Generic peer support groups / drop-ins that give Carers across all care groups the chance to meet others in similar situations and offer peer support at venues across the borough (1 per month in WCC)
- Specialist support groups for: Carers of adults with mental health issues, Carers of adults with learning disabilities (including autism) and or physical disabilities, and mental health needs. (1 per month in WCC)
- Home visiting for Carers as necessary (WCC quarterly target: 15, RBKC quarterly target: 5)
- A quarterly carers forum in both WCC and RBKC
- Distribution of a Carers' information pack - produced on an annual basis with the involvement of Carers (ongoing)
- Production and distribution of a quarterly Carers' newsletter and e-bulletin
- Bi-monthly awareness sessions / briefings for social and health care staff
- Bi-monthly education, training and employment sessions / briefings, e.g. CV writing workshops
- Bi-monthly carers support training, e.g. dementia awareness training
- Partnership working with the shared service (3 borough) adult social care website for supporting health and independent living, PeopleFirst, to ensure carers information is accurate and up to date and reflects the needs of all carer cohorts and our communities within each borough
- Quarterly partnership events to promote Carers' rights, assessments and services and identify hidden Carers. These include Carers' Week and Carers' Rights Day, and others as identified
- Partnership working with care management teams, primary care organisations, general practices and voluntary and community sector and faith

organisations (60 partnership engagement activities per year developing shared outcomes)

9.8.4 Central London CCG and WCC Adult and Older Adult Mental Health

Purpose/Modality	Description	Spend 2017/18
Placements	Mental Health registered care and nursing care placement , purchase on an individual 'spot' contract based by NHS CCG or Local Authority to meet Section 117 Mental Health Act aftercare duties	NHS and LA
Supported Housing	Accommodation with staff support delivered through Housing	NHS and LA
Adult Acute in Patient	Acute Care in Hospital in-patient provision	NHS
Adult Acute PICU	Psychiatric Intensive Care Unit for the care and treatment of persons whose distress, absconding risk, suicidal and challenging behaviour requires a secure environment.	NHS
Rehabilitation(Residential Open & Secure)	Mental Health rehabilitation beds in an in-patient setting identified as 'mental health rehabilitation', to differentiate it from community based rehabilitation , provided by the NHS and independent hospital sector	NHS
ECRs/NCA	Extra Contractual Referral/ Non-Contract Activity	NHS
Specialist Out of Area in Patient Services	In-patient specialist care and treatment in regional or national centres for specific conditions	NHS
OPMH in Patients(functional & Organic)	Older People's Mental Health for Functional(e.g. depression, psychosis) and Organic (Dementia) conditions	NHS
Mental Health & Dementia Care Homes (Local)	Local provision of Nursing Care for functional and organic conditions.	NHS

9.8.5 West London CCG and WCC Adult and Older Adult Mental Health

Tier 4		
Purpose/Modality	**Description**	**Spend 2017/18**
Placements	Mental Health registered care and nursing care placement , purchase on an individual 'spot' contract based by NHS CCG or Local Authority to meet Section 117 Mental Health Act aftercare duties (Include JHT and MH Accommodation Seeker Service and also a percentage of RBKC supported housing contracts for socially excluded group.	NHS and LA
Supported Housing	Accommodation with staff support delivered through Housing	NHS and LA
Supported Living in - borough		NHS and LA
Adult Acute in Patient	Acute Care in Hospital in-patient provision	NHS
Adult Acute PICU	Psychiatric Intensive Care Unit for the care and treatment of persons whose distress, absconding risk, suicidal and challenging behaviour and therefore require a secure environment.	NHS
Rehabilitation (Residential Open & Secure - CNWL Rehabilitation and Specialist)	Mental Health rehabilitation beds in an in-patient setting identified as 'mental health rehabilitation', to differentiate it from community based rehabilitation , provided by the NHS and independent hospital sector	NHS
ECRs/NCA	Extra Contractual Referral/ Non-Contract Activity	NHS
Specialist Out of Area in Patient Services	In-patient specialist care and treatment in regional or national centres for specific conditions	NHS

OPMH in Patients(functional & Organic)	Older People's Mental Health for Functional(e.g. depression, psychosis) and Organic (Dementia) conditions	NHS
Mental Health & Dementia Care Homes (Local)	Local provision of Nursing Care for functional and organic conditions. (Includes Ellesmere Dementia 20 bedded unit)	NHS and LA

10 Spotlight on Dementia

10.1 Introduction

A JSNA specifically on Dementia was published in 2015 and this JSNA does not propose to duplicate this work. Information in this the older adults section of this report includes updates to data where available and service provision.

Dementia is a term used to describe a range of cognitive and behavioural symptoms that can include memory loss, problems with reasoning and communication and change in personality, and a reduction in a person's ability to carry out daily activities, such as shopping, washing, dressing and cooking. The most common types of dementia are Alzheimer's disease, vascular dementia, mixed dementia, dementia with Lewy bodies and frontotemporal dementia. Dementia is a progressive condition, which means that the symptoms will gradually get worse. This progression will vary from person to person and each will experience dementia in a different way – people may often have some of the same general symptoms, but the degree to which these affect each person will vary (Dementia Gateway, Social Care Institute for Excellence).

Dementia mainly affects people over the age of 65 (one in 14 people in the UK in this age group have dementia), and the likelihood of developing dementia increases significantly with age. However, dementia can also affect younger people too. There are more than 42,000 people in the UK under 65 with dementia.

10.2 National Context

In March 2012, the government launched a national challenge to fight dementia. This programme of action was set up to deliver sustained improvements in health and care, create dementia friendly communities, and boost dementia research.

The Prime Ministers' Challenge on Dementia 2020 (launched February 2015) sets out the UK Government's strategy for transforming dementia care within the UK. The Challenge aims to build on the previous programme of action, and, by 2020, see England become

- the best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- the best place in the world to undertake research into dementia and other neurodegenerative diseases.

This will be achieved by:

- Improving diagnosis, assessment and care for people living with dementia
- Ensuring that all people living with dementia have equal access to diagnosis
- Providing all NHS staff with training on dementia appropriate to their role
- Ensuring that every person diagnosed with dementia receive meaningful care

10.3 Prevalence

Current estimates of the number of people living with dementia in the local population are ca. 1,500 in RBKC and 1,800 in Westminster. Approximately 50% of the population with dementia are aged 85+. (JSNA)

Through population projections, the number of people living with dementia is estimated to rise by 70% for Kensington & Chelsea; and by 45% for Westminster by 2030. Diagnostic, treatment and care service provision may need to expand proportionately to meet this increasing need.

10.4 Current Performance against PHE's Dementia Pathway on a Page

The Dementia Pathway on a Page produced by PHE gives snapshot of how dementia is prevented and diagnosed locally. It also shows data on the care that is provided to people with dementia, including end of life care.

Areas of performance highlighted by the profile for are the higher than the England average rates Dementia DSR Emergency Admissions for both CCG areas and the lower rates of people dying in their usual place of residence.

In March 2018 WL CCG had an estimated diagnosis rate of 75.7%%, and CL CCG 73.8%. In comparison to the 70.4% in London and 67.5% nationally rates are better in West London than in London. The diagnosis rate for Central London is similar to London.

Table 89: Dementia Pathway on a Page Central and West London CCGs

		Rate				Count	
Indicator	**Period**	**WLCCG**	**CLCCG**	**LON.**	**ENG.**	**WLCCG**	**CLCCG**
Estimated Dementia diagnosis rate (65yrs+)	2018	75.7%	73.8%	70.4%	67.5%	1,321	1,037
Dementia recorded prevalence (65yrs+)	Sep-17	4.5%	4.7%	4.48%	4.33%	1,325	1,060
Smoking recorded prevalence (16yrs+)	2017/18	18.2%	15.4%	16.8%	17.26%	38,949	31,309
Hypertension recorded prevalence (All ages)	2017/18	9.4	7.9	11.0	13.9	23,418	18,119
Dementia (blood test recorded)	2017/18	75.7	77.3	62.9	67.7	255	157
Dementia care reviewed in past 12months	2017/18	83.9%	78.2	79.9	78.1	1,104	850

Ratio of dementia inpatient use to register	2016/17	49.8	49.9	-	55.1	676	540
Dementia emergency admissions	2016/17	4,380	4,241	-	3,482	1,136	904
Dementia mortality rate (65yrs+)	2016	557	548	-	868	158	128
Deaths in usual place of residence (Dementia)	2016	51.3%	48.4%	55.0%	67.9%	81	62

PHE Fingertips (2019)

10.5 Dementia Friendly City

Services needed by those living with dementia and those who care from them are both dementia specific and non-dementia specific. For details of current services see the Local Services and Asset Mapping section.

For those living with dementia and their carers to have a good quality of life requires not only NHS and LA commissioned services but also for London to become a dementia friendly city. The Alzheimer's Society, the GLA, London Health Board and other partners working together to achieve the ambition of a Dementia Friendly London by 2022 with the following priority areas for action.

- 2,000 dementia friendly organisations
- 500,000 Dementia Friends
- Every London borough working to becoming a dementia friendly community
- Meaningful involvement of people affected by dementia

10.6 Development of a Local Dementia Strategy

A dementia strategy for Westminster and Kensington and Chelsea is currently in development informed by the Dementia JSNA 2015, the North West London Strategic Review of Dementia 2015 as well as new developments in national policy guidance and research. Work is also being informed through a programme of engagement with people who are affected by dementia commencing in January 2019.

11 Health Economics

The following tables detail the return on investment results from *Commissioning cost-effective services for promotion of mental health and wellbeing and prevention of mental Ill-health* (Public Health England, 2017) for Kensington and Chelsea and Westminster, respectively.

The results suggest the highest cumulative financial value for money is from investing in school-based socio-emotional learning, £5.08 for every £1 spent. However other factors, such as the size of the population impacted, the robustness of the assumptions made in the models, should also be considered when deciding on where to best to prioritise investments.

Table 90: Health economics - Kensington and Chelsea

Intervention	Target population	Outcomes	Efficacy	Expected local impact	Time period	Cost 'usual care'	Cost post intervention	Cost of intervention	Savings (net)	Savings (gross)	ROI	Positive ROI in year 1	Savings from	Savings to
Investing in socio-emotional learning: school based resiliance	Children aged 11 (n=1,546)	Reduced incidence of depression	41% reduction in the probability of depression	Reduction in children experiencing depression 93 to 70	7 years	£ 245,783	£ 177,900	£ 13,373	-£ 67,883	-£ 54,510	£5.08:£1	Y	Reduction in hospital care (A&E, inpatient and outpatient), GP services, school nurses/ counsellors, CAMHS/ child psycholgists, social workers, other professionals and absenteeism cost to families	NHS, Local Authority, Families, Schools
Whole school anti-bullying programme	Children aged 7 to 8 years (n = 1,637)	Reduction in incidence of intermittent and intense bullying.	18% reduction in the probability of being bullied compared to no intervention	Reduction in intense bullying 35 to 24 and 252 to 209	4 years	£ 196,003	£ 187,511	£ 5,371	-£ 8,492	-£ 3,121	£1.58:£1	Y	Reduced GP and CAMHS utilisation, reduced ambulance and hospital costs associated with self-harm, and reduced school absence	NHS, Families
Universal workplace well-being programme	Employees (n=500)	Reduction in absentee-ism and presentee-ism	303% Increase in the proportion of workers maintaining their well-being	Increase in employees maintaining well-being 165 to 199	1 year	£ 97,245	£ 41,050	£ 41,050	-£ 97,245	-£ 56,195	£2.37:£1	Y	Absenteeism-related and Presenteeism-related productivity losses avoided, and GP visits avoided	NHS, Employers
Universal programme of CBT for employees identified as being stressed	Employees (n=1000)	Reduction in employees identified as stressed remaining stressed	13% reduction in the probability of remaining stressed	Reduction in employees remaining stressed by 86 per 1,000 employees	2 years	£ 6,985	£ 3,492	£ 3,493	-£ 6,985	-£ 3,492	£2.00:£1	Y	Avoided GP visits and physical care costs, ultilisation of secondary mental health services, medications, occupational health and LA well-being services, reduced productivity losses, presenteeisma and increased retention	NHS, Local Authority, Productivity
Support for adults experiencing problematic debt, without mental health problems, atteng GP surgeries	Adult population in debt (n=20,701)	Reduction in depression, stress and debt	44% reduction in proportion with unmaneagble debt	Increase in the number of people in debt whose debt is maneagble: 16,768 to 17,928	5 years	£ 42,610,472	£ 38,515,638	£ 1,573,506	-£ 4,094,834	-£ 2,521,328	£2.60:£1	N	GP Visits, Depression treatment, Legal and Debt administration, Workplace stress and absence due to debt, Depression productivity losses	NHS, Legal sector, Productivity
Investing in self-harm and suicide prevention	Incidence of suicide * population (n=518)	Reduction in the number of attempted and completed suicides	41% Reduction in the probability of self-harm	At year 10, 7 non-fatal suicide attempts, and 7 completed suicides prevented	10 years	£ 2,128,126	£ 1,985,657	£ 48,675	-£ 142,469	-£ 93,794	£2.93:£1	N	Ambulance, treatment for suicide and self-harm, ongoing psychological treatment, Productivity losses, Police investigations, Coroner Inquests, Intanible costs	NHS, Local Authority, Police, Productivity losses, Intangible losses
Signposting over 65's to group activities	22,627 of whom 6% (n=1,358) engage with the service	Reduction in loneliness leading to reduction in depression and self-harm	8% Reduction in probability sometimes lonely and 8% reduction in probability sometimes lonely	Reduction in 'always lonely' 502 to 460 and sometimes lonely 786 -720	5 years	£ 1,788,218	£ 1,738,064	£ 39,710	-£ 50,154	-£ 10,444	£1.26:£1	N	Reduced GP Visits, Depression and Self-harm treatments, and increased volunteering rates through signposting	NHS, Volunteers (local community)
Collaborative care for people with long-term physical health conditions	People with diabetes and coronary heart disease	Reduction in rates of depression in people with diabetes and coronary heart disease	21% Reduction in the probability of depression	Reduction in depressed 116 to 104 in year 1 and 131 to 129 in year 2	2 years	£ 3,070,119	£ 3,026,794	£ 28,561	-£ 43,324	-£ 14,763	£1.52:£1	Y	Health and Social Care services, Productivity	NHS, Productivity

Table 91: Health economics - Westminster

Intervention	Target population	Outcomes	Efficacy	Expected local impact	Time period	Cost 'usual care'	Cost post intervention	Cost of intervention	Savings (net)	Savings (gross)	ROI	Positive ROI in year 1	Savings from	Savings to
Investing in socio-emotional learning: school based resiliance	Children aged 11 (n=2,092)	Reduced incidence of depression	41% reduction in the probability of depression	Reduction in children experiencing depression 126 to 95	7 years	£ 332,586	£ 240,729	£ 18,096	-£ 91,858	-£ 73,762	£5.08:£1	Y	Reduction in hospital care (A&E, inpatient and outpatient), GP services, school nurses/ counsellors, CAMHS/ child psycholgists, social workers, other professionals and absenteeism cost to families	NHS, Local Authority, Families, Schools
Whole school anti-bullying programme	Children aged 7 to 8 years (n = 2,456)	Reduction in incidence of intermittent and intense bullying.	18% reduction in the probability of being bullied compared to no intervention	Reduction in intense bullying 52 to 35 and 378 to 313	4 years	£ 294,064	£ 281,324	£ 8,058	-£ 12,740	-£ 4,682	£1.58:£1	Y	Reduced GP and CAMHS utilisation, reduced ambulance and hospital costs associated with self-harm, and reduced school absence	NHS, Families
Universal workplace well-being programme	Employees (n=500)	Reduction in absentee-ism and presentee-ism	303% Increase in the proportion of workers maintaining their well-being	Increase in employees maintaining well-being 165 to 199	1 year	£ 97,245	£ 41,050	£ 41,050	-£ 97,245	-£ 56,195	£2.37:£1	Y	Absenteeism-related and Presenteeism-related productivity losses avoided, and GP visits avoided	NHS, Employers
Universal programme of CBT for employees identified as being stressed	Employees (n=1000)	Reduction in employees identified as stressed remaining stressed	13% reduction in the probability of remaining stressed	Reduction in employees remaining stressed by 86 per 1,000 employees	2 years	£ 6,985	£ 3,492	£ 3,493	-£ 6,985	-£ 3,492	£2.00:£1	Y	Avoided GP visits and physical care costs, ultilisation of secondary mental health services, medications, occupational health and LA well-being services, reduced productivity losses, presenteeisma and increased retention	NHS, Local Authority, Productivity
Support for adults experiencing problematic debt, without mental health problems, atteng GP surgeries	Adult population in debt (n=31,950)	Reduction in depression, stress and debt	44% reduction in proportion with unmaneagble debt	Increase in the number of people in debt whose debt is maneagble: 25,879 to 27,669	5 years	£ 65,766,111	£ 59,446,038	£ 2,428,590	-£ 6,320,073	-£ 3,891,483	£2.60:£1	N	GP Visits, Depression treatment, Legal and Debt administration, Workplace stress and absence due to debt, Depression productivity losses	NHS, Legal sector, Productivity
Investing in self-harm and suicide prevention	Incidence of suicide * population (n=779)	Reduction in the number of attempted and completed suicides	41% Reduction in the probability of self-harm	At year 10, 11 non-fatal suicide attempts, and 11 completed suicides prevented	10 years	£ 3,284,605	£ 3,139,842	£ 75,126	-£ 219,889	-£ 144,764	£2.93:£1	N	Ambulance, treatment for suicide and self-harm, ongoing psychological treatment, Productivity losses, Police investigations, Coroner Inquests, Intanible costs	NHS, Local Authority, Police, Productivity losses, Intangible losses
Signposting over 65's to group activities	28,385 of whom 6% (n=1,703) engage with the service	Reduction in loneliness leading to reduction in depression and self-harm	8% Reduction in probability sometimes lonely and 8% reduction in probability sometimes lonely	Reduction in 'always lonely' 630 to 577 and sometimes lonely 986 -903	5 years	£ 2,243,274	£ 2,180,356	£ 49,816	-£ 62,918	-£ 13,102	£1.26:£1	N	Reduced GP Visits, Depression and Self-harm treatments, and increased volunteering rates through signposting	NHS, Volunteers (local community)
Collaborative care for people with long-term physical health conditions	People with diabetes and coronary heart disease	Reduction in rates of depression in people with diabetes and coronary heart disease	21% Reduction in the probability of depression	Reduction in depressed 179 to 160 in year 1 and 203 to 200 in year 2	2 years	£ 4,738,501	£ 4,671,633	£ 44,082	-£ 66,868	-£ 22,786	£1.52:£1	Y	Health and Social Care services, Productivity	NHS, Productivity

12 Appendix A – Scope questions

Questions for the JSNA (following Stakeholder Workshop)								
Key	**Place**	**People**	**Perinatal**	**CYP**	**Adults**	**Older People**	**Service Mapping**	**What Works**
1. What do we mean by mental health and wellbeing? 2. What is the local prevalence and characteristics of mental health and wellbeing? 3. What are the local determinants and factors	1. What are the community assets that support wellbeing and create a socially inclusive community? 2. Who has access to these assets and who does not? 3. How do we maximise the	1. What is the prevalence of mental ill-health in our Boroughs? 2. What are future projections of need? 3. What does the data tell us about wellbeing in the Boroughs?	1. What is the local prevalence of perinatal mental ill-health? 2. What are the risk factors for perinatal mental ill-health? 3. What is the impact of perinatal mental ill-health?	1. What are the specific mental health and wellbeing issues for this age group? 2. What is the pattern of mental health and wellbeing in this age group? 3. What are the risk factors for poor mental wellbeing or ill-health among this age group?	1. What are the risk factors for poor mental wellbeing or ill-health among this age group? 2. What works to improve workplace health and helps people to access employment?	1. What are the risk factors for poor mental wellbeing or ill-health among this age group? 2. What are the facts about social isolation and loneliness in the boroughs? And what works to tackle this? 3. Accessibility: How do we create environments	1. What services and pathways currently exist e.g. primary, secondary care 2. What works/best practice to make services more accessible? 3. Integration of services and integration of commissioning services and its impact on mental wellbeing, and	1. What works to promote and protect wellbeing at different stages of the life course? 2. What works to tackle social isolation and loneliness? 3. What does an effective social prescribing model look like?

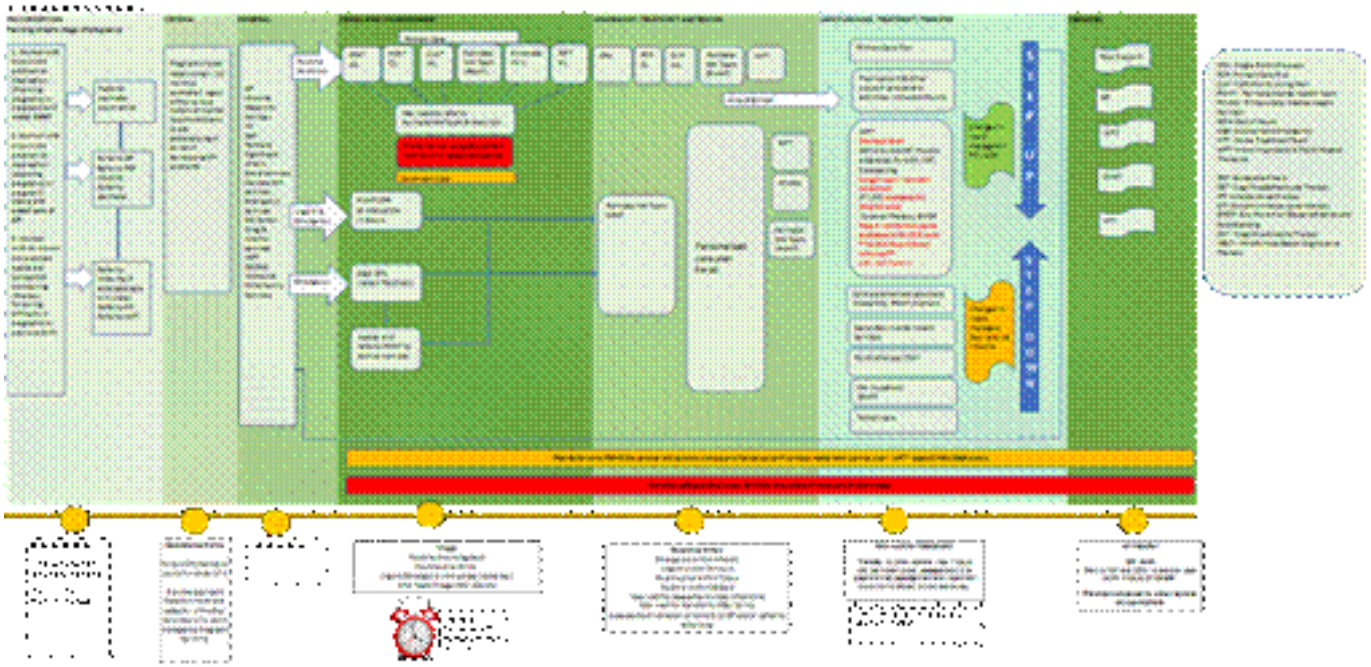
(risk and protective)? 4. What local services and assets in the community are available to meet these needs? 5. What works to promote or protect wellbeing across the life course?	potential of these assets? 4. What are the key determinants for wellbeing in our boroughs?	4. What is the impact of mental illness on individuals, their community and the health and care economy? 5. What are the specific needs at different ages in life?	4. What services are in place for perinatal mental health in the Bi-borough? 5. What support or interventions do parents and families need during the perinatal period?	4. What data do we have for mental health and wellbeing in schools? 5. What is already happening in schools and education to support wellbeing?	3. How do we support individuals and families with low income and those who use the benefits system? 4. How do we reach seldom heard groups?	that are accessible for older people? 4. What are the pre-existing assets and how do we make these accessible? 5. What are the facts around dementia and how do we prevent it/create dementia friendly communities?	the interface between mental and physical health services 4. Can we quantify the number of people who have more than one need that wouldn't be covered by the same service?	4. What interventions are the most cost effective/offer good ROI? 5. How do we measure impact of services/interventions on wellbeing?

6. What are the views and experience of both residents and patients accessing services? 7. What are the potential gaps or areas of unmet need which require local action?		6. What do we know about people who act as carers? 7. What matters to local people and how do we reach seldom heard people?	6. How do we raise awareness of perinatal mental health among the public, parents, and non-mental health professionals?	6. What works to promote and protect mental wellbeing in early years through to adolescence? 7. What role does social media play in mental wellbeing for this age group? 8. How can services best engage with and support particular groups, such as BME or children who find it difficult to communicate? 9. How can we increase the preventative mental	5. What do we know about the wellbeing of those in the criminal justice system? 6. How connected are people living the Boroughs and what works to improve social connectedness?	6. How do we support people to maintain their wellbeing during transitions such as retirement? 7. How do we improve access to adult education?		6. What works to increase uptake of personal budgets?

				wellbeing messages into schools and local communities 10. How do we best support CYP to make the transition to adulthood?				

13 Appendix B - Pathways

13.1 Perinatal Mental Health Care Pathway



13.2 Enhanced Urgent Mental Health Care Pathway for CCGs (2017)