CHILDREN &YOUNG PEOPLE'S MENTAL HEALTH

Drivers & Responses

1. Introduction

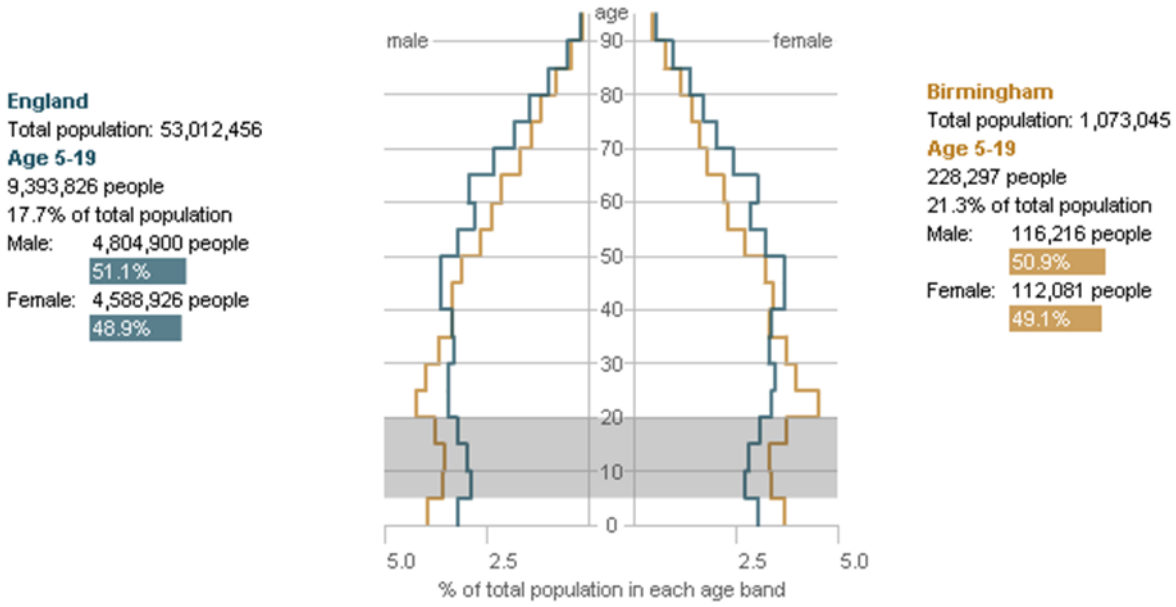
1.1. The Childrens' & Young People's Mental Health service Case for Change document identified difficulties in capacity, continuity, and acceptability of local services resulting in long waiting times, difficult transfers between services, and high dropout rates. The solution offered was to procure a seamless all age service into early adulthood.

1.2. This document takes an initial view of the scope and challenge of this venture in Birmingham.

2. Demography in Birmingham

2.1. Birmingham has a population of just over 1 million people and of this around 21% of this is aged 5-19 years, compared to 17.7% in England. This difference in population structure is shown in the population pyramid (Figure 2.1) where the relevant age range is shaded.

2.2. **Figure 2.1: The Age Structure of Birmingham and England (2013)**

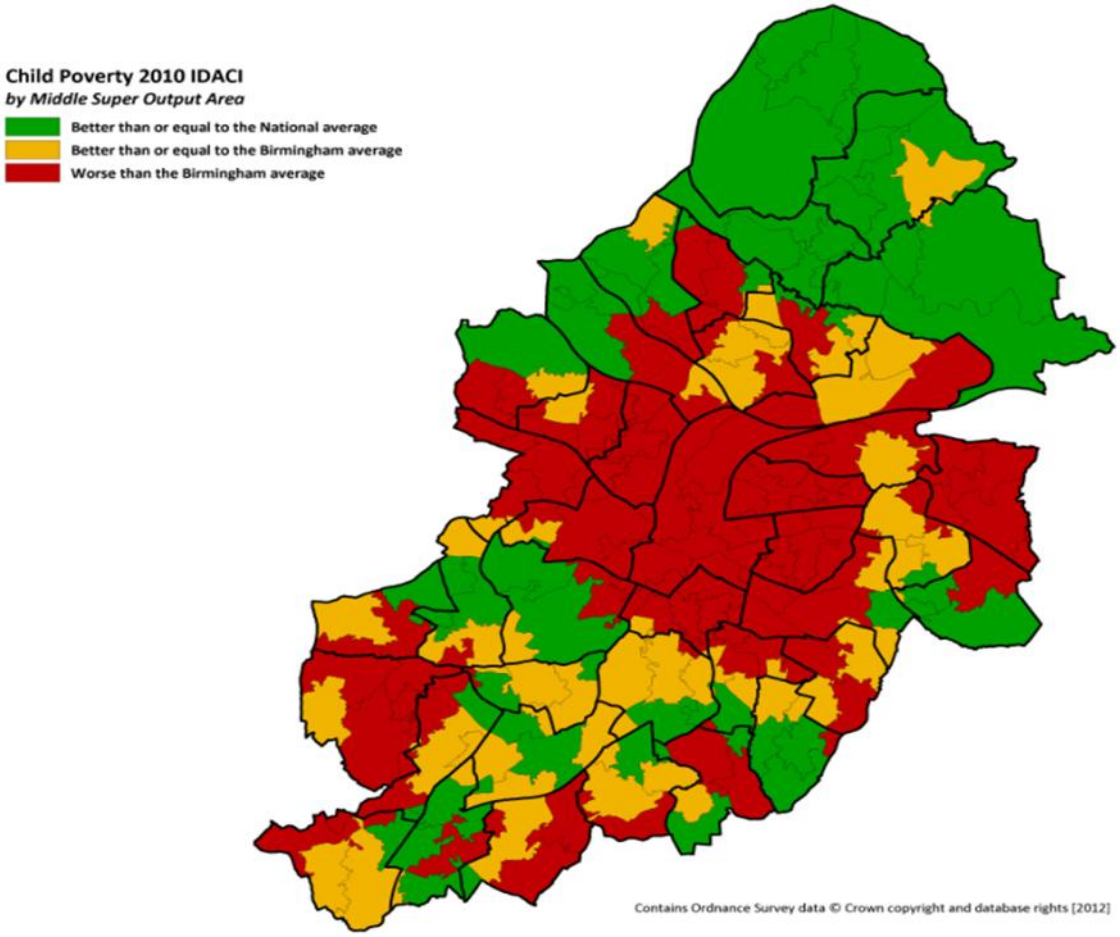


2.3. Birmingham is therefore is a city of young people. In fact 28.8% of the population is under the age of twenty. It is also an extremely ethnically diverse city with 62.9% of school children from a black or minority ethnic group

2.4. The level of child poverty in Birmingham is worse than the national average with 33.5% of children aged less than 16 years living in poverty based on accepted indicators. In particular, the rate of family homelessness is far worse than the England average. The impact of an impoverished childhood upon the emotional health and wellbeing, resilience, and illness of children and young people is significant.

2.5. Children in Birmingham have worse than average levels of obesity. 11.9% of children aged 4-5 years and 24.3% of children aged 10-11 years are classified as obese. 50.8% of children participate in at least three hours of sport a week which is worse than the England average.

2.6. **Figure 2.2: Child Poverty by Electoral Ward in Birmingham (2010)**



3. Predictable Prevalence

3.1. Estimating the number of children and Young People whose emotional health & wellbeing and resilience is challenged is difficult and prone to measurement difficulties.

3.2. Gunnell et al used the Fourth National GP Morbidity Survey (1992) to estimate the General Practitioner consultation patterns for mental illness by young people (16-39 years old)[1]. They compared the consultation rates for all reasons and for mental illness by sex and area of residence (urban or rural) and found that women consulted more than men (Table 3.1).

3.3. Estimates of the prevalence of emotional and behavioural disturbances have been attained by community sampling and assessment research[2,3]. These show much higher rates than suggested by the General Practice consultation rates with interesting differences in gender (Figure 3.1), ethnicity (Figure 3.2), and parental educational achievement, as a proxy for family socioeconomic status, (Figure 3.3) and some change over time[4] (Table 3.2).

3.4. Estimating the number of children and Young People who would benefit from specific or

[1] Gunnell D, Martin R *Patterns of GP consultation for mental illness by young people in rural areas* Health Statistics Quarterly 21 Spring 2004. UK National Statistics

[2] Green H, McGinnity A et al *Mental Health of Children and Young People in Great Britain, 2004* Office for National Statistics 2005

[3] Parry-Langdon N *Three Years On: Survey of the Development and Emotional Wellbeing of Children and Young People* Office for National Statistics 2008

[4] Hagell A, Coleman J, Brooks F *Key Data on Adolescence 2013* Association for Young People's Health

specialist interventions for illness is also fraught with measurement difficulties as much relies on the *visible* illness identified and referred to services. Changes in referral criteria can change/distort these measures. It is clear from the national data[5] that there is a significant variation in the rate of contacts and outpatient appointments with Children and Adolescent Mental Health Services (Figures 3.4 & 3.5). This cannot be explained by any natural variation in the incidence of mental illness in this age group.

3.5. **Table 3.1: Rural and Urban General Practice Consultation Rates for Young People aged 16 to 39 Years (1992)**

Consultation Rate for all reasons

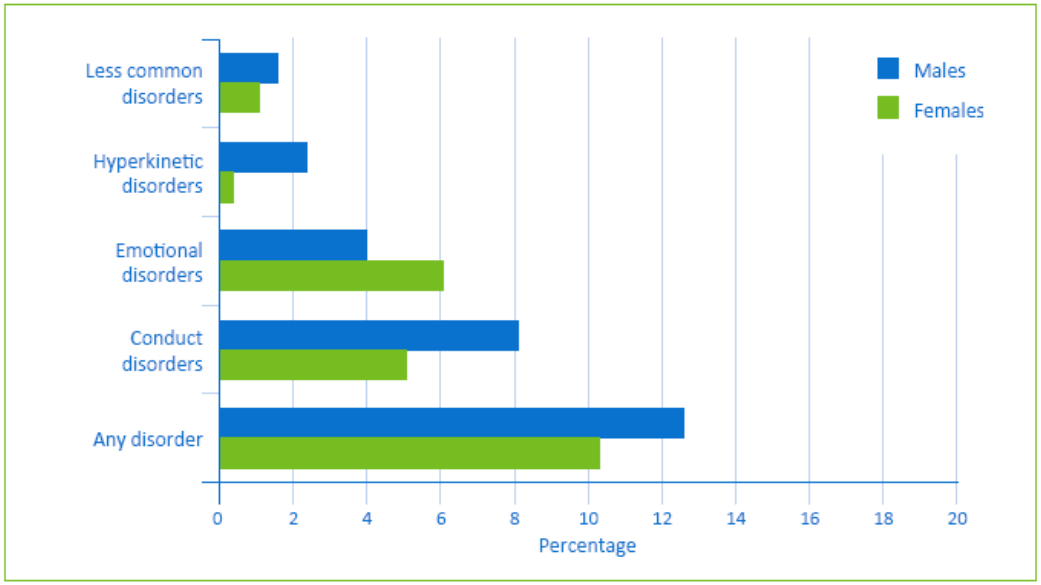
	Men		Women	
	Rate	(95% CI)	Rate	(95% CI)
Urban	2.45	(2.42 to 2.47)	5.42	(5.38 to 5.46)
Rural	2.04	(1.98 to 2.10)	4.67	(4.57 to 4.77)

Consultation Rate for mental disorders

	Men		Women	
	Rate	**(95% CI)**	**Rate**	**(95% CI)**
Urban	0.17	(0.16 to 0.18)	0.37	(0.27 to 0.28)
Rural	0.09	(0.08 to 0.11)	0.21	(0.19 to 0.24)

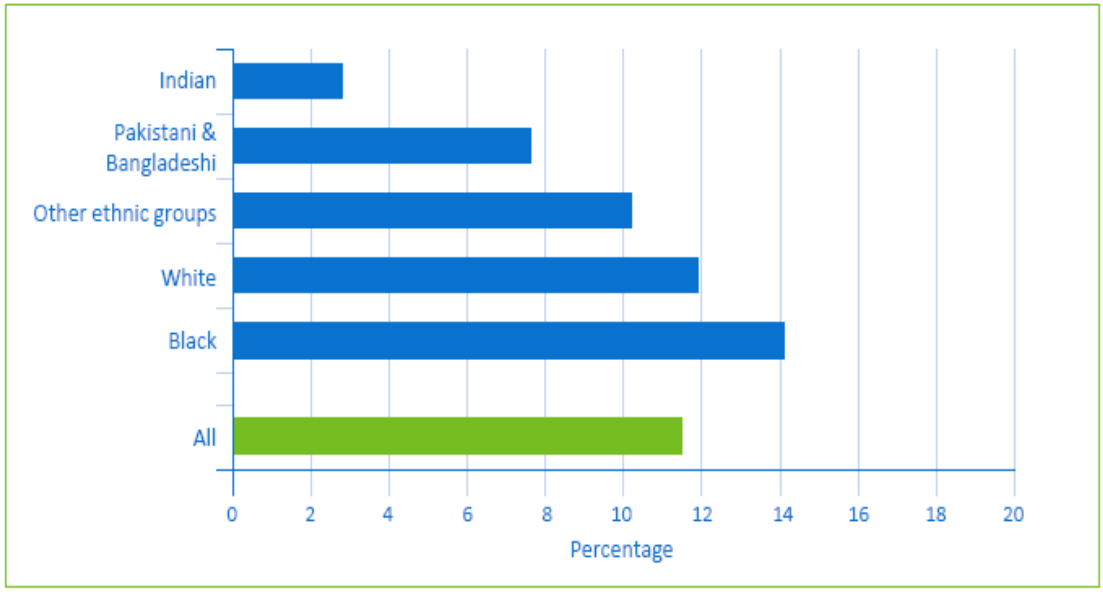
Rate is per person as a % of total cohort.

3.6. **Figure 3.1: Prevalence of Mental Disorders in 11-15 Year Olds in Great Britain (2004)**

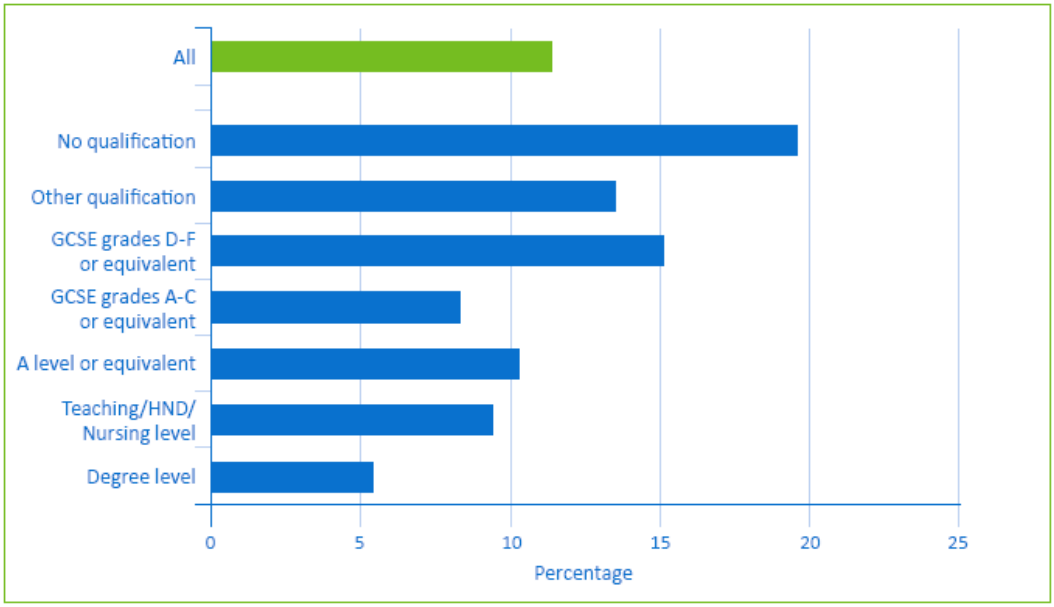


[5] NHS Benchmarking Network *Benchmarking CAMHS Services* May 2012

3.7. **Figure 3.2: Prevalence of Mental Disorders in 11-15 Year Olds in Great Britain by Ethnicity (2004)**



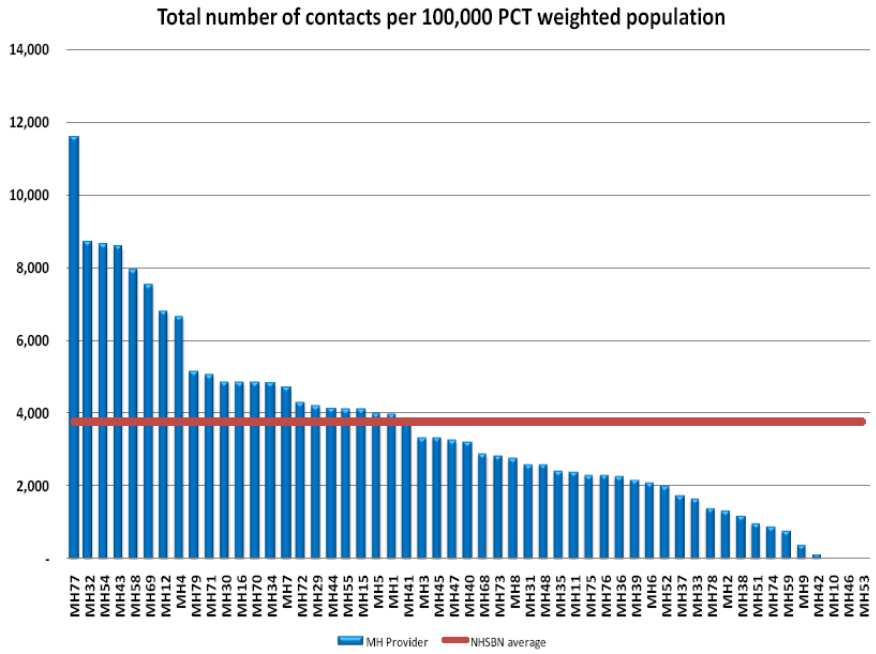
3.8. **Figure 3.3: Prevalence of Mental Disorders in 11-15 Year Olds in Great Britain by Parents educational Background (2004)**



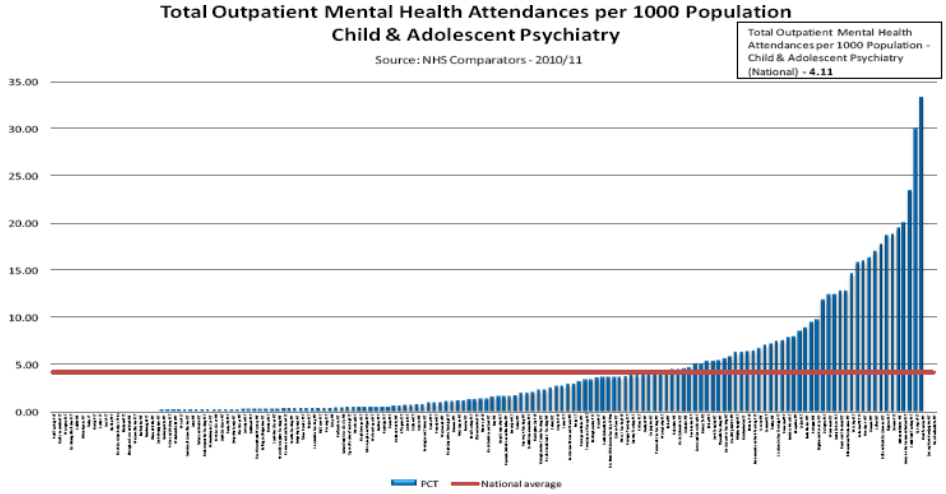
3.9. **Table 3.2: Trends in Mental Disorders in 11-15 Year Olds in Great Britain by Gender (1999 & 2004)**

	Percentage			
	Males		Females	
	1999	2004	1999	2004
Emotional disorders	5.1	3.9	6.1	6
Conduct disorder	8.6	8.8	3.8	5.1
Hyperkinetic disorders	2.3	2.6	0.5	0.3
Any emotional, conduct or hyperkinetic disorder	12.5	12.1	9.2	9.8
Any disorder	12.8	13.1	9.6	10.2

3.10. **Figure 3.4**



3.11. **Figure 3.5**



4. Drivers or risk factors

4.1. The 2004 community sample survey[2] and 2007 follow-up[3] explored the factors associated with the development and persistence of mental health distress and illness. They found that:

4.1.1. **Emotional disorders** were more likely to develop in older children (14-16), especially girls, those with a physical illness, those living in one parent or 'reconstituted' families especially if only two children, and if of low income or no parent working, in rented accommodation. The disorder persisted in 30% of children for 3 years, especially in households in rented accommodation and mothers with 'intermediate' mental health.

4.1.2. **Conduct disorders** were more likely to develop in boys, those with a physical illness, and those with special educational needs, those living in 'reconstituted' families or had changed from two to one parent especially if there are three or more children or mother had n educational qualifications, living in rented accommodation or no parent was working. The disorder persisted in 43% of

children for 3 years, especially in older children (11-13, those with specials educational needs, and lower income families.

4.2. They also found that the children's emotional resilience was enhanced or undermined by the quality of their relationships and their perception of the safety of their community.

4.3. These findings may seem to be more relevant to attempts to prevent these disorders arising but they also give an important insight into the factors that should be assessed and addressed in all interventions to reduce the impact of the disorder but especially any opportunities to intervene early in the development of these disorders.

5. Children & Young People's Health & Wellbeing in Birmingham

5.1. How are these insights reflected in the experience of the children and Young People of Birmingham?

5.2. Each year a survey of a sample of children and Young People is undertaken in schools[6]. The results of this suggests that:

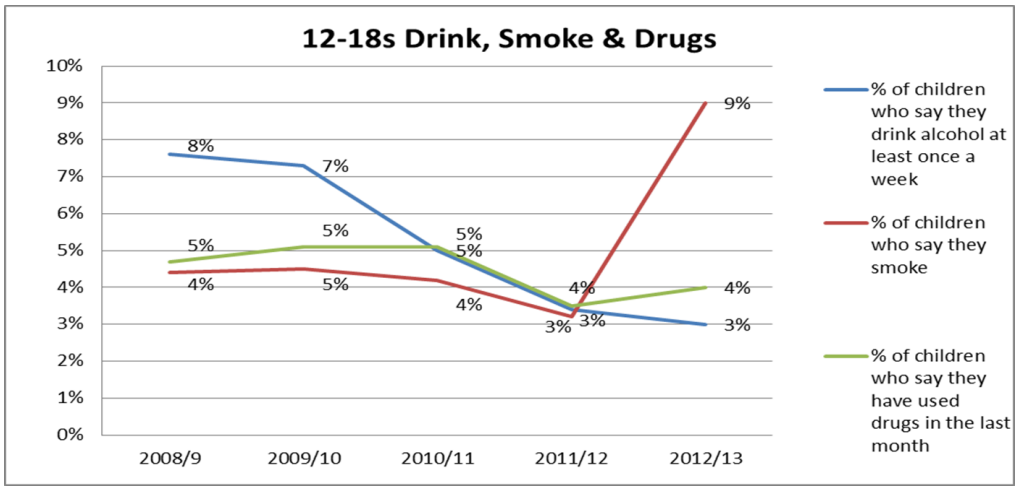
5.2.1. 3% of 12-18s said they drink at least once a week

5.2.2. 9% of 12-18s said they smoke (The figures are changed hugely as the way this information was been recorded had a fault which is now rectified and the figures from 12/13 will reflect the true picture)

5.2.3. 4% of 12-18s said they had used drugs in the last month

5.2.4. Alcohol consumption has decreased over the years and have been similar in last two years.

5.3. **Figure 5.1:**



5.4. In Junior School students it was reported that:

5.4.1. 14% of children have significant behaviour problems. This appears to have reduced in comparison to previous years

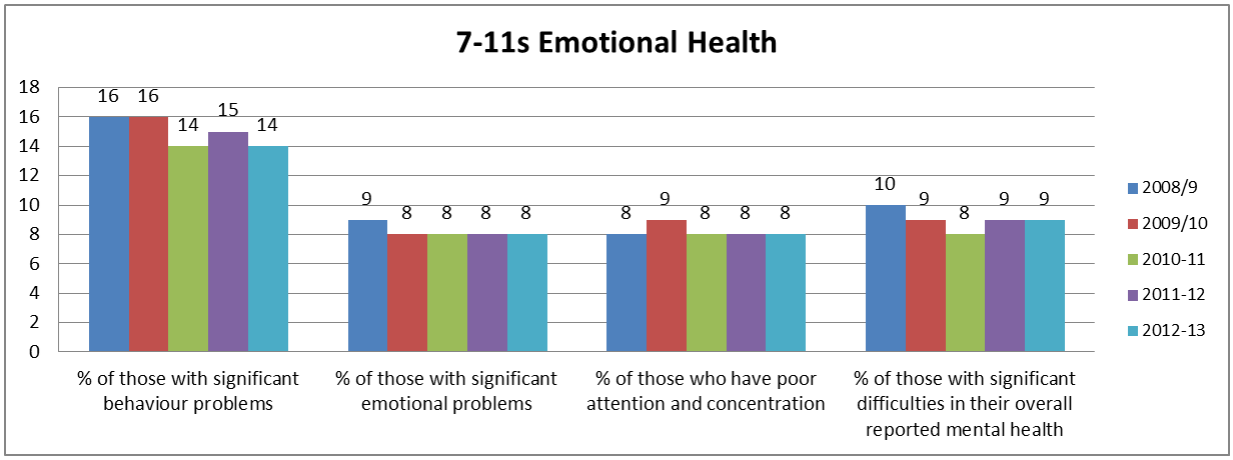
5.4.2. 8% of children have significant emotional problems (e.g. anxiety and depression).

5.4.3. 8% of children have problems with attention, concentration or hyperactivity.

5.4.4. 9% of children have difficulties in their overall mental health.

[6] Syed Z *Child Wellbeing Survey 2012-13* Birmingham City Council 2013

5.5. **Figure 5.2**



5.6. In Secondary School students it was reported that:

5.6.1. 14% of children have significant behaviour problems/conduct disorders, which appears to be a light increase in 12/13.

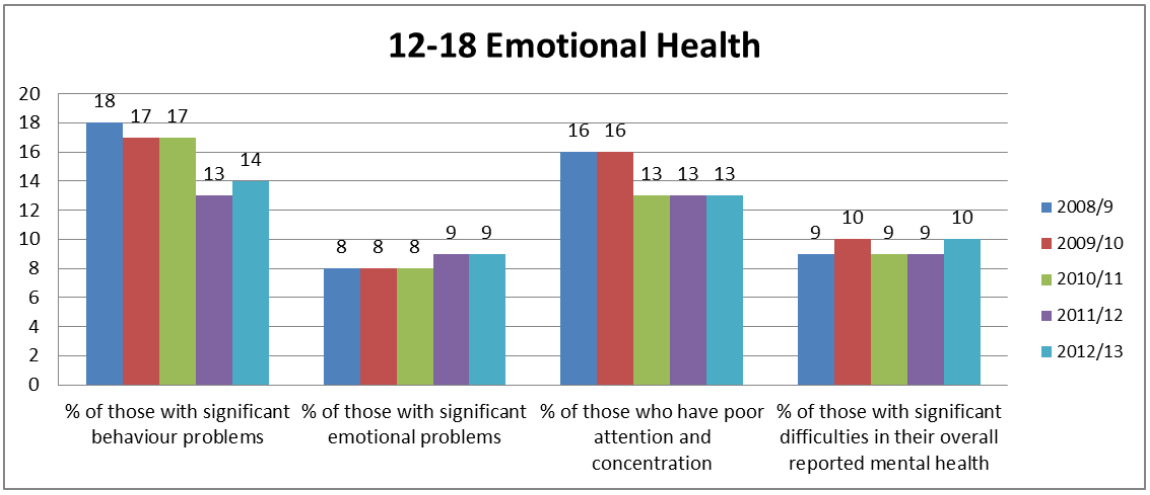
5.6.2. 9% of children have emotional problems

5.6.3. 13% of children have poor attention and concentration.

5.6.4. 10% have overall difficulties in their mental health, which also appears to be a slight increase compared to previous years.

5.6.5. Note a higher proportion of 12-18s compared to 7-11s have poor attention and hyperactivity problems (13% vs. 8%) and overall difficulties (10% vs 9%). However, a similar proportion have emotional and behaviour problems.

5.7. **Figure 5.3**



5.8. The reports of students relationships and social skills suggest that:

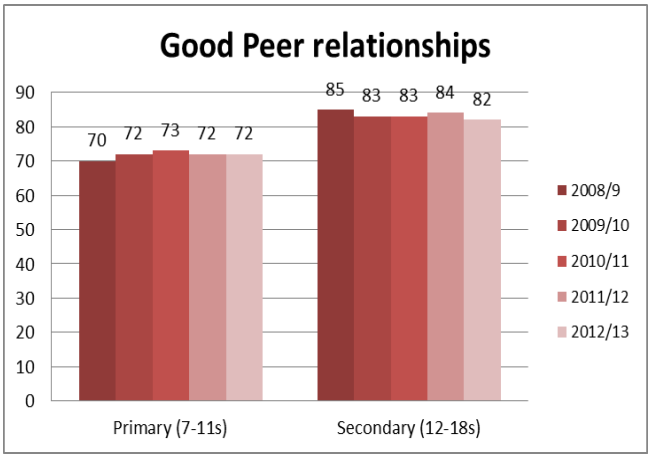
5.8.1. 72% of 7-11s and 82% of 12-18s have good peer relationships

5.8.2. 8% of 7-11s and 2% of 12-18s have significant problems with peer relations (e.g. preferring to play alone, not having at least one good friend, being picked on by other children etc)

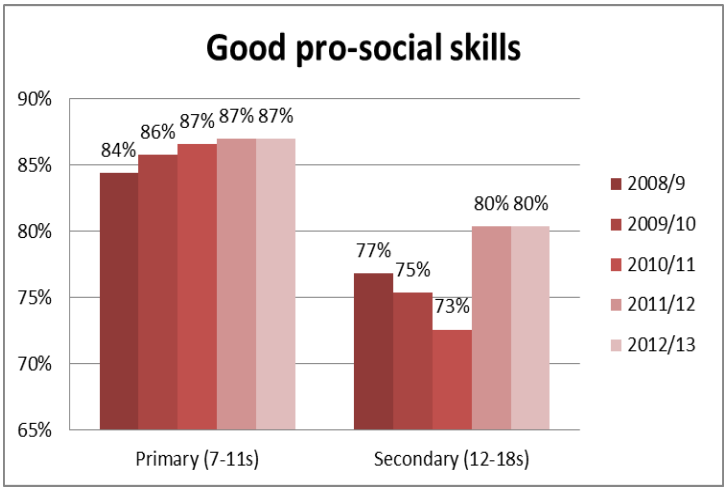
5.8.3. 87% of 7-11s and 80% of 12-18s have good pro-social skills.

5.8.4. 8% of 7-11s and 14% of 12-18s have significant problems with pro-social skills (e.g. being considerate of others feelings, sharing, being helpful if someone is hurt, being kind and volunteering to help etc)

5.9. **Figure 5.4**



5.10. **Figure 5.5**



5.11. There are some striking differences in these patterns when compared with the national norms, namely:

5.11.1. 8% of 11-15s who completed the survey in Birmingham have emotional problems compared to the national average 5%.

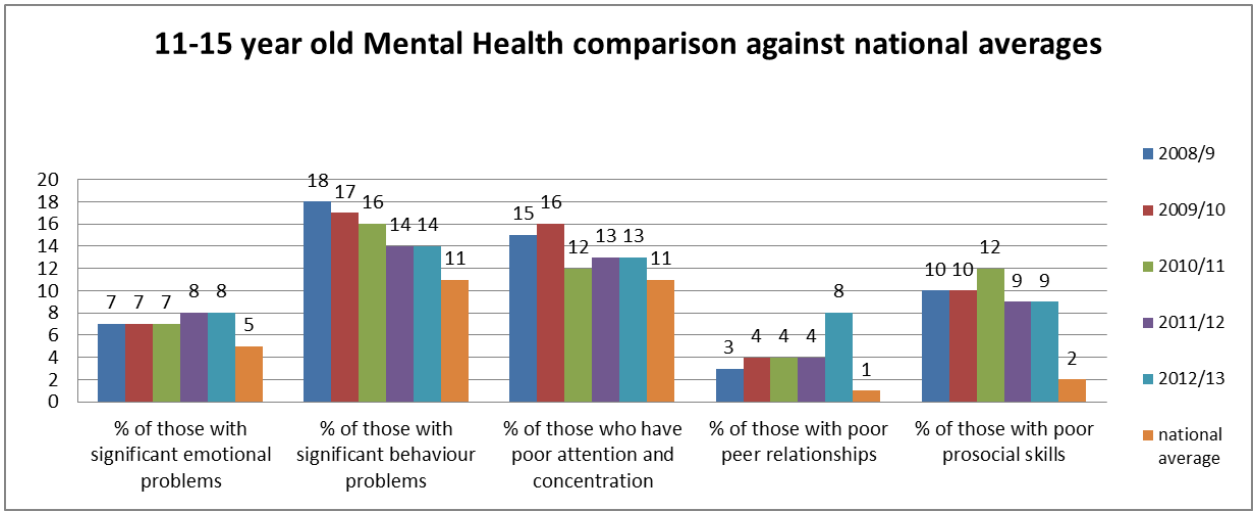
5.11.2. 14% of 11-15s who completed the survey in Birmingham have conduct disorders compared to the national average 11%. Although there appears to be a decrease in trend, it still has been consistently higher than the national average.

5.11.3. 13% of 11-15s who completed the survey in Birmingham have poor attention and concentration, compared to 11% national average.

5.11.4. 4% of 11-15s who completed the survey in Birmingham have poor peer relationships compared to the national average 1%.

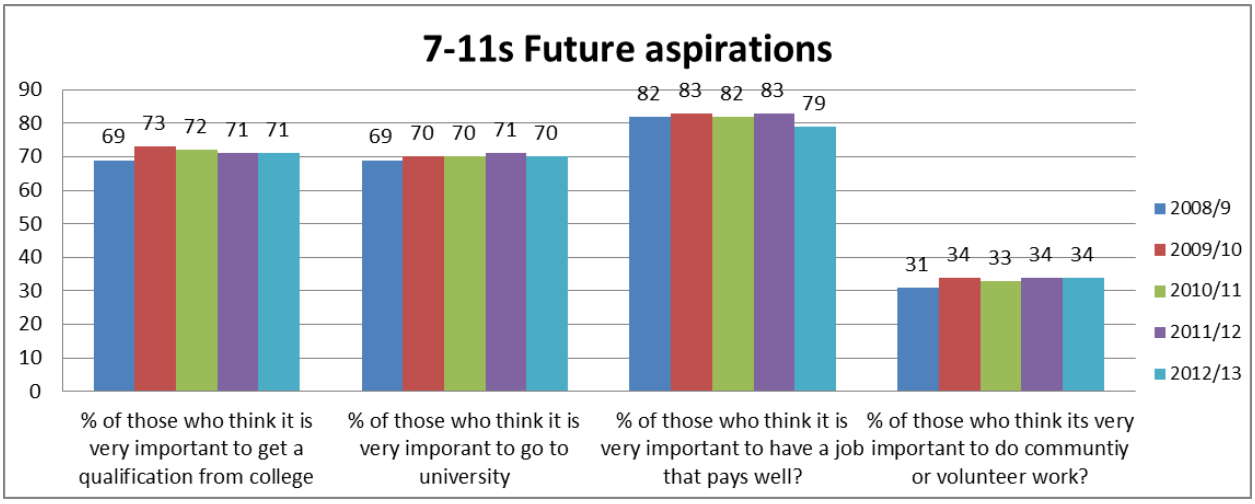
5.11.5. 9% of 11-15s who completed the survey in Birmingham have poor pro-social skills compared to the national average 2%.

5.12. **Figure 5.6**

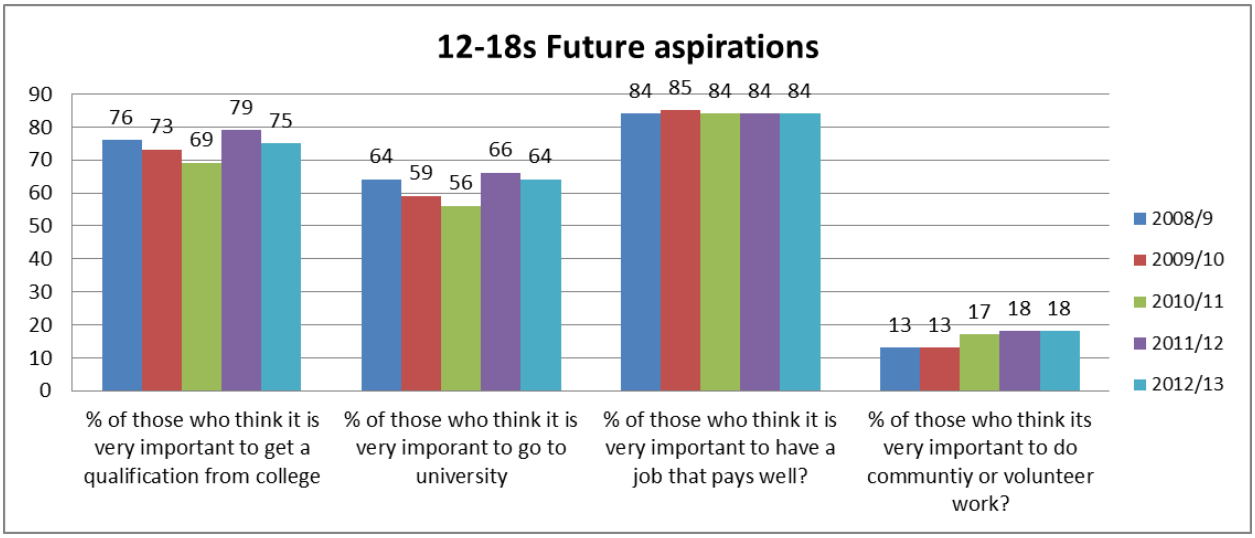


5.13. Over the past five years 20% of junior school students and 10% of secondary school students reported being quite often bullied. Over the same timeframe all children have been reporting similar proportions of future aspirations although university aspirations are lower in secondary school students.

5.14. **Figure 5.7**



5.15. **Figure 5.8**

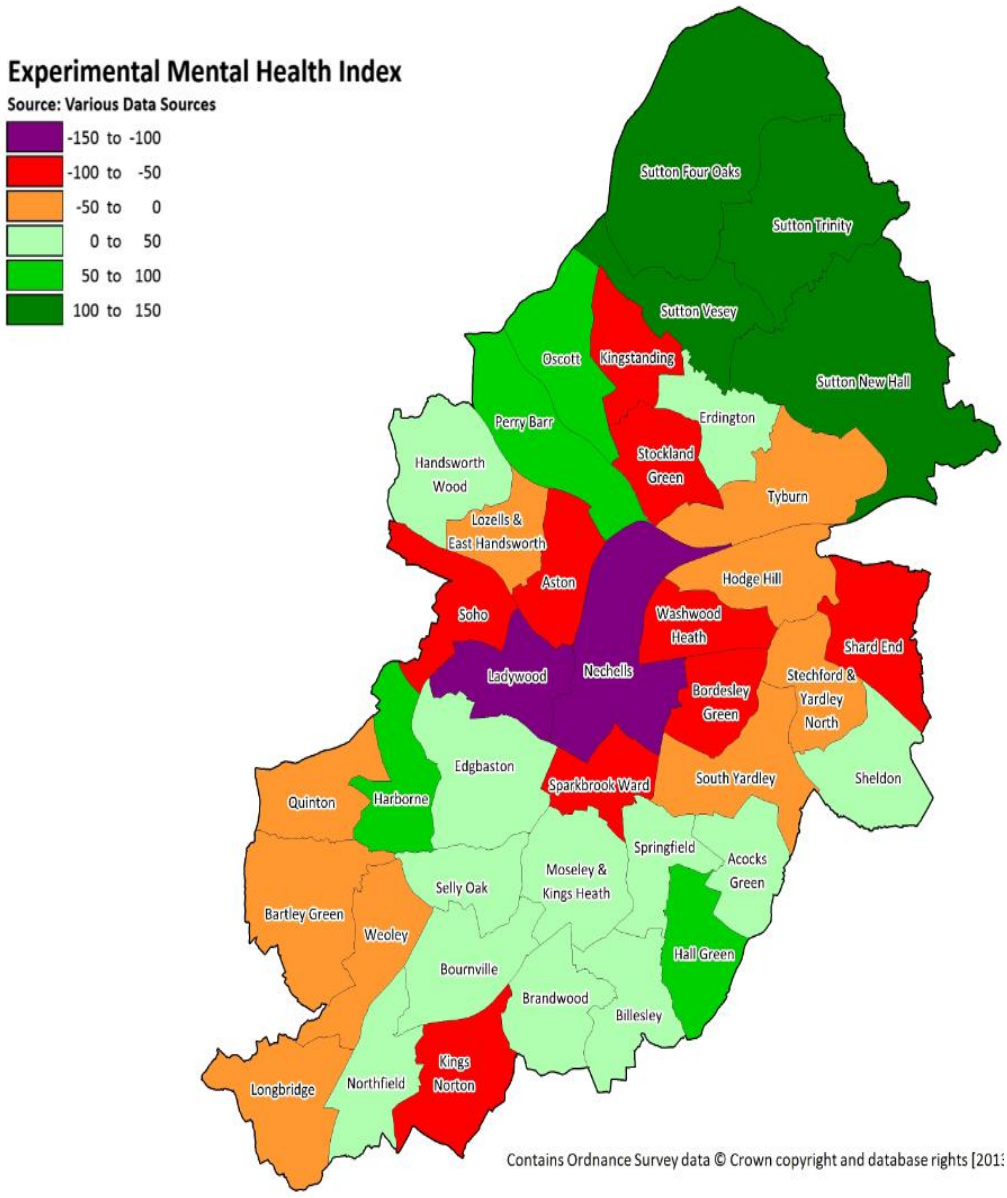


5.16. Can this national and local research assist us in predicting where our communities of greatest need might be?

5.17. An attempt to do this resulted in a local Mental Health Index. It scored the factors identified in the published research to have an impact upon children's emotional health. It was then used to identify communities with a more or less of these factors and therefore an influence on the likelihood for the children to develop emotional distress or mental illness.

5.18. The city average for each of the identified indicators was set at zero, with wards scoring better than average receiving a positive score and those scoring worse than average a negative one. The index was calculated by averaging the scores of the indicators within a particular ward. i.e. the lower the score the worse the index[7] (Figure 5.9).

5.19. **Figure 5.9:**



5.20. The national profiles of Childrens Health[8] compare Birmingham with core cities and national benchmarks. These do not however enable us to see more localised insights

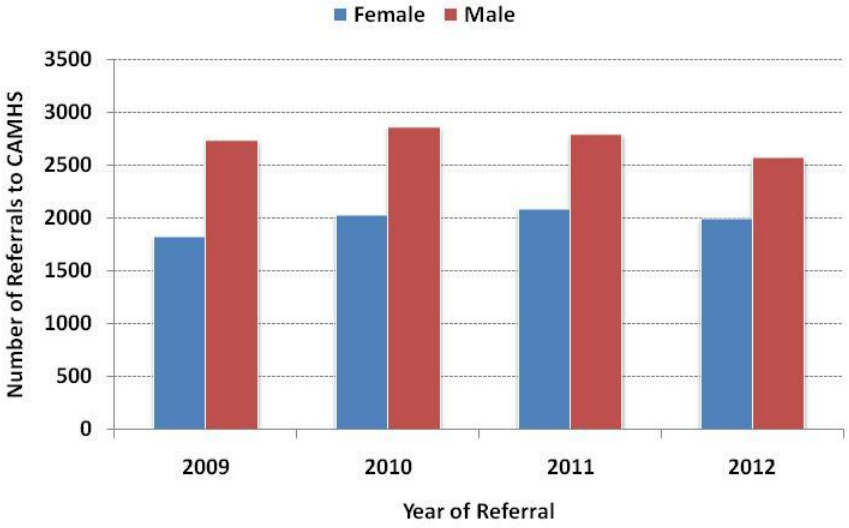
[7] Mahmood H *Mental Health Resilience in Children & Young People: An Index of Susceptibility* Birmingham Public Health, Birmingham City Council 2013

[8] CHIMAT *Birmingham Child Health Profile* PHE March 2014

upon which to shape our service responses.

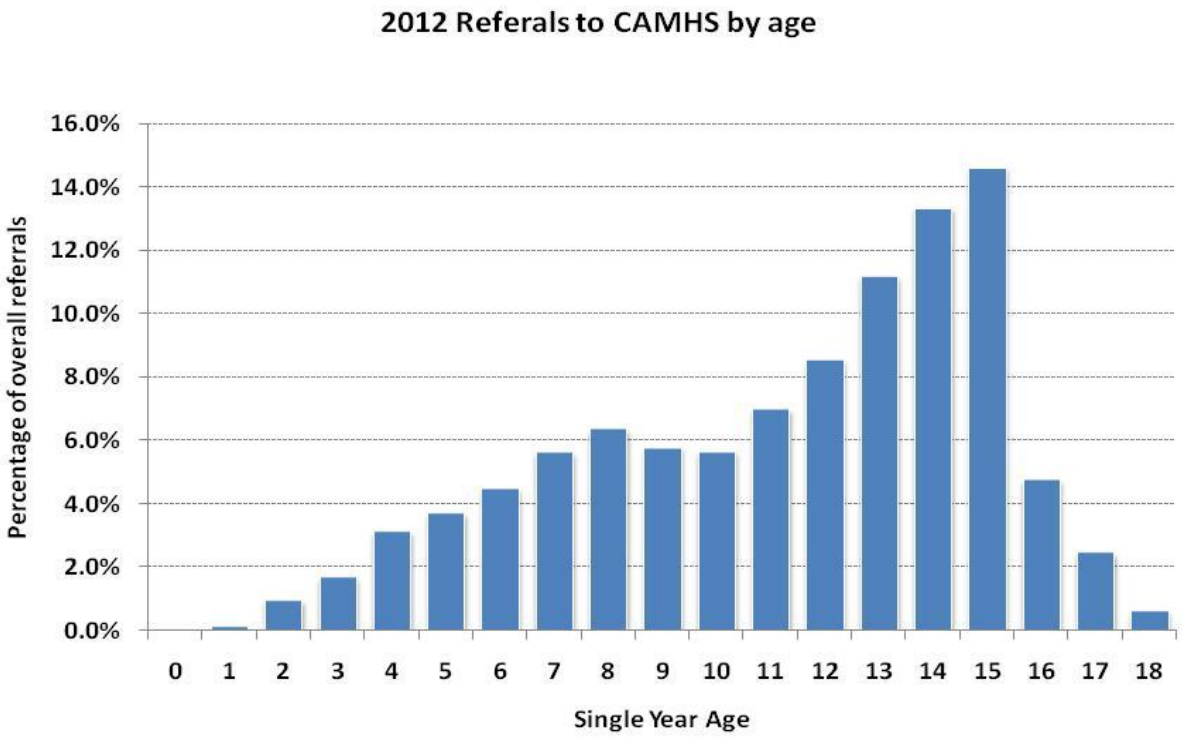
5.21. It is clear from the data presented earlier (Figures 3.4 & 3.5) that there is a lot of unwarranted variation in reported activity. Nevertheless local provider data can start to shape our understanding of the local demand. The number of referrals taken by the Birmingham Child & Adolescent Mental Health Service seems stable (Figure 5.10) which, given the local concerns about waiting times and difficulties of access, would suggest service saturation rather than a stable demand.

5.22. **Figure 5.10: Number of Referrals to Child & Adolescent Mental Health Service in Birmingham (2009-2012)**



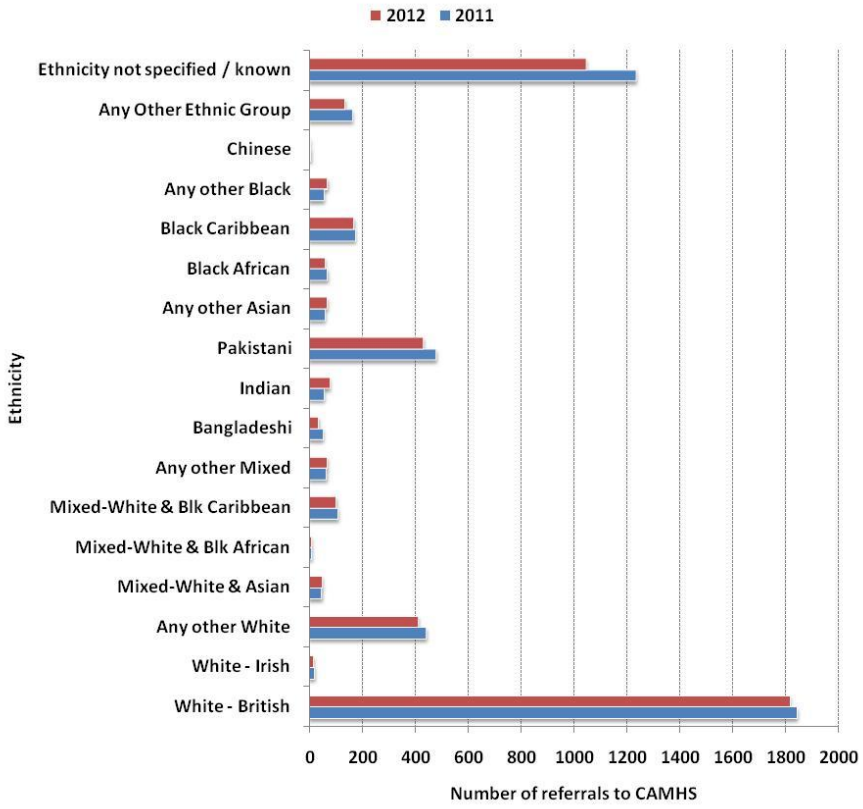
5.23. The Age specific proportions of these referrals in 2012 suggests two peaks of primary and later secondary school students possibly reflecting two different needs (Figure 5.11)

5.24. **Figure 5.11:**



5.25. The known ethnicity of referrals (Figure 5.12) does not appear to reflect the city wide picture (paragraph 2.3) but this might be masked by the large number of referrals whose ethnicity is not specified or known, i.e. not recorded.

5.26. **Figure 5.12: Ethnicity of Child & Adolescent Mental Health Service referrals in Birmingham**



6. What's Needed & What Works?

6.1. The work of Field[9], Munro[10], Allen[11], and Marmot[12] has been developing the case for earlier intervention to prevent or diminish the development of child and family dysfunction leading to impaired Health & wellbeing of children and an adverse impact upon their achieving their potential. This feeds into impaired next generation functioning with recurrent socioeconomic disadvantages and achievements.

6.2. Allen in particular called for action to set up a culture of early interventions to develop a virtuous spiral out of recurrent difficulties. The evidence for this case is developed in more detail by a local Task & Finish Group[13].

6.3. The work of this Task & Finish Group identified there were two groups of early interventions. **Reactive Early Interventions,** namely interventions delivered early in the development of a child's or family struggle thereby preventing escalation of need for

[9] Field F *The Foundation Years: Preventing Poor Children Becoming Poor Adults The Report of the Independent Review on Poverty and Life Chances* Department of Health December 2010

[10] E Munro, 2010: *The Munro review of child protection interim report: The child's journey*; www.dera.ioe.ac.uk

[11] Allen G. 2011; *Early Intervention: The Next Steps*, www.dwp.gov.uk/docs/early-intervention-next-steps.pdf

[12] Marmot review report; *Fair Society, Healthy Lives* 2010

[13] *EARLY INTERVENTIONS TO IMPROVE THE HEALTH & WELLBEING OF CHILDREN & YOUNG PEOPLE OF BIRMINGHAM: Findings of a Search for the Evidence of Effectiveness and the Analysis of Local Descriptive Epidemiological Data* Birmingham City Council 2013

specialist assistance, and **Programmed Early Interventions** which are delivered early in the child and family's life with the aim of reducing the likelihood of difficulties arising in the first place and enhancing the child's development to improve the likelihood of achieving their full potential. Both are an important part of the virtuous spiral described by Allen[11].

6.4. The Task and Finish Group supported the commissioning of services that strengthen family functioning and build resilience through evidence-based interventions such as **Functional Family Therapy, Family Group Conferencing** and **Solution Focussed Therapy.** The approaches aim to change family interaction and family relationships, and through this, individual problem behaviour.

6.5. Established challenging behaviours or conduct disorders in young people were identified as requiring attention through the use of evidence-based interventions that tackle challenging behaviour in children such as specific **Cognitive Behaviour Therapy Programmes** related to **Aggression Reduction Therapy** and **Multi-Systemic Therapy.** These programmes combine elements of direct work with young people, parenting support and practical assistance with the aim of rebuilding relationships between the young person, the family and the networks around them. The approach equips the family with the tools to solve problems in the future, thereby effecting sustainable change such as reducing anti-social behaviour and enabling children to live safely at home.

6.6. In response to the mental health needs of young people, it was proposed that the systematic use of **Cognitive Behaviour Therapy** by health professionals is increased and available early at the point of identified need for teenagers with anxiety, depression or psychological issues

6.7. **Selective Programmed Early Intervention** is the rationale of the *Right Service, Right Time* framework adopted locally by the Birmingham Safeguarding Children Board. In Birmingham there are programmes which have been shown to have a positive impact upon children and families before entrenched problems have arisen, namely Family Nurse Partnership, Triple P, Safe Care, Incredible Years and Promoting Alternative Thinking Strategies.

7. Concluding Thoughts

7.1. The Task and Finish Group were focussed on the commissioning of reactive and programmed Early Interventions. These and the evidence base of effectiveness of brief and specialist interventions, often but not exclusively appraised by National Institute of Clinical Excellence, should be incorporated into the service specification for the proposed Children, Adolescent, and Young Adult Mental Health Service.

7.2. It is clear that there needs to be in place a range of opportunities for earlier intervention to reduce the need for more complex or specialist interventions in order to limit the damage that distress, dysfunction, and illness has on children, Young People, and their families.

7.3. Figure 7.1 attempts to draw these themes together and may be a framework for commissioning this system of response and care. It does not colour in the specific interventions or settings but provides a framework into which these can be placed once agreed.

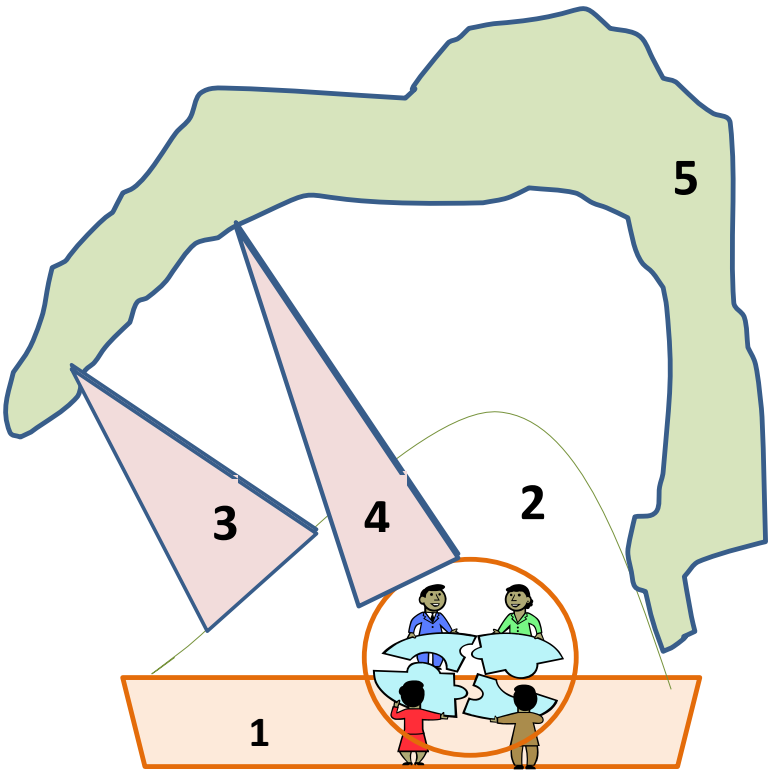
7.4. The evidence presented and referenced does give some indicators of some current stronger approaches. It also reminds us[2,3] that Children and Young People do not live in isolation but in families and communities which have an influence. All service and

intervention approaches will have to take this into account by adopting a Think Family approach and having connections to other adult and social organisations.

7.5. The Map of Mental Health Index (Figure 5.1) should aid the discussion of setting distribution according to likely need.

7.6. The ambition here is to encompass the whole life course of children, adolescents and Young Adults. The age distribution of current Child & Adolescent Mental Health Service clients (Figure 5.11) reminds us that different ages bring different challenges and needs. This has to be reflected and explicit in any service specification.

7.7. **Figure 6.1:**



Applying the Right Service Right Time Early Intervention Approach

The Family trying to put the pieces back together are at the heart of this approach.

1= The Social Network of extended family, neighbourhood, school, faith group, workplace etc.

2= Generalist services with undifferentiated accessibility to and by the family and assessment skills +/- brief interventions (e.g. GPs, Health Visitors, School Nurses, Children Centres)

3= Targeted model with a range of more specialist skills and interventions, which may overlap with 5, and with a referral portal by generalists

4= Targeted model with a range of specialist skills and interventions which is accessible directly by families or through the generalists.

5= The specialist services for complex or intensive needs.

Dr Dennis Wilkes MRCGP FFPH
Consultant in Public Health (Childrens Health & Wellbeing)
Birmingham City Council
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