Richmond
Mental Health Needs Assessment

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Public Health

LONDON BOROUGH OF RICHMOND UPON THAMES

Contents

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Acronyms

A&E: Accident & Emergency
ACE: Adverse Childhood Experience
ADHD: Attention Deficit Hyperactivity Disorder
AMHP: Approved Mental Health Practitioners
APMS: Adult Psychiatric Morbidity Survey
ASC: Adult Social Care
ASCOF: Adult Social Care Outcomes Framework
ASD: Autism Spectrum Disorders
CCG: Clinical Commissioning Group
CAHMS: Children and Adolescent Mental Health Services
CBT: Cognitive Behavioural Therapy
CECS: CAMHS Emergency Care Service
CMD: Common Mental Disorder
CMHT: Community Mental Health Team
CQC: Care Quality Commission
CRHTT: Crisis Resolution Home Treatment Team
CYP: Children and Young People
EMHIP: Ethnicity and Mental Health Improvement Project
GAD: Generalised Anxiety Disorder
GLA: Greater London Authority
GP: General Practice
HBPoS: Health Based Place of Safety
HES: Hospital Episode Statistics
HRBQ: Health-Related Behaviour Questionnaire
IAPT: Improving Access to Psychological Therapies
ICS: Integrated Care System
IMD: Index of Multiple Deprivation
KARAT: Kingston and Richmond Assessment Team
LA: Local Authority
LAS: London Ambulance Service
LD: Learning Disability
LGB: Lesbian, gay and bisexual
LGBTQI: Lesbian, gay, bisexual, transgender, questioning and intersex
LGB: Lesbian, gay, bisexual
MHA: Mental Health Act
MHAA: Mental Health Act Assessment
MHNA: Mental health needs assessment
MHST: Mental Health Support Team
NHS: National Health Service
NICE: National Institute for Health and Care Excellence
OHID: Office for Health Improvement and Disparities
ONS: Office for National Statistics
OP: Older People
PBS: Positive Behaviour Support
PHE: Public Health England
PICU: Psychiatric Intensive Care Unit
PTSD: Post-Traumatic Stress Disorder
QOF: Quality and Outcomes Framework
S136: Section 136
SEND: Special Education Needs and Disabilities
SMI: Severe Mental Illness
SPA: Single Point of Access
SWL: South West London
SWLStG: South West London and St Georges (Mental Health Trust)
UK: United Kingdom

Recommendations

Children and young people

1 Develop a public mental health strategy to prevent mental disorder and improve community resilience.
2 Provide appropriate advice, information and training to help parents and carers develop increased resilience in children and young people.
3 Increase access to targeted early help services to reduce adverse childhood experiences
4 Increase the coverage of Mental Health Support Teams to cover all schools and colleges.
5 Consolidate whole-school approaches to improve the mental health and well-being of children and young people.
6 Increase access to advice, guidance, and targeted early intervention to meet the unmet mental health needs of children and young people.
7 Implement a needs-based system of support for children experiencing mental health disorder based upon the Thrive Framework.[1]
8 Support vulnerable children and young people (Carers, SEND, LGBTQ+, children in need) to access evidenced-based prevention and early intervention programmes in universal settings.
9 Integrate voluntary and third sector provision with the statutory services to provide a seamless comprehensive Child and Adolescent Mental Health Service.
10 Develop and disseminate clear care pathways for children and young people's mental health need based upon NICE guidance.
11 Evaluate the effectiveness of the Kooth Mental Health Programme to meet children and young people's mental health need
12 Improve communication, support and resources for children and families waiting for treatment.
13 Develop and communicate a clear guide of local community, voluntary sector and national resources to support children and families to access appropriate levels of support.
14 Increase access to targeted support for children and young people with emerging anxiety, depression and self-harm.
15 Improve crisis care, self-harm, and suicide prevention pathways by implementation of the self-harm prevention toolkit in universal services.
16 Increase the provision of early intervention (tier 2) targeted support for children and young people with emerging anxiety and depression.
17 Explore ways to increase referrals of boys and young men into early intervention services.
18 Work closely with parents and carers of children with special educational needs to co-produce effective care and support interventions.
19 Prioritise a multi-agency, multi-disciplinary workforce development strategy to improve recruitment and retention of children's workforce.

Adults and Older Adults

1 Develop clear and accessible evidenced-based treatment pathways to support residents with mental health disorders.
2 Build capacity in the community and voluntary sector to support care and recovery.
3 Improve the uptake of psychological therapies for 18–24-year-old women.
4 Review service provision to ensure adequate support for the increasing numbers of residents experiencing trauma-related conditions especially in young adult populations.
5 Explore ways to reduce the number of people who do not attend appointments.
6 Increase the representation of ethnic minority groups in early intervention services.
7 Explore the impact of changes to access services e.g. e-consultations on certain groups including older people, ethnic minorities and those from low socioeconomic backgrounds
8 Improve access to psychosocial support for the family and carers of people with dementia including bereavement and talking therapy services.
9 Support primary care to systematically identify and screen carers and people with long-term conditions for common mental disorder.
10 Increase access to appropriate psychological therapies for older people.
11 Place increased emphasis on maintaining recovery to avoid mental health crisis.
12 Improve integrated working for people with co-occurring mental health and substance misuse conditions.
13 Prioritise workforce development plans to improve recruitment and retention of mental health professionals.
14 Improve engagement and support for vulnerable groups including LGBTQI+, those with learning needs and neurodiverse communities.
15 Implement the Richmond Suicide and Self-Harm Prevention Strategy, focussing particularly on improving crisis support for people experiencing financial hardship.
16 Ensure maternity, general practice and health visiting services effectively implement perinatal mental health care pathways[2]

Introduction

Good mental health, like good physical health, is vital for leading a healthy and happy life.

Our mental health affects how we make choices; how we relate to others; how we build resilience and recover from stressful life events; and significantly contributes to our overall health and wellbeing. Never has this been more evident than during the COVID-19 pandemic. This mental health needs assessment for Richmond upon Thames, referred to as Richmond for the remainder of the document, provides a timely review of the mental health needs of the borough's residents, charting how mental health affects us from childhood through to old age, including the imprint left by the pandemic.

Mental health is defined by the World Health Organisation as, "a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community". [3]

Mental health problems are common. At any one time, one in four adults and one in ten children (aged 5–16) experience a mental health problem.[4] Mental ill health has significant effects on the lives of individuals, families and communities, and has broad impacts across social, educational, occupational and health outcomes. This has become more evident during the COVID-19 pandemic.

Along with substance abuse, mental illness accounts for 21.3% of the total burden of disease in England.[5] The estimated economic cost to the UK is £118 billion a year, equivalent to 5% of the GDP.[6]

Anyone can experience mental ill health though certain groups are at a significantly higher risk. Social inequality is a significant driver of mental ill health as unfavourable social, economic, and physical environments increase the risk of becoming unwell. These avoidable and unfair disadvantages often start before birth and accumulate throughout life. Half of mental health problems are established before the age of 14 and three quarters are established by 24 years, demonstrating the importance not only of early identification and treatment but also of prevention. Taking early action to prevent ill health and encourage wellbeing is therefore the cornerstone of improving mental health across the population.

Why Undertake a Mental Health Needs Assessment?

A health needs assessment is a systematic process to assess the health problems facing a population. This includes determining whether certain groups appear more prone to illness than others and identifying any inequalities in service provision. The aim is to maximise the health gain from available resources by identifying priorities for commissioning.

The last mental health needs assessment for Richmond was undertaken over a decade ago, and since then, the profile of mental health has significantly increased. The NHS Long Term Plan, launched in 2019, committed to improving access to mental health support for those who require it.[7] National evidence suggests that there is a growing number of people seeking help from mental health services, and that this has been exacerbated by the COVID-19 pandemic.[8] Anecdotally, there is evidence that mental health need in Richmond is growing, and this needs assessment endeavours to investigate and examine this hypothesis.

The MHNA will provide a systematic evidence base for future policy and commissioning intentions in Richmond for the next five years and help to ensure that services are sufficiently equipped to ensure sufficient, effective and safe delivery of mental health services to meet the needs of all Richmond residents.

Aims and Objectives

The MHNA will provide an overview of the impact of mental health disorders across the life-course and assess the current challenges facing commissioned services in meeting this need. The life-course cohorts are as follows:

- Childhood and adolescence (0-19 years)
- Working age and adults (16-64 years)
- Older people aged 65+

The aims of the needs assessment are to:

- Understand the level of mental health need in Richmond and how this is being met by services.
- Inform policy and commissioning intentions for mental health services in Richmond over the next five years.

This will be achieved by:

- Estimating the scale of mental health need in the Richmond population, including groups at increased risk of mental ill health.
- Estimating levels of unmet mental health need.
- Understanding the impact of the COVID-19 pandemic on the mental health of the Richmond population and whether any specific groups have been disproportionately affected.
- Developing recommendations for more effective and efficient services that better meet the mental health needs of the population.

Methodology

This health needs assessment uses the following approaches:

- **Epidemiological:** considering the epidemiology of mental health disorders across the population, current service provision, and the effectiveness and cost-effectiveness of interventions and services.
- **Comparative:** comparing service provision between different populations and boroughs with a similar population.
- **Corporate:** eliciting the views of stakeholders including professionals and service users.

Steering Groups

Health needs assessments require a multi-disciplinary approach and engagement from a range of stakeholders. Two steering groups were formed – one for CYP, the other for adults and older adults – to guide the development of the needs assessment and support strategic decision making. Members of the steering groups included representation from South West London CCG, Children's Services, Social Care, the Data, Insights and Analytics Team, voluntary sector organisations and the local mental health trust. Both steering groups met monthly from December 2021 to June 2022..

Core Data Sources

The core data sources available to support an understanding of the prevalence of mental health disorder for the purpose of the MHNA are:

- Mental Health of Children and Young People in England, 2017 [PAS], NHS Digital
- Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey.
- Adult Psychiatric Morbidity Survey: Survey of Mental Health and Well-being, England,2014, NHS Digital.

National studies are established in seven-year cycles and the most recent APMS was carried out in 2014. The next survey is due imminently, however, will not be completed early enough to inform this MHNA. National mental health datasets were also used including from NHS Digital and NHS Benchmarking .

Data specifications were developed and distributed to relevant stakeholders in the borough. This data was requested to understand how mental health services are being used, by who and how the pandemic has affected service provision. Data was collected from NHS services, local authority commissioned services, CCG commissioned services, social care and from the voluntary sector.

Stakeholder Engagement

Focus groups were conducted with multiple stakeholders to provide detailed insight into the mental health needs of Richmond's population. A semi-structured discussion guide was created to support them. This approach ensured that stakeholders were able to lead the discussion within a flexible framework. A copy of the discussion guides can be found in the appendix.

Focus groups were delivered at the following forums:

- Richmond Wave 4 School Cluster
- Richmond Mental Health and Wellbeing Alliance
- Richmond CVS
- Richmond Learning Disabilities Partnership Board
- Free2B LGBTQ+ Youth Group
- Older Adults Mental Health Network Group
- Richmond MIND
- RUILS "Bridging the Gap" Project
- RUILS Social Prescribers Link Workers Group
- Housing Allocation Group
- Elias Ward, Tolworth Hospital

Stakeholder views were also obtained through the THRIVE framework[9] and South West London Mental Health Strategy workshops. The voice of CYP was captured through responses to the 2022 Richmond Young People's Survey issued to multiple schools through the School Health and Education Unit.

National Policy Context

Over the last decade the profile of mental health has increased significantly. It is now firmly on the public and political agenda, with a significant change in public attitudes towards those with mental illness.[10] This has become even more apparent following the COVID-19 pandemic as the effects of lockdown, illness, isolation, and the loss of life has impacted the mental health and wellbeing of an entire population.

The government has renewed its commitment to improving mental health services for all. In 2012 the Health and Social Care Act pledged to ensure parity of esteem, meaning that those with a mental health problem would receive the same safe and effective care as those with a physical health problem.[11] Despite this, in February 2016 an Independent Mental Health Taskforce published the Five Year Forward View for Mental Health which acknowledged ongoing significant failings in care quality and access to services.[12] It made a series of recommendations to improve outcomes, which along with the NHS Long Term Plan7, adds further commitments to improve mental health services. These include[13]:

- getting care at the right time.
- an integrated mental and physical health approach.
- promoting good mental health and preventing poor mental health.
- improving access to jobs, quality relationships and community.
- tackling inequalities, as mental health problems disproportionately affect those living in poverty, are unemployed and who already face discrimination.

In March 2021 the government announced its Mental Health Recovery Action Plan backed by £500 million to address the impact of the pandemic on the public's mental health.[14]

There is widespread recognition of the significant impact that mental health disorders cause and the need to redress the inequality in the current allocation of resources in the health system.

Richmond Policy Context

Policy	Key Points Related to Mental Health
Improving Children and Young People's experience of Mental Health Services in Kingston & Richmond 2021 Data Pack, SWL CCG 2021	• Provides a summary position of the available data for CYP's mental health services in South West London to improve CYP's experience of mental health services in Richmond.
	• Issues identified and actions required include: long wait times for post assessment care; review of treatment pathways; review referrals into Tier 3 and Tier 4; address data gaps; review experience of young people and their carers; gain understanding of funding streams supporting CYP's mental health in Richmond.
Joint Strategic Needs Assessment Richmond 2021	• Commitment to integration through the theme of "prevention and joined-up services throughout people's lives, to enable all residents to start well, live well and age well".
	• Importance of promoting resilience and emotional wellbeing for all CYP.
	• Tackling poor emotional and mental wellbeing for adults which are responsible for significant ill health and long-term conditions in the borough.
	• Identifying that loneliness and isolation are principal concerns among older adults.
Parental Mental Health and the Impact on the Child, Kingston and Richmond Local Safeguarding Board Deep Dive 2021	• Audit of social care cases where parental mental health was a factor in the social care needs, findings and best practice identified.
	• The audit identified the value of early help, the importance of information sharing and multi-disciplinary visits.
	• Best practice includes engaging with fathers, supporting young carers, and prioritising the needs of the child at all times.
Richmond and Wandsworth Mental Health Transitions Framework 2020-2023	• The transition framework provides guidance to manage mental health transitions for young people and their parents/carers by providing a clear pathway.
	• The framework clarifies the role of each agency to simplify and clarify the process involved in accessing support leading up to and during transition from Children's to Adult Mental Health Services.
SWL Suicide and Self-Harm Health, Needs Assessment, SWLCCG 2021–2022	• The aim of the strategy is to reduce the rate of suicide, suicidal behaviour, and self-harm.
	• It sets out how this will be done: improve understanding of local need; challenge the stigma and discrimination associated with mental health disorder; improve access to information and postvention support; prevent self-harm amongst young people; improve crisis responses and pathways.
Children and Young People's Needs Assessment; London Borough of Richmond upon Thames 2019	• Provides information on the needs of CYP and their families in Richmond including early years, education, mental health, school age children, children with special educational needs, children who need extra support, crime, housing, homelessness, and poverty.
Dementia Health Needs Assessment (Prevention and Care) 2019	• Assessed the health needs related to dementia with a focus on prevention and social care. Designed with the aim of informing adult social care commissioning activities in the borough
Children and Young People's Plan 2017 – 2022 Richmond	• The plan sets out partnership and vision priorities to support and help young people in the borough of Richmond. It was refreshed in 2021 to include COVID-19 related priorities, aims, and outcomes.

Prevention and Mental Health

Public mental health in Richmond is concerned with a population-based approach that considers:[15]

- Primary prevention – focuses on stopping people from developing a mental health disorder and promoting good mental health for everyone.
- Secondary prevention – focuses on supporting those who are at higher risk of developing a mental health disorder.
- Tertiary prevention – focuses on supporting those with an established mental health problem to stay well.

As with other initiatives across the borough it is concerned with preventing mental illness by:

- Promoting good mental health and wellbeing for all.
- Preventing the development and worsening of mental distress across the population.
- Preventing the development of mental health problems.
- Preventing suicide and alleviating mental distress.
- Improving the lives of people living with, struggling with, and recovering from mental ill health.

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Risk Factors for Mental Disorders

Our mental health and wellbeing are influenced by multiple factors and are shaped to a large extent by the social, economic, and physical environments in which we grow, live, work and age. These factors can either act to protect or work against our mental health. The link between mental illness and the social context is well established, and social inequalities are associated with an increased risk of many common mental health disorders. [16]

Determinants of mental health and wellbeing include:

- **Individual attributes and behaviours:** these include our innate and learned ability to deal with our thoughts and feelings, to manage daily life and to engage with the social world. This can be influenced by genetic and biological factors.[17]
- **Social, economic, and environmental circumstances:** these social determinants of health include non-medical factors that place individuals at a higher risk of becoming unwell and developing a health disorder, as the capacity of any individual to flourish in society is significantly influenced by their surroundings.[18]

Table 1: Mental Health Determinants. From WHO report on overview of vulnerabilities and risk factors

Level	*Adverse factors*		*Protective factors*
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety

Source: WHO report on risks to mental health: an overview of vulnerabilities and risk factors.

Demographic Risk Factors

Age:[19]

- Mental disorder is more common in middle aged adults (35-54 years) than any other age group.
- In CYP mental disorder is more common in later adolescence with young women aged 16-24-years-old emerging as a key risk group for poor mental health

Sex:[20]

- Mental disorder prevalence changes throughout adolescence depending on whether you are male or female.
- In early adolescence boys experience greater likelihood of developing behavioural disorders. During the secondary school years girls are more likely than boys to experience emotional disorders and by the late teens, mental disorder is noticeably more common in young women than young men.[21]
- Women are more likely to have mental health problems than men, with young women at particularly high risk.

Ethnicity:[22]

- There are no meaningful differences between ethnic groups in men who experienced a common mental disorder.
- Black women experience higher levels of common mental disorders than women from White British and Other White ethnic groups.
- Common mental disorders are more prevalent in White British women than in Other White women.
- A higher percentage of Black men than White men experience psychotic disorders.

Risk Factors in Childhood:

- Poor child-parent relationships are predictive of significantly increased risk of mental disorder in adulthood with increasingly poor relationships associated with increasing risk.[23]
- Persistent poverty and transition into poverty is strongly associated with child mental disorder.[24]
- School absence and exclusion is associated with increased risk of adolescent mental disorder. [25]
- Sexual abuse in childhood is associated with increased risk of mental disorder in adulthood.[26]
- Child adversity accounts for 30% of adult mental disorder and is one of the strongest predictors of mental disorder, particularly when associated with dysfunctional family functioning such as parental mental disorder, child abuse, neglect.[27]

Socioeconomic Risk Factors:[28]

- Children living in the most deprived areas and the most deprived communities have lower levels of happiness
- Children in families with problem debt have low wellbeing levels compared to households without problem debt
- Adolescent wellbeing is lower in those growing up in the poorest households compared with least poor
- In adults, lower wellbeing is associated with being unable to keep the house warm enough and in a decent state of repair, replacing worn out furniture and making regular savings.

Lifestyle Risk Factors:

- Studies show that smoking is strongly associated with lower life satisfaction, as well as lower optimism and purpose in life[29]
- Drug use among 11–15-year-olds is associated with lower wellbeing[30]
- Alcohol problems and mental ill health are closely linked. Research shows that those who have severe mental health problems are more likely to have problems with alcohol, and those who consume high levels of alcohol are more likely to develop mental health problems[31]
- Less exercise is associated with increased risk of low mental wellbeing[32]
- Decreased fruit and vegetable intake is associated with lower wellbeing in adults.[33]

Health Risk Factors:

- Obesity is associated with lower self-esteem, lower quality of life in children, and lower mental well-being in adults[34]
- Poorer self-reported general health among 11–15-year-olds is associated with lower wellbeing.[35]
- Poor health is strongly associated with low life satisfaction and mental wellbeing. The odds of low life satisfaction are 7-10 times greater in those with very bad health compared to those with very good health.[36]
- Chronic medical illness is associated with impaired quality of life and wellbeing.[37]

Groups at Increased Risk of a Mental Disorder

Certain subgroups within the population are at higher risk of mental ill health due to exposure to these unfavourable wider determinants. For example, there is good evidence that some common mental disorders are distributed according to a gradient of economic disadvantage across society.[38] This disadvantage often starts before birth and accumulates throughout life.

These groups require proportionately more targeted prevention, promotion, and treatment to prevent widening of inequalities.

A recent briefing paper from the Royal College of Psychiatrists identifies the following groups as more vulnerable to experiencing a mental disorder[39]:

- Looked after children
- People with intellectual disabilities and neurodevelopmental disorders
- People who are homeless
- People who are unemployed or who are on low incomes
- People in contact with the criminal justice system
- Refugees and asylum seekers
- Certain ethnic groups
- Gypsy, Roma, and traveller populations
- People who Identify as LGBTQ+

- People with chronic physical health conditions
- Young women

It is important to recognise that inequalities lead to multiple vulnerabilities so that some people will belong to more than one group. For example, people who are homeless are more likely to experience chronic physical conditions, be in contact with the criminal justice system, experience alcohol and drug dependencies and be unemployed.[40]

Wellbeing and Mental Health

In the consultations many stakeholders raised the idea of wellbeing and the 'unofficial' work being done in families, friendship groups, and wider communities to support people's wellbeing; and how this in turn affects mental health.

Though closely related and able to impact each other, it remains important to distinguish between mental wellbeing and mental health. In relation to mental wellbeing, the WHO states that, "wellbeing exists in two dimensions, subjective and objective. It comprises an individual's experience of their life as well as a comparison of life circumstances with social norms and values".[41] It induces a person's overall sense of self and the ability to live as close as possible to the way they want. Mental health on the other hand is defined by a very specific set of signs and symptoms that cause significant and persistent emotional distress which can be classified as a mental health problem, or mental illness.

Both physical and mental health can influence wellbeing, and conversely mental wellbeing can influence mental and physical health.

It is crucial to understand that mental wellbeing is not simply the opposite of mental illness. Someone could have a mental disorder and high levels of wellbeing; while someone else could have low levels of mental wellbeing without a mental disorder.[42] However, low levels of mental wellbeing over a long period could make a person more likely to develop a mental health problem, and those with a mental health problem are more likely to experience low mental wellbeing.[43]

In addition, people with high levels of wellbeing are 1.14 times more likely to recover from illness than those with a low level of wellbeing. High levels of wellbeing are also associated with reduced mortality and a lower likelihood of engaging in risky behaviours such as smoking, drug use and alcohol use. [44]

It has been identified that promoting social networks, physical activity and time spent socialising delivers health benefits, including wellbeing.[45] There is a strong evidence base for the following actions to improve mental wellbeing:

NHS Guidance [46]

Five Steps to Mental Wellbeing

1. Connect with other people
2. Be physically active
3. Learn new skills
4. Give to others
5. Pay attention to the present moment (mindfulness)

Improving the mental health and wellbeing of the Richmond population would have wide reaching effects. As identified nationally, it would[47]:

- Equip people with the social and emotional skills to manage their lives, to have a sense of meaning and purpose, to develop and maintain good relationships and to be able to cope with life's challenges.
- Create healthy, inclusive, and pro-social places and communities, safe and pleasant physical environments and healthy organisations and settings.
- Tackle socioeconomic and environmental factors such as poverty, financial insecurity, discrimination, access to education, employment, transport, housing, and support for the most vulnerable people; and increase individual and community resilience.
- Improve physical health through reducing the likelihood of developing a range of chronic illnesses.
- Make workplaces more productive with reduced absenteeism.

This report acknowledges the importance of supporting wellbeing through policies and local initiatives, and the informal support provided by families, friends, and wider networks. However, due to the scope of the report its focus will be on mental health.

The Effect of the COVID-19 Pandemic on Mental Health

The COVID-19 pandemic has had an unprecedented impact on our communities, as this novel virus caused high rates of morbidity and mortality, and sustained periods of social isolation and economic insecurity.

The crisis heightened risk factors associated with poor mental health - unemployment, insecurity, and fear - whilst simultaneously depriving individuals of the usual coping mechanisms to mitigate this uncertainty, including social connection, daily routines, physical exercise and attendance at school or work.[48] This has led to a significant and unprecedented worsening of the population's mental health.[49]

Studies have also found that the COVID-19 pandemic substantially impacted the mental health of CYP.[50] Data from February and March 2021 shows that rates of probable mental disorder among CYP increased between 2017 and 2021. Among 6–16-year-olds, data shows that this increased from 11.6% in 2017 to 17.4% in 2021, and among 17-19-year-olds this increased from 10.1% to 17.4% over the same period.[51] Data from NHS Digital shows that in 2020 potentially one in six young people had a diagnosable mental health disorder, up from one in nine in 2017.

The proportion of CYP with possible eating problems also increased. Among 11-16-year-olds, the proportion increased from 6.7% in 2017 to 13% in 2021, and among 17-19-year-olds the proportion increased from 44.6% to 58.2% in the same period.[52] These trends have been found to have more negatively impacted girls and young women.[53]

Ofsted, in its second report on the impact of the pandemic, report that children who were hardest hit by school closures and restrictions have regressed in some basic skills and learning. Some young children, who were previously potty-trained, have lapsed back into nappies, particularly those whose parents were unable to work flexibly.

Older children have lost stamina in their reading and writing, some have lost physical fitness, others show signs of mental distress, including an increase in eating disorders and self-harm. Concerns remain about children who were out of sight during school closures, with falling referrals to social care teams raising fears that domestic neglect, exploitation, or abuse is going undetected.[54]

In 2019, the proportion of adults aged 18 and over reporting clinically significant levels of psychological distress was 20.8%. This increased to 29.5% in April 2020.[55] The percentage reduced in September 2020, however increased again in January 2022 to 27.1%.[56] The fluctuant nature of the psychological distress coincides with periods of national lockdown and high COVID-19 cases.

Certain groups have been identified as being particularly affected by the pandemic, reporting high levels of anxiety and distress. These include[57]:

- Young women
- Individuals with pre-existing mental health conditions
- Those facing increased financial insecurity
- Older adults
- Those advised to 'shield'
- Those exposed to violence
- Frontline workers
- Those directly affected by COVID-19 infection, including those with long COVID or the those who were very unwell and requiring rehabilitation.[58]

In response to the impact of the pandemic on mental health the government launched the Mental Health Recovery Action Plan in March 2021 which granted additional funding, with a focus on supporting those most affected by the pandemic.[59]

The successive waves of COVID-19 have not only affected the population's mental health, but the care systems that meet this need. The prioritisation of COVID care during the first two waves of the pandemic meant that all but the most urgent of non-COVID care was substantially reduced, leading to a mounting backlog, and causing significant delays to the identification and treatment of health needs.[60] In addition, some services dramatically changed their mode of delivery from face-to-face to digital. Therefore, the long-term health impacts for those who did not or were unable to access services during the pandemic also need to be considered.[61]

Demographics of the Richmond Population

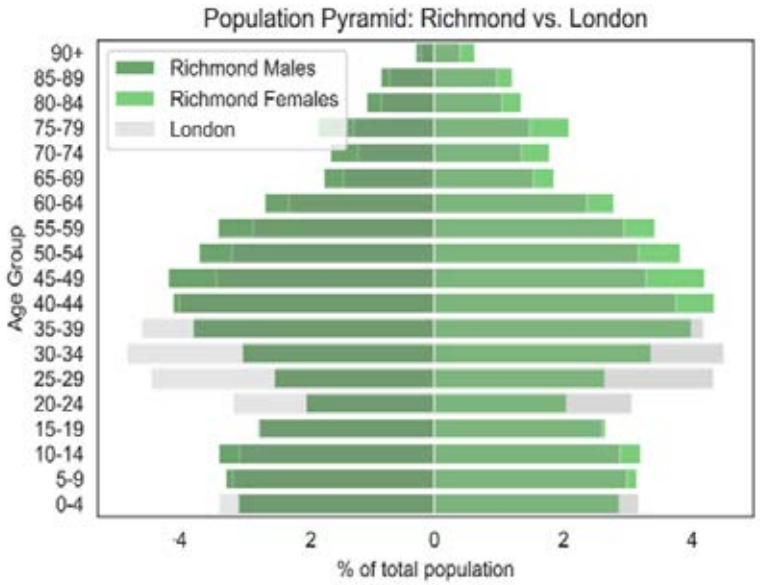
Age[62]

- Richmond has the second smallest borough population in London with an estimated 200,705 residents.
- By 2029 the borough's population is projected to increase by 1% to 213,582. The largest increase is projected to be within the 80+ year old age group with a projected increase of 34%.
- The number of 0–17-year-olds is projected to decrease by 9% between 2019 and 2029 (from 44,734 in 2019 to 40,762 in 2031).
- The proportion of children aged 5-17-years-old (23%) is higher than the London average (22%).
- Richmond has one of the highest proportions of those aged 40+ years in London, whereas those aged 20-39 represent a much smaller proportion than would be expected.

Sex and Gender[63]

- The borough's population is made up of 51% females and 49% males, and these are projected to increase by 6% and 7%, respectively, by 2029.
- The proportion of women and men are roughly equal across the life-course age-bands until later in life.
- As women experience longer life expectancy than men, by the time people are aged 85 years and over, there are more than twice as many women as men.
- In 2019, there were estimated to be more females living alone in Richmond than males and these numbers are projected to increase by 2029.

Figure 2: Population Pyramid by Quinary Age Group for Year 2021 – Richmond vs. London



Source: Richmond Joint Strategic Needs Assessment. 2021

Ethnicity[64]

- Those who identify as White British make up the largest ethnic group in Richmond.
- Almost one in six identify as Black, Asian and minority ethnic, which is a lower proportion than seen in London and Outer London.
- The Black, Asian and minority ethnic population has a higher proportion of children and fewer older people.

Table 3: Ethnicity breakdown in Richmond, Inner London and London by number and percentage

Ethnicity	Richmond (n)	Richmond (%)	Outer London (%)	London (%)
White	**168,551**	**84.0**	**56.5**	**56.6**
White British	133,075	66.3	41.9	39
White Irish	5,741	2.9	1.8	2
White Other	297,35	14.8	12.7	15.6
Black, Asian and minority ethnic	**32,151**	**16.0**	**43.5**	**43.3**
Black Caribbean	1,091	0.5	3.4	3.8
Black African	1,939	1.0	6.8	7.2
Pakistani	1,767	0.9	3.8	3
Indian	6,084	3.0	10.0	7.1
Other Black Asian Minority Ethnic	21,270	10.6	20.7	22.2
Total	**200,702**	**100**	**100**	**100**

Source: Greater London Association Housing-led ethnic group projections

Inequalities and Deprivation in Richmond

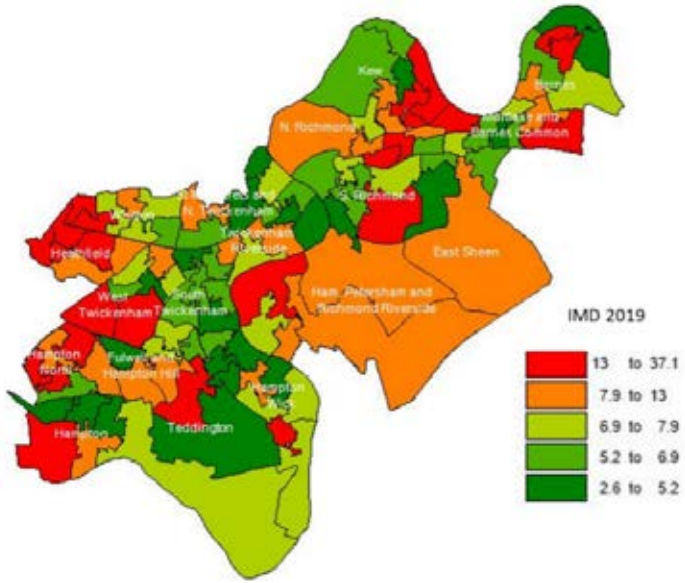
The social context in Richmond can influence the risk and resilience factors of developing a mental illness as described above.

The Index of Multiple Deprivation (IMD) provides a set of relative levels of deprivation across small geographical areas in England. A rank of 1 is the most deprived while a rank of 32,844 is the least deprived. The indicators fall across seven broad domains: income; employment; health and disability; education, skills, and training; barriers to housing and services; crime; and living environment.

Richmond compares favourably against the national benchmark and is in the least deprived third of local authorities nationally for five of the seven deprivation domains. These are: Barriers to Housing and Services; Education, Skills and Training; Employment; Health Deprivation and Disability; and Income.[65] In 2019 Richmond was the least deprived local authority in terms of Education, Skills and Training.[66] According to the public health outcomes framework deprivation score IMD in 2019, Richmond is the least deprived borough in London.[67]

It is notable that those living in the most deprived areas in the borough are more affected by poor health: 5.2% report having bad or very bad health compared to 3.3% in other areas.[68] While in the least deprived areas 57.3% report having very good health compared to only 50% in the most deprived.[69]

Figure 2: Ward-level IMD scores in Richmond in 2019



Source: Richmond JSNA.

Relative IMD can give an indication of risk factors for poor emotional wellbeing and mental illness and inform where higher levels of service demand may be. Individuals who are unemployed, have low educational attainment, live in poverty and are socially isolated have a greater risk of poor mental health.

Unemployment in Richmond

The unemployment rate for men in Richmond is 7.1%, this is above the London average of 5.5%. On the other hand, the unemployment rate for women in Richmond is 4.2%, which is below the London average of 6%.[70]

Children and Young People Living in Low-Income Households

In Richmond the number of children under 16 living in families with absolute and relative low income is lower than in London and England.[71]

Table 4: Number and percentage of children under 16 living in families with absolute and relative low income

	Richmond n	Richmond %	London n	London %
Children under 16 living in families with Absolute Low Income	2,152	5.2	258,530	14.1
Children under 16 living in families with Relative Low Income	**2,668**	**6.4**	**322,107**	**17.6**

Source: DataRich 2018-2019[72]

80.6% of children between 0 –5-years-old in Richmond are achieving a good level of development, which is higher than in London (74.1%) and in England (71.8%).[73]

However, the percentage of children in Richmond eligible for free school meals who are achieving a good level of development is significantly lower at 57%. This is lower than in London (63%) and England (73%).[74]

Children and Young People: Start Well

Introduction

There has been growing concern about the mental health and wellbeing of young people in recent years with national data demonstrating that CYP were facing a mental health crisis even before the pandemic.[75]

In 2018 it was estimated that one in seven young people between the age of 11-19 years had a mental health disorder.[76] Recent evidence suggests that CYP's mental health and wellbeing have further deteriorated due to the unprecedented disruptions caused by the pandemic. According to the Centre for Mental Health, 1.5 million CYP in England need new or additional mental health support as a direct consequence of the pandemic.[77]

The South West London CCG's local transformation plan 2021 confirms the significant and ongoing impact of COVID-19 on the mental health of local children, young people and their families.[78] The government have committed to supporting post-Covid recovery and South West London CCG has secured additional funding including:[79]

- £1.2 million for CYP's community and crisis services.
- £363k for developing 18-25 services.
- £335k for eating disorder services.
- £2.4m for supporting discharge from inpatient services across adults, CYP.

Meeting this increased mental health need is made more challenging by the gap that has long existed between the availability of services and the need for treatment.[80] In addition, stakeholders consulted for this needs assessment reported that mental health conditions among young people in Richmond are increasing in prevalence, complexity, acuity and longevity, placing additional demand on services.

Children and Young People in Richmond

There are 44,737 CYP aged 0–17 years living in Richmond.[81] By 2029 the number of 0–17-year-olds is projected to decrease by 9% to 40,762.

Table 5: Current population of CYP in Richmond between the ages of 0–19 by number and percentage.

Age	Richmond population (n)	% of total Richmond population
0-4	10,585	5.36
5-9	12,345	6.26
10-14	13,583	6.88
15-19	11,545	5.85
15-19	7,144	3.62

Source: Data Rich using GLA 2020 based Population projections

Predictors of Mental Disorder Among Children and Young People

It is significant that half of adult mental health problems start before the age of 24. Evidence shows that many mental and physical health conditions emerge in later life but originate in early childhood.[82]

Adverse conditions during this early period are associated with higher risk of mental disorders, with family-related factors and socioeconomic status having a significant effect. Experience of ACEs are associated with increased prevalence of a range of problems in adulthood. A UK survey identified that those who had suffered four or more ACEs had an increased prevalence of problems including poor mental wellbeing, health-harming behaviour, and chronic disease.[83]

The Institute for Health Equity found that certain factors in early childhood have a particularly significant impact: "lack of secure attachment, neglect, lack of quality stimulation, and conflict, negatively impact on future social behaviour, educational outcomes, employment status and mental and physical health."[84]

The Mental Health of Children and Young People in England 2017 report also found that social and family context was associated with a mental health disorder.[85]

A summary of their key findings is below:

Social/Family Context	Impact on Mental Health
Parental Mental Health	Rates of mental disorder tended to be highest in children living with a parent with poor mental health, or in children living with a parent in receipt of disability related income.
Adverse Life Events	Children with a mental disorder were more likely than those without one to have experienced certain types of adversity in their lives, like parents' separation or financial crisis at home.
Social Support and Participation	Having low levels of social support, a smaller social network, and not participating in clubs or organisations (either in or out of school) were all associated with the presence of mental disorder.
Family Functioning	Family functioning was associated with the presence of mental disorder. Over a third (38.2%) of children living in families with the least healthy functioning had a mental disorder. While problems with family functioning may contribute to the onset of mental disorder, the presence of mental disorder could also lead to problems with family functioning.

Figure: adapted from Mental Health of Children and Young People in England 2017. Summary of Key Findings.

Multiple stakeholders have also identified that CYP in Richmond face a particular set of stressors related to the relative wealth of the borough. High areas of affluence can be linked to poor emotional resilience and CYP can experience a form of neglect known as 'affluent neglect'. This has been associated with high levels of risky behaviours in Richmond. For example, hospital admissions for under 18s for alcohol specific conditions is 32 per 100,000 compared to a London average of 18 per 100,000.[86]

Estimated Mental Health Need Among Children and Young People in Richmond

Assessing the prevalence of mental health disorders among CYP in Richmond is particularly challenging due to incomplete data sets, lack of clinical diagnoses at a community level and unavailable data for some groups. It has therefore been necessary to apply national data to the local population to estimate the level of need. It is expected that the pattern of mental disorders seen nationally are representative of the Richmond population.

Method of Estimating Local Prevalence Based on National Data

When estimating local prevalence of mental health disorders in age bands the ONS mid-year population estimates were used for 2020. The total number of 5–19-year-olds according to ONS mid-year 2020 results for Richmond was 37,389. To calculate ethnicity the Census 2011 population was used as a source of age and ethnic breakdown. The total number of 5–19-year-olds from the 2011 Census was 30,019. Due to the calculation of each figure individually 'All' does not necessarily equate to the total sum of figures in the tables.

The figures presented below are estimates and should be interpreted with caution. When applying national level surveys to a smaller geographical areas local factors are more likely to have an effect and should be considered when interpreting these estimates.

Summary of National Data Findings

The Mental Health of Children and Young People Survey in England provides data on the trends in child mental health in England. The survey was carried out in 1999, 2004, 2017 and most recently in 2021. The survey assessed for a range of different types of mental health disorder according to the International Classification of Disease (ICD-10) diagnostic criteria.

Disorders were grouped into four broad categories: emotional disorders, behavioural disorders, hyperactivity disorder, and other less common disorders (see table below). To meet the threshold of a mental health disorder the symptoms experienced need to be sufficiently severe to cause distress to the child or young person or to impact on their functioning.[87]

Table 6: Types of mental health disorders affecting children aged 2-4-years-old.

Type of Disorder	Description
Emotional Disorders	Include a range of anxiety and depressive disorders that manifest themselves in fear, sadness, and low self-esteem
Behavioural (Conduct) Disorders	Characterised by repetitive and persistent patterns of disruptive and antisocial behaviour in which the rights of others and social norms or rules are violated. Generally, only diagnosed in CYP.
Hyperactivity	Start in childhood and are characterised by developmentally inappropriate patterns of inattention, impulsivity and hyperactivity.
Less Common Disorders	Less common mental and neurodevelopmental conditions were also identified. These included: ASD, eating disorders, tic disorders, and a number of very low prevalence conditions such as psychosis, stereotypic movement disorder, selective mutism, and attachment disorders. In the preschool population feeding, sleeping, and toileting disorders were also assessed.

Source: adapted from Mental Health of Children and Young People Survey (2017)[88]

The Mental Health of Children and Young People Survey (2017) found that:

- One in eight 5–19-year-olds had at least one mental disorder when assessed in 2017.
- One in twenty 5–19-year-olds met the criteria for two or more mental disorders.
- There has been a slight increase in overall rates of mental disorder between 1999 and 2017.
- Emotional disorders have become more common, with an increase in both boys and girls, while other disorder types were stable.
- Rates of mental disorder were higher in older age groups: young people between 17–19 years were three times more likely to have a disorder than those under 17.

Estimated Local Prevalence of Mental Health Disorder in Preschool Children aged 2-4 years

Mental disorders in this age range are grouped under the four categories described above. For this age group in particular, the threshold of a mental disorder is reached when the manifestation of the symptoms is in excess of levels expected in preschool aged children or exceed age-appropriate societal norms.[89]

The total number of 2–4-year-olds in Richmond is estimated to be 6,838.[90] When the prevalence rates from the Mental Health of Children and Young People in England Survey (2017) were applied to the borough population, it is estimated that the following numbers of pre-school children will experience a mental health disorder in Richmond.

Table 7: Estimated number of children aged 2–4 years in Richmond with a mental disorder by sex, based on national prevalence

Type of Disorder	All 2-4-year olds (n)	Boys 2-4 year olds (n)	Girls 2-4 year olds (n)
Any Mental Disorder	411	262	152
Any Emotional Disorder	75	38	33
Any Behavioural Disorder	187	119	69
Any Hyperactivity Disorder	37	23	11
Any Less Common Disorder	209	138	69

Source: Prevalence of mental disorder by age and sex. Using ONS Mid-year population estimates, UK, June 2020

- In this age group boys are more likely than girls to have a disorder across all four categories
- Behavioural and less common disorders were the most common disorders in this age group
- One in eighteen preschool children were identified with at least one mental disorder

Estimated Local Prevalence of Mental Health Disorder in Children and Young People aged 5–19 years

When the prevalence rates from the Mental Health of Children and Young People in England Survey (2017) are applied to the borough population, it is estimated that the following numbers of CYP aged 5-19 will experience a mental health disorder in Richmond.

Table 8: Estimated number of CYP in Richmond aged 5–19-years-old with a mental health disorder by age group, based on national prevalence

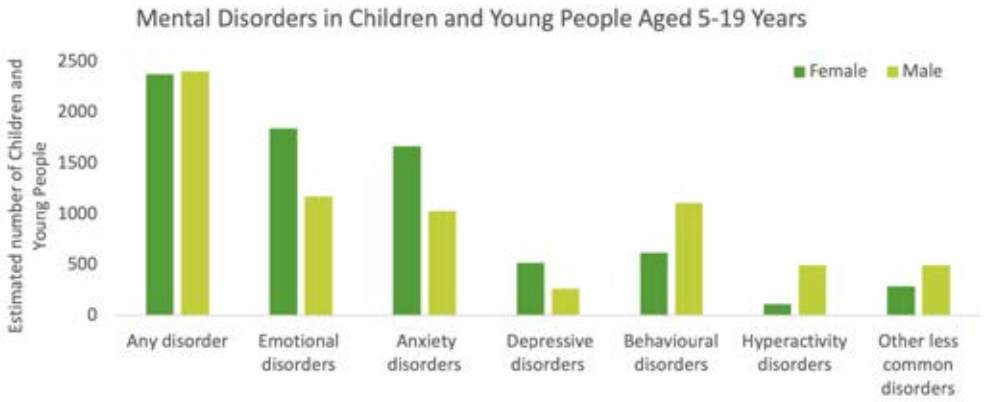
Type of Disorder	5–10-year olds (n)	11–16-year olds (n)	17-19-year olds (n)	All
Any Mental Disorder	1,582	2,168	953	4,703
Any Emotional Disorder	685	1,351	840	2,876
Any Behavioural Disorder	832	941	45	1,818
Any Hyperactivity Disorder	286	301	45	632
Any Less Common Disorder	366	331	100	797

Source: NHS Digital: Mental Health of children and young people in England, 2017. Table: Prevalence of mental disorder by age and sex. Using ONS Mid-year population estimates, UK, June 2020

Estimated Prevalence by Age and Sex

- Over the life course of CYP, it is predicted that there will be a shift from a higher prevalence of mental disorders in males to females.
- It is estimated that the prevalence of mental disorders will be highest among boys between the ages of 5–10 years.
- Between the ages of 11–16 years the prevalence is estimated to be relatively equal.
- There is then estimated to be a higher prevalence of mental disorder in girls when considering CYP between the ages of 17–19 years.
- There is a higher prevalence of behavioural, hyperactivity and other less common disorders among boys, whereas girls are more likely to experience emotional, anxiety and depressive disorders.

Figure 9: Estimated number of mental disorders in CYP aged 5-19 years by type of disorder and sex, using ONS mid-2020 population estimates.



Source: NHS Digital: Mental Health of children and young people in England, 2017.

Estimated Prevalence by Ethnicity

- Estimates suggest that mental disorders in Richmond will be highest among CYP from White British ethnic groups.

Table 10: Estimated number of CYP in Richmond aged 5–19-years-old with a mental disorder by ethnicity and sex, based on national prevalence

Ethnicity	All	Boys	Girls
White British	3,159	1,590	1,569
White Other	237	124	113
Black/Black British	29	9	21
Asian/Asian British	116	43	75
Mixed/Other	343	197	144

Source: NHS Digital: Mental Health of children and young people in England, 2017. Table 6: Any mental disorder by ethnic group and sex. Using census 2011 ethnic group by sex and age (DC2101EW)

Estimated Prevalence of Emotional Disorders in Children and Young People Aged 5–19 Years

Emotional disorders are further divided into three broad categories: anxiety disorder, depressive disorder and bipolar affective disorder/manic episode.

Anxiety Disorders: include separation anxiety; generalised anxiety disorder; obsessive compulsive disorder; specific phobia; social phobia; agoraphobia; panic disorder; post-traumatic stress disorder; other anxiety disorders; and body dysmorphic disorder.

Depressive Disorders: characterised by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration. Major depressive episode and other depressive episode are included in this survey.

Table 11: Estimated number of CYP in Richmond aged 5–19-years-old with emotional disorders by age and sex, based on national prevalence

	5-10 year-olds			11-16 year-olds			17-19 year-olds		
Type of Disorder	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
All emotional disorders	388	295	685	547	802	1,351	223	626	840
Anxiety disorders	371	280	652	480	713	1,195	177	567	736
Depressive disorders	31	19	50	126	283	410	91	183	271

Source: NHS Digital: Mental Health of children and young people in England, 2017. Table 5: Any mental disorder and specific disorders by age and sex, 2017. Using ONS Mid-year population estimates, UK, June 2020

- In those under 10 years boys are more likely to have an emotional disorder; in those aged 11 years old and above girls are more likely.
- Anxiety disorders are the most common type of emotional disorders across all age groups.
- The highest number of emotional disorders is among those aged 11–16 years.

Estimated Prevalence of Hyperactivity Disorders in Children and Young People Aged 5–19 Years

These disorders are characterised by developmentally inappropriate patterns of inattention, impulsivity, and hyperactivity. Children with hyperactivity disorders may find it hard to sit still, act without thinking first, and not finish the things they start. While most children behave like this sometimes, for those with hyperactivity disorders these symptoms are marked, persistent and cause problems in more than one setting, such as at nursery, at home and in social situations40.

Table 12: Estimated number of CYP in Richmond aged 5–19-years-old with hyperactivity disorders by age and sex, based on national prevalence

	5-10-year-olds			11-16-year-olds			17-19-year-olds		
Type of Disorder	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Hyperactivity disorders	220	63	286	248	54	301	44	Not available	Not available

Source: NHS Digital: Mental Health of children and young people in England, 2017. Table 5: Any mental disorder and specific disorders by age and sex, 2017. Using ONS Mid-year population estimates, UK, June 2020

- Hyperactivity disorders are more common in boys than girls between the ages of 5–16 years.

Estimated Prevalence of Less Common Disorders in Children and Young People aged 5–19 years

Less common disorders are further divided into four broad categories: ASD, eating disorders, tics and other less common disorders. Each is described in further detail below[91]:

Autism Spectrum Disorder: characterised by severe impairment in social interaction, communication, and the presence of stereotyped behaviours, interests, and activities.

Eating Disorders: characterised by disturbances in eating behaviours, appetite, or food intake. They include anorexia nervosa, bulimia nervosa, and binge-eating. They usually start in the teenage years. Eating disorders can cause heart and kidney problems and even death.

Tics: fast, repetitive muscle movements that result in sudden and difficult to control body jolts or sounds. Tourette's syndrome involves vocal and motor tics that have persisted for over a year.

Other less common disorders: this includes psychosis, stereotypic movement disorder, selective mutism, attachment disorders.

Table 13: Estimated number of CYP in Richmond aged 5–19-years-old with other less common disorders by age and sex, based on national prevalence

	5-10-year-olds			11-16-year-olds			17-19-year-olds		
Type of Disorder	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Other less common disorders	284	78	366	185	146	331	39	62	100
Pervasive Developmental Disorder/Autism Spectrum Disorder	211	32	245	137	48	184	27	Not available	28
Eating disorders	5	<5	n/a	18	71	89	Not available	45	44
Tics/other less common disorders	136	52	190	64	31	95	12	23	35

Source: NHS Digital: Mental Health of children and young people in England, 2017. Table 5: Any mental disorder and specific disorders by age and sex, 2017. Using ONS Mid-year population estimates, UK, June 2020

- Eating disorders are most common among 11-16-year-old girls. Stakeholders also identified that eating disorders as a particularly concerning issue in Richmond – this is discussed in detail later in the report.
- Tics and other less common disorders are most common among 5-10-year-olds.
- ASDs are more common in boys across all age groups.

Estimated Prevalence of Self-harm and Suicide in Children and Young People aged 5–19 years

Self-harm is when somebody intentionally damages or injures their body, usually as a way of coping or expressing overwhelming emotional distress. More than half of people who die by suicide have a history of self-harm. Although some people who self-harm are at a high risk of suicide, most people who self-harm do not want to end their life. Self-harm is a risk factor for suicide and provides an important indicator to inform preventative interventions.[92]

A young person with a diagnosed mental health disorder is more likely to have self-harmed or attempted suicide at some point.[93]

Recent data from 2017 highlights that for young people between 11-16 years with a mental health disorder, 25.5% had self-harmed or attempted suicide at some point compared to 3.0% for those without a disorder.[94] For those between 17-19 years old with a disorder the rate is even higher with almost half (46.8%) reporting that they had made a suicide attempt or self-harmed at some point.[95] Young women with a mental disorder between 17-19 years old have been identified as a particular high-risk group with just over half (52.7%) reporting that they had self-harmed or made a suicide attempt.[96]

Since 2011, hospital admissions for self-harm in young people in Richmond aged 10–24 years have been consistently higher than the London average. The most recent data (2020/21) identifies that Richmond has the second highest rate of self-harm (10–24-year-olds) in London at 367.8 per 100,000. [97]

Our consultation with stakeholders also raised concerns about the increased rates, pace and early onset of self-harm and suicidal ideation among CYP in Richmond. In particular, schools reported a high number of students with significant levels of anxiety, which tended to escalate quickly into self-harm behaviour and suicidal ideation.

Estimated Prevalence of Behavioural Disorders in Children and Young People Aged 5–19 Years

Behavioural disorders are characterised by repetitive and persistent patterns of disruptive and violent behaviour which exceed age-appropriate societal norms causing problems in school, at home and in social situations. They include oppositional defiant disorder, socialised conduct disorder and unsocialised conduct disorder.

Table 14: Estimated number of CYP in Richmond aged 5–19-years-old with behavioural disorders by age and sex, based on national prevalence

	5-10-year-olds			11-16-year-olds			17-19-year-olds		
Type of Disorder	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Behavioural disorders	564	263	832	574	368	941	29	15	45

Source: NHS Digital: Mental Health of children and young people in England, 2017. Table 5: Any mental disorder and specific disorders by age and sex, 2017. Using ONS Mid-year population estimates, UK, June 2020

- Behavioural disorders are more common among boys for all age groups
- The highest number of CYP with behavioural disorders are aged 11–16 years

Primary Care Data: Common Mental Health Disorders

Primary Care Data has been supplied in May 2022 for CMD and SMI in CYP registered with a GP in Richmond.

It is acknowledged that not all CYP who present to their GP with a mental health problem will be captured under these indicators. There are multiple reasons for this. Not all patients who present to their GP with symptoms of mental ill health will receive a diagnosis and, as QOF is a voluntary programme, not all practices will participate. Consequently, these figures may not be representative of the true prevalence in the population.

The depression and mental health indicators were extracted from the QOF long term condition indicators while the anxiety indicator was extracted from GP databases. QOF covers four domains, and each domain consists of a set of measures of achievement against which General Practices accrue points.[98] Ultimately the aim of QOF is to improve standards of care.

The number of patients on the clinical registers can be used to calculate disease prevalence.[99] Caution must be taken however when using this data to estimate prevalence as figures differ depending on how sources code and define disease, leading to differences in the estimates.[100]

Table 15: Number of CYP in Richmond aged 0–18-years-old recorded with a mental health disorder in Primary Care Data

Data Source	Age 0 – 4	Age 5 – 18
QOF Depression	Not available	223
QOF Mental Health	Not available	12
Anxiety Database	<5	195

Source: South West London Health & Care Partnership. Depression and mental health data extracted from Long Term Conditions and QOF indicators; anxiety data extracted from GP database

- These figures are lower than expected from the national prevalence estimates, suggesting that this metric does not capture the expected need of the CYP of Richmond.

Comparison with Other London Boroughs

The South West London CCG, which provides CYP's mental health services in Richmond, have identified that the borough's CYP have high levels of risky behaviour compared to its neighbours in South West London.[101] In particular, Richmond has higher rates of hospital admission for self-harm and alcohol than its neighbours.

These areas for which Richmond has comparatively high rates in London are explored in detail in this section.

Hospital Admission as a Result of Self-Harm Broken Down by Age

- Compared to other London boroughs Richmond was second highest with rates of hospital admissions due to self-harm across all age groups (10–24-years-old) in 2020/21. Of all the South West London boroughs only Croydon is outside the top ten.[102]
- Between the ages of 10-14 years for 2020/21 Richmond was fifth highest with a rate of 185 per 100,000.[103]
- Hospital admissions as a result of self-harm between 15–19-year-olds in 2020/21 was the second highest in London behind Kingston with a rate of 542.6 per 100,000. The London average is 330.9 per 100,000.[104]
- Between the ages of 20-24 years the hospital admissions rate as a result of self-harm in 2020/21 was the second highest in London after Kingston at 373 per 100,000. The London average is 181.5 per 100,000. [105]

Hospital Admission as a Result of Alcohol

- he trend of admission to hospital due to alcohol-specific conditions for under-18s has been getting worse in Richmond since 2015. Latest figures (for 2018/19 – 2020/21) show that Richmond has the highest rate in London of 36.4 per 100,000. The London average is 14.3 per 100,000.[106]
- It is of particular concern among females under 18 where the rate is the highest in London at 59.5 per 100,000; the second highest is Kingston with a rate of 42.6 per 100,000. The London average for females is 17.8 per 100,000.[107]
- For males under 18 the Richmond rate is seventh highest at 14.3 per 100,000. The London average is 10.9 per 100,000 for this demographic.[108]

Hospital Admission for Mental Health Conditions

- CYP in Richmond are requiring a greater level care for their mental health difficulties at a higher rate than their London peers.
- Richmond has the highest rate of hospital admissions for mental health conditions for those <18 in 2020/21 – 120.1 per 100,000 compared to the London average of 61.3 per 100,000.[109]
- It has the third highest rate for new referrals to secondary mental health services in London. Behind Merton and Kingston upon Thames that are also in SW London. Th Richmond rate is 6,965 per 100,000 for <18 years in 2019/20.[110]
- Richmond has the fifth highest rate of inpatient stays in secondary mental health services in London; and has a higher rate than all the other SW London boroughs that are represented.[111] Richmond is also the bottom third among London boroughs for young people who attended community and outpatient mental health services in 2019/20.[112]

Estimated Mental Health Need: Key Findings

- There are an estimated 4,703 5–19-year-olds with a mental health disorder in Richmond.
- Estimated prevalence of disorders between boys (2,405) and girls (2,377) are similar.
- Emotional disorders have become more common, with an increase in both boys and girls, while other disorder types were stable.
- Anxiety disorders are the most common type of emotional disorders across all age groups.
- The highest number of emotional disorders is among those aged 11-16.
- Rates of mental disorder were higher in older age groups: young people between 17-19 were three times more likely to have a disorder than those aged 5-17.
- Richmond has high rates of hospital admissions for mental health, self-harm and alcohol presentations compared to the rest of London.

Vulnerable Groups and Mental Disorders

Mental health problems in CYP can have a wide range of causes. For many there is likely to be a combination of factors that make them more susceptible to poor mental health outcomes particularly in relation to social and family context.[113] Having a parent who is struggling with mental problems and experiencing adverse childhood experiences increases risk. Other risks include poverty, discrimination, inaccessibility to good quality support services and overall lack of awareness about mental health. The following section highlights groups of CYP who are more vulnerable to mental health disorders due to adversity. It sets out the evidence of increased vulnerability and provides estimates, using local data, to identify need relating to each group.

Estimates of local need have been calculated by applying local population data to relevant prevalence studies for each vulnerable group. Population estimates were identified through GLA 2020-based population projections unless otherwise indicated. It is important to recognise that the smaller the geographical area becomes when applying estimated prevalence from national level surveys, the more likely local factors come into play making the estimates used less reliable. This must be taken into consideration when interpreting the estimates in the table below. Examples of local factors include socioeconomic deprivation, access to services, levels of crime, the extent of community cohesion etc.

Note: There are inconsistencies in the terminology relating to mental health disorder, psychiatric disorder, and psychological symptoms. Where limited availability of evidence prevents local estimates, relevant proxy-indicators have been included.

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Young Carers	Risk factors for the poor mental health of young carers:[114] • Poor physical health • High stress levels • Poor sleep • Loneliness • Lack of awareness from professionals.	Children of parents with a mental illness were at a greater risk of poorer outcomes than their peers, with higher rates of mental illness and poorer development in behavioural and academic domains. CYP who cared for a parent with a mental illness may be at higher risk of a range of emotional, behavioural, and mental health needs. Aggregated data suggested that a child had a 30–50% chance of developing a serious mental illness if they had two parents with mental illness[115]	In 2021/22, 500 young carers (5-18 years) were registered with the Richmond Carers Centre • In 2022, there were 118 (23.6%) young carers, caring for a parent with a mental health disorder. • In 2022, there was a 23% increase in young carers, caring for a parent with a mental health disorder since 2018/19
Gypsy, Roma and Traveller	Risk factors for poor mental health in Gypsy, Roma and Traveller communities:[116] • Poverty • Economic instability • Social exclusion • Stigma and discrimination • Racism and racial discrimination • Low educational achievement • High rates of school exclusion • Poorer physical health • Poor access to services • Poor awareness of mental health • Distrust of support services	Research identifies that in the Gypsy, Roma, and travellers experience two and a half times higher rates of poor mental health compared to samples of the general population.[117]	Limited evidence available

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Learning Disabilities	Risk factors for poor mental health in people with Learning disabilities: [118] • Pain • Physical ill health • Taking multiple types of medication • Genetic syndromes associated with specific mental health problems • Experience of deprivation, poverty, abuse, and other negative life events earlier on in life • Lack of social support and reduced coping skills • Stigma and discrimination	CYP with special educational needs and disabilities (SEND) (5-19) with a mental health disorder:[119] • 51.0% boys • 39.1% girls CYP (5-16 years) with a learning disability:[120] • 36.0% with a Psychiatric Disorder • 12.0% with an Emotional Disorder • 20.5% with a Conduct Disorder • 8.3% with a Hyperkinetic Disorder CYP with SEND (6-16 years): [121] • 56.7% with a probable mental health disorder	In 2021/22, there were 1050 boys (5-19) with an Education and Health Care Plan (EHCP). • Estimated 536 boys with a mental health disorder In 2021/22, there were 427 girls (5-19 years) with an EHCP. • Estimated 167 girls with a mental health disorder In 2021/22, there were 1477 CYP (5-19 years) with an EHCP (AfC, 2022) • Estimated 531 with a Psychiatric Disorder • Estimated 177 with an Emotional Disorder • Estimated 303 with a Conduct Disorder • Estimated 123 with a Hyperkinetic Disorder In 2021/22, there were 1202 CYP (6-16) with an EHCP • Estimated 682 with a probable mental health disorder
LGBTQ+	Risk factors for poor mental health in LGBTQ+ young people: [122] • Negative experience of healthcare • Discrimination and bullying in school • Victimisation and violence • Loneliness and isolation • Gender dysphoria • Higher levels of drug and alcohol use	Non-heterosexual young people (14-19 years): [123] • 34.9% with a mental health disorder	It is estimated in Richmond that there are • 937 (13.2%) non-heterosexual girls (14-19) • 511 (7.1%) non-heterosexual boys (14-19 years) • Estimated 327 non-heterosexual girls (14-19) with a disorder • Estimated 178 non-heterosexual boys (14-19) with a disorder

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Looked after Children	Risk factors for poor mental health in looked after children and young people:[124] • Adverse childhood experiences • Low social economic status • Overcrowded housing • Parental marital distress • Parental criminality • Parental mental health • Parental drug and alcohol use • Poor attachment • Experience of abuse and neglect	Children (5-17 years) looked after by local authorities:[125] • 45.3% Psychiatric Disorder • 12.4% Emotional Disorder • 37.7% Conduct Disorder • 8.4% Hyperkinetic Disorder	From March 31, 2022, Richmond Council was responsible for 107 Looked After Children (5-17 years). • Estimated 48 looked after children with a psychiatric disorder • Estimated 13 looked after children with an emotional disorder • Estimated 40 looked after children with a conduct disorder • Estimated 9 children with a hyperkinetic disorder Richmond Children's Services has identified 21 (50%) looked after children (5-16) whose emotional wellbeing is a cause for concern. [126]
Low Income families	Children in low-income households are disproportionately more likely to experience: [127] • Poor housing conditions • Poor nutrition • Trauma • Stressful life events • Domestic abuse • Social isolation • Parental mental disorder • Parental drug and alcohol use • Punitive parental practice Children in low-income households are disproportionately less likely to benefit from: • Exposure to varied environments • Exposure to positive educational activities and materials • Positive parent led experiences	Parental receipt of benefits, low-income and or disability (5-10 years): [128] • 16.9% with a mental health disorder Parental receipt of benefits, low-income and or disability (5-19 years) [129] • 20.7% with a mental health disorder	In 2017, there were 860 children (5-10 years) with a parent receiving low income and or disability benefits. • Estimated 145 with a mental health disorder In 2017, there were, 1,525 young people (11-19 years) with a parent receiving low-income and or disability benefits. • Estimated 316 with a mental health disorder

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Refugees and asylum seekers	Risk factors for poor mental health in child refugees and asylum seekers:[130] • Poverty • Poor physical health • Trauma • Family breakdown and separation • Bereavement • Victims of violence and abuse • Imprisonment • Unstable living conditions • Poor access to healthcare	Unaccompanied Asylum-Seeking Children:[131] • 41.9% Psychiatric Disorder • 30.6% Post Traumatic Stress Disorder	As of March 31, 2022, there were 25 Unaccompanied Asylum-Seeking Children in Richmond • Estimated 10 with a psychiatric disorder • Estimated 8 with Post Traumatic Stress Disorder
Young Women	Young women have emerged as a high-risk group, with high rates of common mental disorder, self-harm, and positive screens for posttraumatic stress disorder (PTSD) and bipolar disorder. The gap between young women and young men increased markedly over the last 20 years. The evidence is under-developed, there are several theories including: [132] • Intimate partner violence • Physical and sexual abuse • Gender discrimination • Misogyny • Social media consumption • Physiological differences including hormonal influence	Females (17-19 years):[133] • 23.9% any mental disorder • 52.7% with a mental disorder had self-harmed or made a suicide attempt. Females (16-24 years): [134] • 26.0% Common mental disorders • 12.6% Post Traumatic Stress Disorder • 25.7% ever self-harmed	In 2022, there are 3,237, females (17-19 years) (DataRich, 2022) • Estimated 774 with a mental disorder • Estimated 408 with a mental health disorder had self-harmed or made a suicide attempt In 2022, there are 8,015 Females (16-24 years) • Estimated 2,804 common mental disorder • Estimated 1,010 Post Traumatic Stress Disorder • Estimated 2,060 ever self-harmed

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Youth Justice	Risk factors for poor mental health in children and young people in the youth justice system: [135] • Homelessness • Inconsistent and erratic parenting • Over harsh discipline • Hyperactivity • Learning difficulties • Numeracy and literacy problems • Risk taking behaviours • Drug and alcohol dependency • History of abuse • Interactions with the criminal justice system	Prevalence of young people in contact with the criminal justice system with a mental health disorder.[136] • 25% to 81%, with highest rates for those in custody • 69.9% Detained male adolescents (10-19 years) with a Psychiatric Disorder • 84% Male young offenders (10-21-year-olds) on remand with a personality disorder • 88% Male young offenders sentenced(10-21 years) on sentenced young offenders The Youth Offending Service use the Asset Plus Assessment system to identify mental health need amongst young people in the youth justice system.	During 2021-22, 27 young people received 'substantive outcomes' these cover the following categories: Out of court disposal; first tier penalty, community penalty; and custodial sentence. Applying the Mental Health Foundation research, it is estimated that at least 7 young people in this cohort had a mental health disorder. This will be the minimum number of young people with a disorder in this cohort and the actual number is likely to be higher. The number of young people receiving a custodial sentence in Richmond was less than 5 and therefore the exact data is suppressed to maintain confidentiality. The Asset Plus Assessment identified that in 2021/22, 16 young people in the Richmond Youth Offending Service had mental health needs.

Vulnerable Groups and Mental Disorders: Key Findings

- There has been a 23% increase in numbers of children caring for a parent with a mental health condition since 2018/19.
- It is estimated that in children and young people with Education and Health Care Plans, boys are three times more likely to have a mental health disorder than girls.
- More than half of children and young people with SEND have a probable mental health disorder.
- Emotional health is a cause for concern in half of Looked After Children.
- It is estimated that 1 in 3 children and young people who identify as non-heterosexual have a mental health disorder.
- Young women are emerging as a high-risk group for mental disorder, it is estimated that:
  - 1 in 4 (2,804), 16-24-year-old-females have a common mental disorder
  - 1 in 4 (2,060), 16-24-year-old-females have self-harmed
  - Over 1,000 16-24-year-old-females in Richmond have Post Traumatic Stress Disorder

Service Activity

This section presents data on service activity with the aim of using it to understand levels of unmet mental health need in CYP.

It will first outline how services are commissioned including the move to the THRIVE framework; then it will look at the effect of COVID-19 on service provision; before outlining the local system of care and how CYP with differing mental health needs access the services they need including from AfC, the NHS Trust and from the voluntary sector.

For most services outlined below, data provided for 2021/22 is only quarters 1-3. This has been noted where applicable. Where Q1-3 is not specified you can assume the data provided is for the full year.

South West London Context

In April 2020 South West London's six CCGs (Croydon, Kingston, Merton, Richmond, Sutton, Wandsworth) merged into one South West London CCG. This was in line with the national move towards Integrated Care Systems. The move provides an opportunity for collaboration and joint working across health and care.

Several areas have been prioritised in South West London for the care of CYP which is relevant for the Richmond population. These include:

- Early support and prevention to promote resilience.
- The implementation of the THRIVE framework in place of the tiered approach to service delivery (see detailed description below).
- New mental health support teams to help children with mild to moderate mental health needs within schools and colleges.

Common themes and challenges have been identified across South West London that also reflect what stakeholders have experienced in Richmond.[137] These include:

- That demand for CYP mental health services continues to grow and acuity is more complex, particularly after the pandemic.
- Some services have long waiting times.
- There are complex and sometimes fragmented commissioning arrangements for CAMHS/CYP provision across the six boroughs in SW London with multiple providers (both NHS and non-NHS), resulting in variability of service provision.

Effect of Covid-19 on Service Delivery South West London

The pandemic had a significant effect on the delivery of services. Many psychological interventions began to be delivered online, although 42% of NHS commissioned CAMHS saw patients face to face. Some voluntary sector providers such as Off The Record shifted entirely to remote working. During the first lockdown the delivery of Kooth, an online counselling platform for young people was expanded to the whole of South West London.

The biggest impact of COVID-19 was on the number of referrals to mental health services. In April 2020, referrals to SWLStG CAMHS were at 40% of the level that they were in previous year. As referrals often involve schools, a dip in referrals was also experienced in January 2021 as schools were closed for most pupils. [138]

The Local System of Care

Child and Adolescent Mental Health Services is a specialist mental health service that provide assessment and treatment for CYP who have emotional, behavioural or mental health difficulties.

Within CAMHS there are different levels of support traditionally known as tier 1, tier 2, tier 3, and tier 4. Richmond is moving from this system to the THRIVE system of care which is described in more detail below.

Tier 1: Provides universal support in the form of early intervention and prevention and is not delivered by mental health specialists. It includes GPs, Social Workers, Health

Visitors, Teachers delivering social and emotional skills and Healthy Schools Curriculum.

Tier 2: In Richmond, tier 2 CAMHS are provided by Achieving for Children. The service is called the Emotional Health Service which has an early intervention approach for CYP who experience mild-moderate mental health disorders. [139]

The service offers assessment and treatment with the aim of helping improve a person's ability to function and cope with the difficulties they experience.

Tier 3: In Richmond, tier 3 services are provided by SWLStG. This service offers assessment, diagnosis and treatment to CYP who have signs and symptoms of a mental health disorder that has significant impact on their ability to function.[140]

Tier 4: In Richmond, tier 4 services are provided by SWLStG. This service offers inpatient services for CYP with exceptionally high levels of distress and complex mental health disorders.[141]

THRIVE Framework

The THRIVE framework moves away from the traditional tiered system of service provision and is instead needs-led. This focuses on what support young people and their families require through shared decision making alongside professionals, rather than a service-led definition of severity, diagnosis, or pathway. This model is currently being implemented in Richmond.

The framework is characterised by five 'needs based groupings' these can be seen in the diagram below.

- **Thriving.** Most CYP can cope with day-to-day life and will not need individualised advice or support around their mental health.
- **Getting Advice.** This group includes both those with mild or temporary difficulties and those with fluctuating or ongoing severe difficulties, who are managing their own health and not wanting goals-based specialist input.
- **Getting Help.** This grouping comprises those children, young people and families who would benefit from focused, evidence-based help and support, with clear aims, and criteria for assessing whether these aims have been achieved.
- **Getting More Help.** This is not conceptually different from Getting Help. It is a separate needs-based grouping only because need for extensive resource allocation for a small number of individuals may require particular attention and coordination from those providing services across the locality.
- **Getting Risk Support.** This grouping comprises those children, young people, and families who are currently unable to benefit from evidence-based treatment but remain a significant concern and risk.

Figure 16: The THRIVE Framework for System Change

Source: THRIVE Framework for system change. London: CAMHS Press.

Using the THRIVE Framework to Estimate the Numbers of Children and Young People in Richmond at Each Level of Need

The THRIVE Framework provides a helpful proxy measure to understand the estimated numbers of CYP requiring the different needs-based approaches. The evidence for this model was gathered as part of the Tavistock Portman research into a CAMHS Payment System.[142] This proxy is helpful to understand unmet need and to help plan future resourcing.

The model identifies that most young people requiring a mental health intervention sit within the 'Getting Advice' and 'Getting Help' groups. Interventions in these groups rely on a well-co-ordinated and resourced system. The single largest grouping is 'Getting Help', this part of the system is often referred as to as Tier 2 and is typified by single professional support.

Table 17: Estimated number of CYP in Richmond aged 5-17-years-old requiring a mental health intervention according to the THRIVE Model

Needs Based Grouping	Estimated Percentage of 5-17 Years	Estimated Number of 5-17 Years
Thriving	80%	28,500
In Need of a Mental Health Intervention	20%	7,000
Total Population of CYP in Richmond	100%	35,500

Source: CAMHS Payment System, Tavistock Portman and GLA-2020-based population projections

Table 18: Estimated number of CYP in Richmond aged 5-17-years-old by needs based grouping according to the THRIVE Model

Needs Based Grouping	Estimated Percentage of Children and Young People Aged 5-17 Years	Estimated Percentage of Children and Young People Aged 5-17 Years
Getting Advice	30%	2,100
Getting Help	60%	4,100
Getting More Help	5%	350
Getting Risk support	5%	350
Total	100%	7,000

Source: CAMHS Payment System, Tavistock Portman and GLA-2020-based population projections

However, this model was developed in 2015 and does not take into consideration the impact of the COVID-19 pandemic on the mental health of CYP. Prevalence of mental disorders in CYP has increased since its development. The model is helpful to illustrate proportion of need but was not developed to be used as a predictive model so caution should be taken when interpreting estimated numbers.

The Local System of Care in Richmond

This section will look at a particular selection of services under each tier that were identified by the steering groups. There is a focus on the demographics of those referred to service, to see if these are in keeping with the expected prevalence in the population; on waiting times; reasons for referral and sources of referral to understand how young people are accessing services.

Tier 1: Getting Advice

Mental Health Support Teams in Schools

The 2017 Green Paper Transforming children and young people's mental health provision recognises the crucial need for schools to be equal partners in identifying and supporting the mental health needs of CYP.

In Richmond, the MHSTs in Schools initiative is a collaborative project between education and mental health services. The teams are delivered by Achieving for Children as part of the Emotional Health Service. The service is run in both primary and secondary schools.

The MHST offers a variety of support through individual interventions, group work and the whole-school approach. It is funded through the national Trailblazer Programme.

In Richmond there are three MHST clusters. The first cluster began in 2019 while the second started in 2020 and the third in 2021. Cluster 1 and 3 are delivered by AfC and focus on reducing inequalities in health associated with self-harm and alcohol misuse and building emotional resilience. Cluster 2 is for SW London and is focused on reduced inequalities in health for 16-18-year-olds with a focus on transition. It is delivered by SWLStG.

In Richmond, MHSTs currently cover 25 out of 44 (57%) primary schools; 8 out of 11 (73%) secondary schools and one out of three special schools. There are 19 primary schools with no MHST provision, however six of these have commissioned the Emotional Health Service for mental health work.

The number of schools with MHST continues to expand but more data is needed before it is possible to effectively analyse the service. The teams are not captured in the full scale of need in schools.

Use of Mental Health Support Teams in Richmond

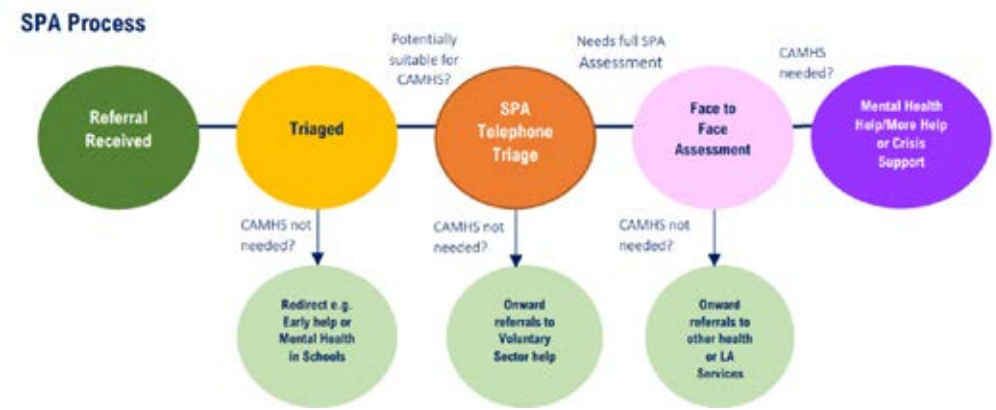
- The number of service users to MHSTs has increased since the programme started.
- More females than males have accessed this service which is in keeping with expected prevalence.
- Wait times increased in 2021/22.
- The service is overwhelmingly used by those between the aged of 5–16 years. In 2020/21 most service users were aged 11-16-year-olds. However, in the first three quarters of 2021/22 most service users have aged 5-10 years.

Tier 2: Getting Help

Children's Single Point of Access

All CYP that require mental health support access this through a referral to the Children's SPA. In Richmond the AfC SPA is for social care and early help referrals; while the SWLStG SPA is for CAMHS referrals only.

Figure 19: SPA Process in Richmond [143]

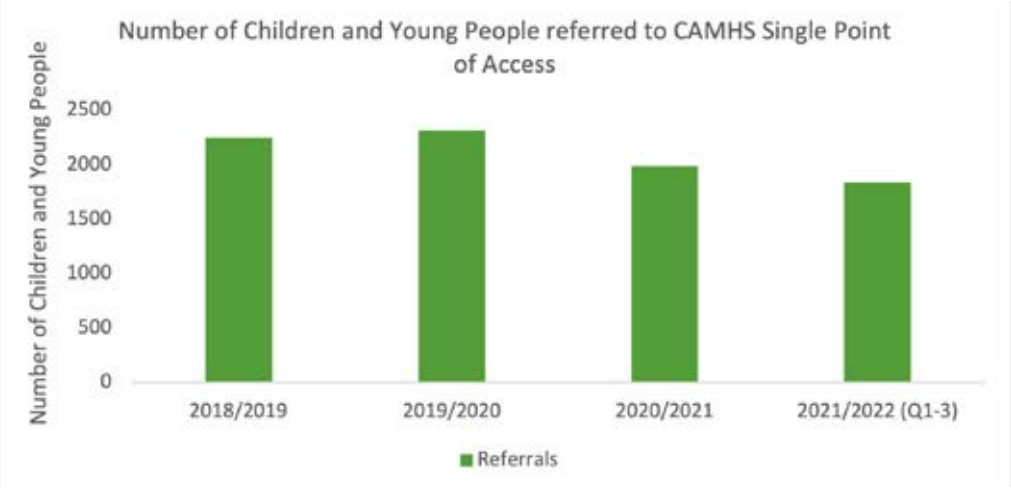


Source: South West London Clinical Commissioning Group. 2021.

Referrals to CAMHS Single Point of Access

- Between 2018 to 2022 there were 8,388 CYP referred to CAMHS SPA services in total.
- In 2018/19 and 2019/20, numbers of referral were relatively stable, at 2,245 and 2,316 referrals each year, respectively.
- In 2020/21, there was a noticeable drop in the number of referrals to the service, falling to 1,990 CYP.
- It is likely that this was caused by the impacts of the COVID-19 pandemic, as the closure of schools and restrictions to accessing GP surgeries posed barriers to obtaining a referral to CAMHS SPA services.[144]
- In Q1-3 of 2021/22 there have been 1,837 referrals to CAMHS SPA. This is only 8% lower than the total referrals in 2020/21.

Figure 20: Number of CYP referred to CAMHS SPA in Richmond between 2018/19 and 2021/22



Source: CAMHS Single Point of Access. South West London St Georges NHS Trust. 2018-2022.

Age of Referrals to CAMHS Single of Point Access

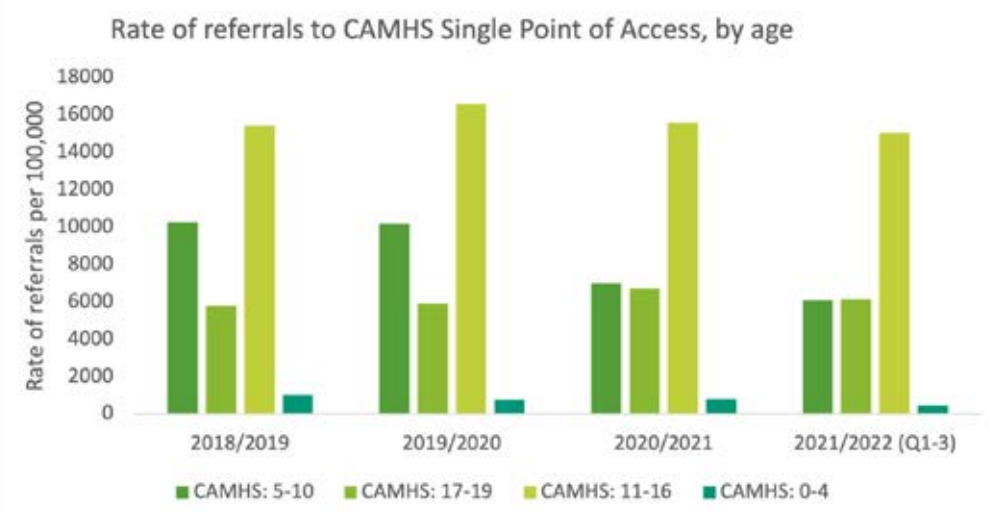
- Across the period, most referrals to CAMHS Tier 3 were in the 11–16-year-old age group (av. 15,674 per 100,000), followed by 5–10-year-olds (av. 8,380 per 100,000) and 17–19-year-olds (av. 6,146 per 100,000).
- There were only a small number of 0–4-year-olds referred to the service (av. 769 per 100,000).
- From 2020, there was a decline in the rate by which 5–10-year-olds were referred to the service; this fell from a rate of 10,278 per 100,000 and 10,185 per 100,000 in 2018/19 and 2019/20, to 6,980 per 100,000 and 6,077 per 100,000 in 2020/21 and 2021/22 (Q1-3).
- This is likely to have been a consequence of the closure of schools during the COVID-19 lockdowns, as schools are responsible for a significant proportion of referrals to CYP from this age bracket to CAMHS services.[145]
- By contrast, the rate of referral of 17-19-year-olds increased over the same time period, rising from 5,802 per 100,000 in 2018/19 and 5,902 per 100,000 in 2019/20, to 6,724 per 100,000 in 2020/21 and 6,154 per 100,000 in 2021/22.
- There is a male/female imbalance within each of the age bands referred to CAMHS SPA. This reflects the prevalence of disorders through childhood to adolescence; there are more boys than girls referred to CAMHS 0-4 years and CAMHS 5-10 years services, whereas there are more girls than boys referred to CAMHS 11-16 and CAMHS 17-19 years services.

Table 21: Number of CYP referred to CAMHS SPA by age and sex between 2018/19 and 2021/22

	Female				Male			
Age	2018/19	2019/20	2020/21	2021/22 (Q1-3)	2018/19	2019/20	2020/21	2021/22 (Q1-3)
0-4	22	16	20	8	40	31	27	19
5-10	294	300	223	211	567	553	361	297
11-16	689	707	765	742	470	539	400	385
17-19	117	106	127	114	46	60	62	59
Total	**1,122**	**1,129**	**1,135**	**1,075**	**1,123**	**1,183**	**850**	**760**

Source: CAMHS Single Point of Access. South West London St Georges NHS Trust. 2018-2022.

Figure 22: Rate of referrals to CAMHS SPA by age between 2018/19 and 2021/22

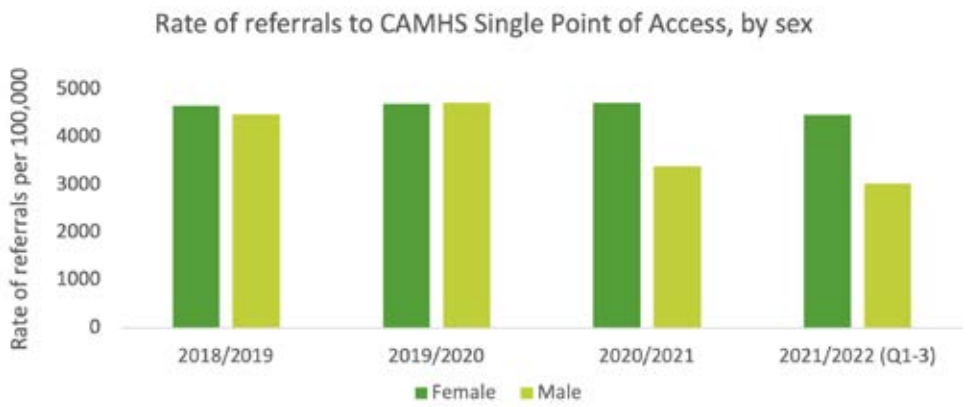


Source: CAMHS Single Point of Access. South West London St Georges NHS Trust. 2018-2022.

Sex of Referrals to CAMHS Single Point of Access

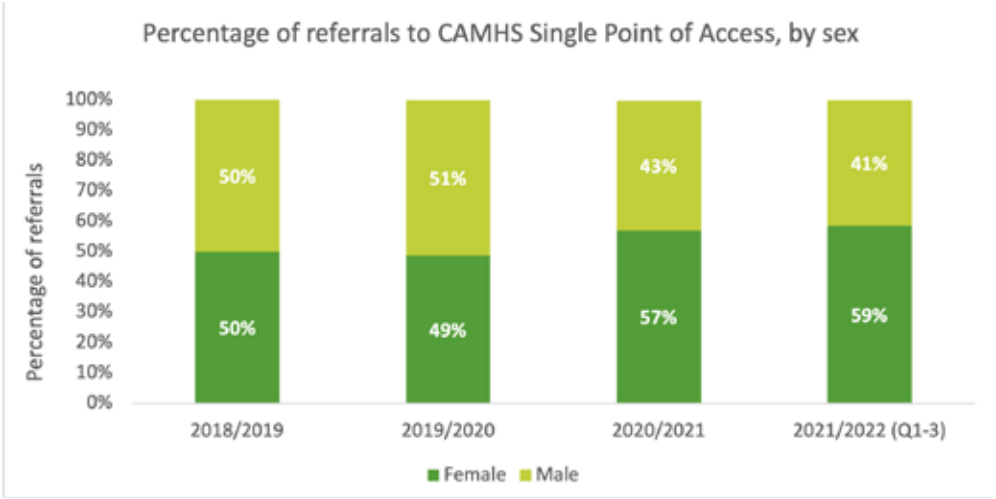
- In 2018/19 and 2019/20, the numbers of males and females referred to CAMHS SPA services were relatively equal.
- From 2020/21 there was a decline in the rate of male referral to the service. The rate of male referral fell from 4,473 per 100,000 and 4,712 per 100,000 in 2018/19 and 2019/20, to 3,386 per 100,000 and 3,027 per 100,000 in 2020/21 and 2021/22 (Q1-3).
- The declining rates of male referral was most acute in the 5-10-year-old and 11-16-year-old age groups.
- By contrast, the rate of females referred to the service remained relatively stable across the four-year period and saw a small increase in 2020/21.
- The declining number of males referred to CAMHS SPA meant that in 2020/21 and 2021/22 (Q1-3), females made up 57% and 59% of referrals to CAMHS SPA, and males constituted just 43% and 41%.

Figure 23: Rate of referrals to CAMHS SPA by sex between 2018/19 and 2021/22



Source: CAMHS Single Point of Access. South West London St Georges NHS Trust. 2018-2022.

Figure 24: Percentage of referrals to CAMHS SPA by sex between 2018/19 and 2021/22

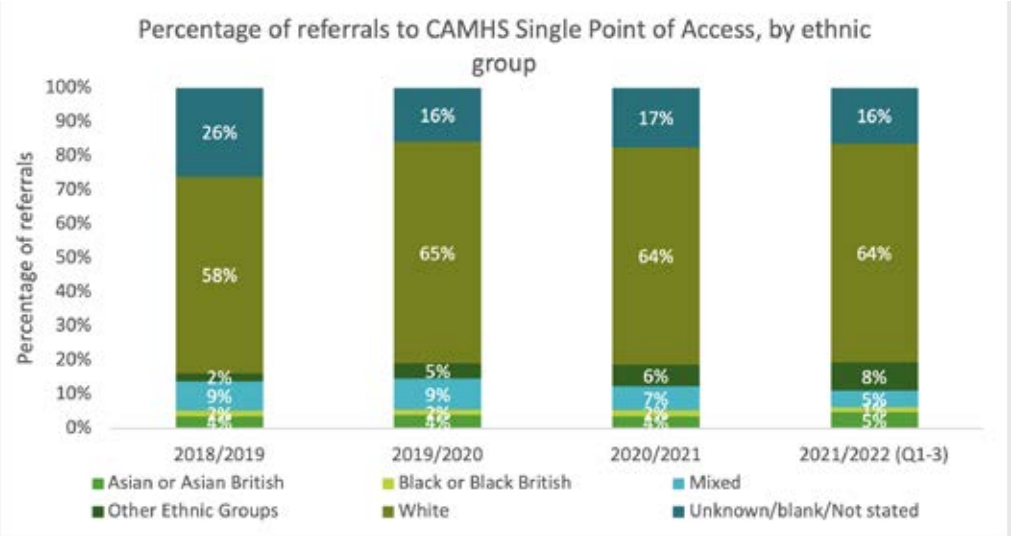


Source: CAMHS Single Point of Access. South West London St Georges NHS Trust. 2018-2022.

Ethnicity of Referrals to CAMHS Single Point of Access

- Between 2018/19 and 2021/22, the majority of referrals to CAMHS SPA were from White ethnic groups (av. 63%).
- This was followed by clients from Mixed ethnic groups (av. 7%), Other ethnic groups (av. 5%), Asian or Asian British ethnic groups (av. 4%) and Black or Black British ethnic groups (av. 2%).
- A large percentage of those referred to CAMHS SPA have an unknown ethnicity. This makes it challenging to provide a comprehensive analysis of the ethnicity of clients referred to CAMHS SPA services.

Figure 25: Percentage of referrals to CAMHS SPA by ethnic group between 2018/19 and 2021/22

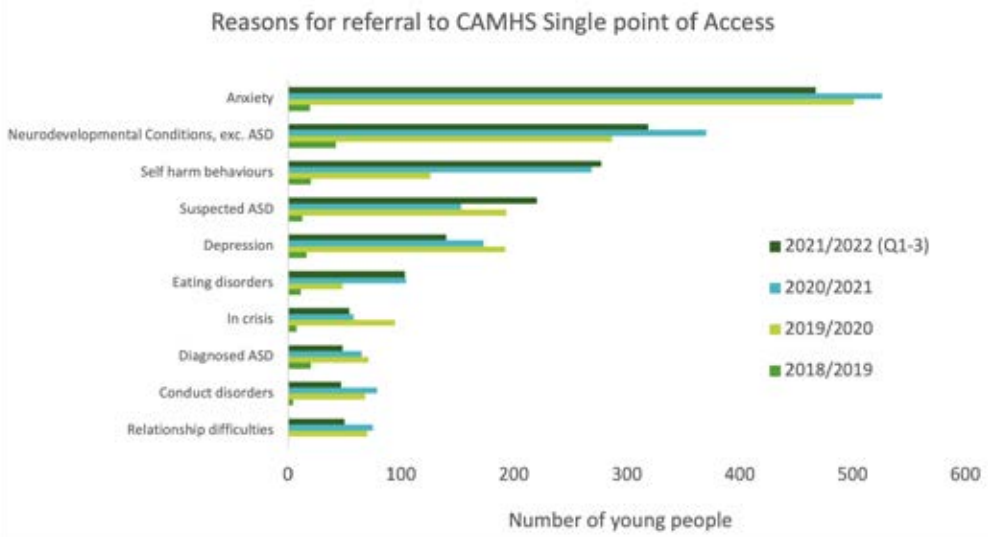


Source: CAMHS Single Point of Access. South West London St Georges NHS Trust. 2018-2022.

Reason for Referral to CAMHS Single Point of Access

- There is a lack of data recorded on the reason for referral to CAMHS SPA in 2018/19.
- The majority of CYP are referred to CAMHS SPA for anxiety (29% of referrals), neurodevelopmental conditions (19% of referrals) and self-harm behaviours (13% of referrals).
- There was an increase in referrals for self-harm behaviours and eating disorders in 2020/2021, and these remained elevated in 2021/2022.
- The number of referrals for self-harm behaviours increased by 113.5% from 126 referrals in 2019/2020 to 269 referrals.
- The number of referrals for eating disorders increased by 116.7% from 48 referrals in 2019/2020 to 104 referrals.
- This increase in referrals for self-harm behaviours and eating disorders is likely to be due to the impact of the COVID-19 pandemic, which has been recognised nationally to have elevated rates of self-harm and eating disorders.[146]
- It is noticeable that the number of referrals for in-crisis and depression have reduced over the three-year period.

Figure 26: Reasons for referral to CAMHS SPA between 2018/19 and 2021/22

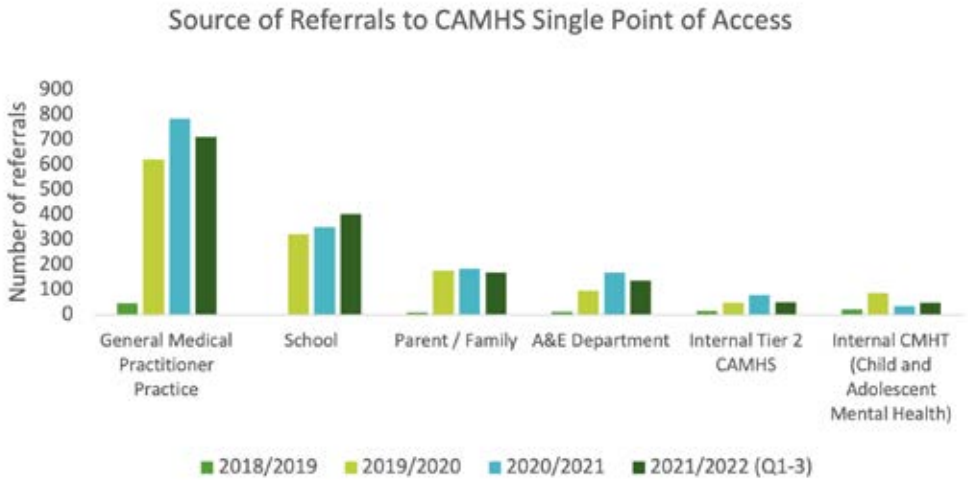


Source: CAMHS Single Point of Access. South West London St Georges NHS Trust. 2018-2022.

Source of Referral to CAMHS Single Point of Access

- There is a lack of data recorded on the source of referral to CAMHS SPA in 2018/19.
- The majority of CYP were referred through general practitioners, education settings and parents/families; these three sources referred 72% of clients between 2018 and 2022.
- It is noticeable that the number of referrals from the A&E department has grown from 6% of referrals in 2019/2020 to an average of 8.5% of referrals from 2020/21 to 2021/22 (Q1-3). This may be a result of the COVID-19 pandemic, which increased rates of risky behaviours among CYP and hindered access to early intervention services, such as GPs.[147]

Figure 27: Source of referrals to CAMHS SPA between 2018/19 and 2021/22



Source: CAMHS Single Point of Access. South West London St Georges NHS Trust. 2018-2022.

Emotional Health Services

The EHS is a multi-disciplinary team of clinical specialist and mental health clinicians who provide mental health support to CYP in Richmond.

The service works with any child meeting thresholds for support and referred through the single point of access. Referrals are accepted when the problem is having a significant impact on the child's general functioning despite interventions from universal services.

These may include anxiety; panic; phobias; persistent low mood and superficial self-harm; eating problems; relationship or attachment difficulties; difficulties coping with everyday life after experiencing trauma or significant life challenge; and mild obsessional compulsive disorder.

Demographics of Referrals to the Emotional Health Service

- The number of referrals to the EHS has continued to decrease each year.
- Most service users are aged between 12-14.
- Use of the service has dropped since the pandemic amongst all age groups apart from 12-14 which has been consistent between 2020-22.
- Females have attended more than males every year except for 2019/20.
- Males using the service have continued to decrease from 2019/20.
- White service users make up the majority of attendees with Black service users attending the least. Ethnicity data was not stated or not recorded for a large number of service users.

Table 28: Use of the EHS in Richmond between 2019/20 and 2021/22

Demographics of Referrals to Emotional Health Service	2019/20	2020/21	2021/22
Total referrals received	**883**	**714**	**683**
Age			
0-2 Years	7	n/a	0
3-5 Years	42	22	27
6-8 Years	162	110	117
9-11 Years	208	186	172
12-14 Years	251	213	213
15-17 Years	210	180	152
18+ Years	<5	<5	<5
Sex			
Female	428	400	370
Male	455	313	313
Missing Data	0	<5	0
Ethnicity			
Asian	25	29	26
Black	9	11	11
Mixed	84	54	36
Other	30	42	44
White	525	415	417
Not Stated	149	129	108
Not Recorded	61	34	41

Source: Emotional Health Service. Achieving for Children. 2019-2022.

- The number of those referred to the service has declined each year.
- Most referrals are received from the GP followed by schools although in 2021/22 there was a reduction in GP referrals.
- Since 2019/20 most service users have waited 13-18 weeks for their first appointment; this has increased to 12-26 weeks in 2021/22.
- In 2020/21 6 CYP waited over a year for their first assessment.
- The reason for most referrals has been anxiety. In 2019/20 the second most common reason was low mood. In 2020/21 and 2021/22 the second most common reasons are not specified/unknown.

Table 29: Presenting issues of Kooth service users by percentage between 2019/20 and 2021/22

	2019/20	2020/21	2021/22
Total referrals received	**883**	**714**	**683**
Referral Source			
Child Social Services	48	28	28
Counselling	<5	0	<5
Family/Friend	77	75	54
GP	330	323	226
Health Professional	12	0	<5
Hospital	12	14	12
Paediatrics	41	10	14
Early Help	65	78	107
School	247	146	201
Self	<5	<5	<5
Tier 3	49	38	36
Waiting Times to 1st Assessment			
4 Weeks or Less	33	42	
5-8 Weeks	58	55	24
9-12 Weeks	112	63	26
13-18 Weeks	153	111	57
19-26 Weeks	46	70	108
6 Months -1 Year	15	35	120
Over 1 Year	0	6	52
Referrals Received – by Reason			0
Anger	13	9	6
Anxiety	292	262	219
Behavioural Difficulties	41	88	31
Eating Difficulties	n/a	n/a	0
Low Mood	257	109	94
Neuro Development Difficulties	47	30	32
Not Specified/Unknown	195	172	245
Other	12	7	17
Phobia	4	n/a	0
Self-harm	22	37	39

Source: Emotional Health Service. Achieving for Children. 2019-2022.

Kooth Online Counselling

Kooth provides rapid online access to counselling, peer support and self-help information across south west London.

- There were 3817 new user registrations in 2021/22 across south west London.
- 47% of new registrations were from ethnic minority groups.
- 70% of logins were out of normal office hours.
- Most users were active between 19:00 and 20:00.
- 73% of users were female.

Table 30: Table showing the percentage of Kooth service users by presenting issues between 2019 and 2022

Demographics of Referrals to Emotional Health Service	Percentage of all recorded presenting issues		
	2019/20	2020/21	2021/22
Anxiety/Stress	38.1	26.1	38.8
Suicidal Ideation	9.5	15.2	21.3
Depression	4.8	8.7	11.3
Family Relationships	4.8	19.6	10
Self-harm	19	32	17.5
Eating Issues	4.8	13	11.3

Source: A Kooth Conversation: South West London 2021/22

Off the Record Twickenham

OTR is a registered charity providing one-to-one counselling sessions for young people aged 11-24 years who live, work or study in Richmond. OTR offers young people up to twelve weekly sessions of counselling, as well as 'one-off' counselling sessions for those waiting to access services.

Referrals to Off The Record Twickenham

- The number of service users attending Off the Record have increased over the past four years. Although numbers dropped in 2020/21 during the COVID-19 pandemic, this returned to previous levels in 2021/22.
- This growth in service use has particularly been seen among the 11–16-year-old age group. The proportion of 17–19-year-olds attending the service has fallen over the period.
- There are more females than males using Off the Record. Whilst female service attendance has returned to pre-pandemic levels, the number of males remains reduced.

Table 31: Demographics of referrals to OTR Twickenham between 2018/19 and 2021/22

Demographics of Referrals to Emotional Health Service	2018/19	2019/20	2020/21	2021/22
All Service Users	**324**	**504**	**394**	**473**
Age				
Age 11 – 16	168	298	251	300
Age 17 – 19	96	103	63	94
Age 20 – 25	60	103	80	79
Sex				
Female	231	314	243	317
Male	92	190	148	142
Other	<5	-	<5	14
Ethnicity				
White British	219	340	245	293
Other white	25	39	42	46
Mixed	32	59	43	38
Asian	16	21	26	27
Black	6	13	10	8
Other	12	12	<5	23
Not stated	14	20	23	38

Source: Off the Record Twickenham. 2018-2022.

Use of Off The Record Twickenham

- The wait time to receive a first assessment for Off the Record has increased over the past four years from 1-2 weeks to 2-3 weeks.
- On average, only 36% of service users complete at least six of the twelve counselling sessions offered.

Table 32: Use of OTR Twickenham services between 2018/19 and 2021/22

Use of Off The Record Twickenham Services	2018/19	2019/20	2020/21	2021/22
Number of service users referred and accepted to service	414	590	436	553
Waiting times for first assessment	1-2 weeks	1-2 weeks	2 weeks	2-3 weeks
Number of service users that complete 6+ counselling sessions	169	192	145	199

Source: Off the Record Twickenham. 2018-2022.

Wild Minds Project

The Wild Minds Project is a voluntary sector service that aims to support the emotional and mental wellbeing of young people through nature-focused interventions and creative activities.

Referrals to the Wild Minds Project

- 79 of 129 participants of the project reside in Richmond.
- All referrals were accepted into service.
- Three quarters of participants are girls.
- Most clients come to the programme through self-referral or referral from parent/carer.

Tier 3: Getting More Help

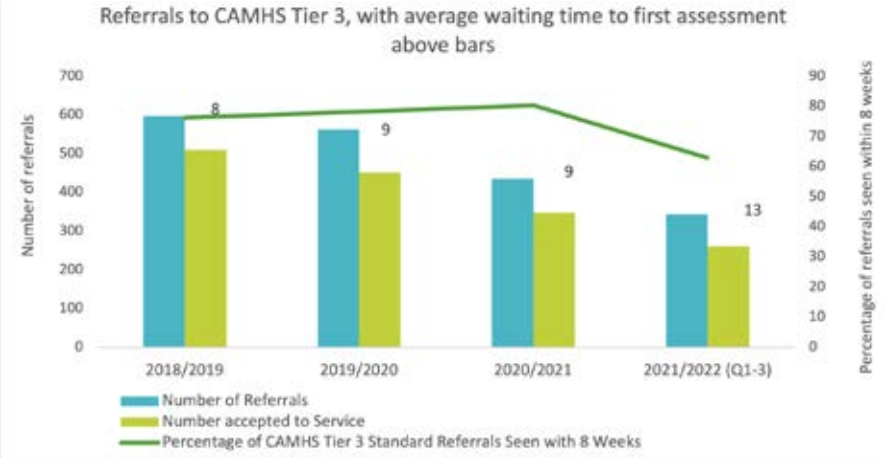
CAMHS Tier 3

CAMHS Tier 3 is a comprehensive assessment and treatment service for young people experiencing severe, complex, and persistent emotional and mental health disorders. The service offers a range of evidence-based talking therapies such as Cognitive Behavioural Therapy, Interpersonal Therapy for Adolescents and Family Therapy. In some circumstances, the service may also consider treatment through medication.

Referrals to CAMHS Tier 3 and Use of the Service

- Across the four-year period there has been a decline each year in the number of CYP referred and accepted into CAMHS Tier 3 services.
- The decline in referrals was most acute in 2020/21; the number of referrals fell by 27% from 563 CYP in 2019/20 to 435 CYP in 2020/21. This is likely due to the impacts of the COVID-19 on referrals to health services. [148]
- In 2021/2022 (Q1-3), the average wait time to first assessment increased to a high of 13 weeks.
- In the same year, there was a decline in the number of referrals seen within 8 weeks to just 63% of referrals.
- This may have been due to the impact of the COVID-19 pandemic on the operation of health services.[149]

Figure 33: Referrals to CAMHS Tier 3, with average waiting time to first assessment above bars, between 2018/19 and 2021/22

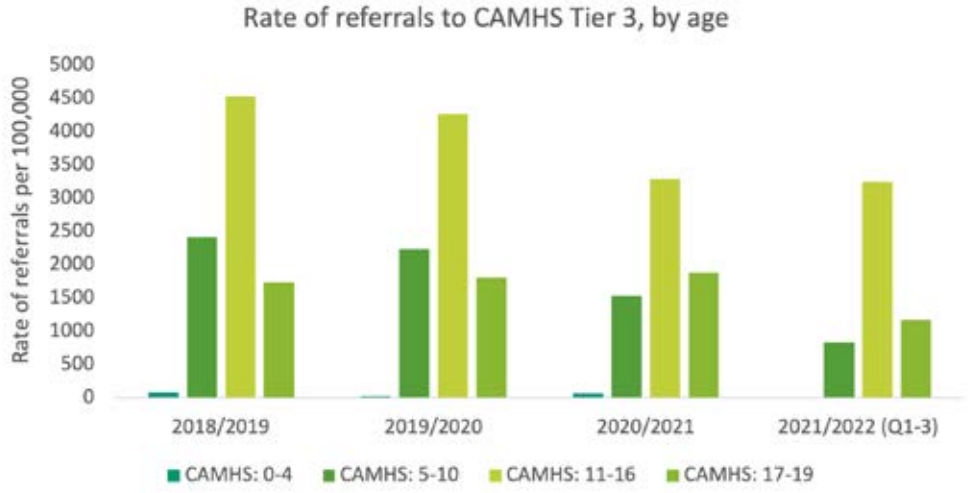


Source: CAMHS Tier 3. South West London St Georges Mental Health Trust. 2018-2022.

Age of Referrals to CAMHS Tier 3 Services

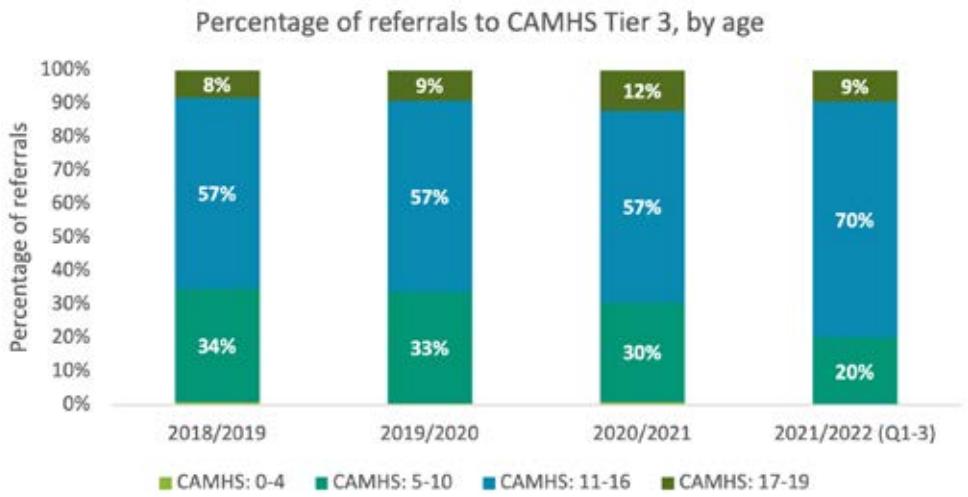
- Across the period, the majority of referrals to CAMHS Tier 3 were in the 11–16-year-old age group (av. 3840 per 100,000), followed by 5–10-year-olds (av. 1759 per 100,000) and 17–19-year-olds (av. 1654 per 100,000).
- There were only a small number of 0–4-year-olds referred to the service (av. 47 per 100,000).
- From 2020, there was a decline in the rate by which 5–10-year-olds were referred to the service; this fell from a rate of 2,420 per 100,000 and 2,244 per 100,000 in 2018/19 and 2019/20, to 1,538 per 100,000 and 835 per 100,000 in 2020/21 and 2021/22 (Q1-3).
- This is likely to have been a consequence of the closure of schools during the COVID-19 lockdowns, as schools are responsible for a significant proportion of referrals to CYP from this age bracket to CAMHS services.[150]
- All age groups saw reduced rates of referral in 2021/22 except 11-16-year-olds, which maintained a stable rate of referral.

Figure34: Rate of referrals to CAMHS Tier 3 by age between 2018/19 and 2021/22



Source: CAMHS Tier 3. South West London St Georges Mental Health Trust. 2018-2022.

Figure 35: Percentage of referrals to CAMHS Tier 3 by age between 2018/19 and 2021/22

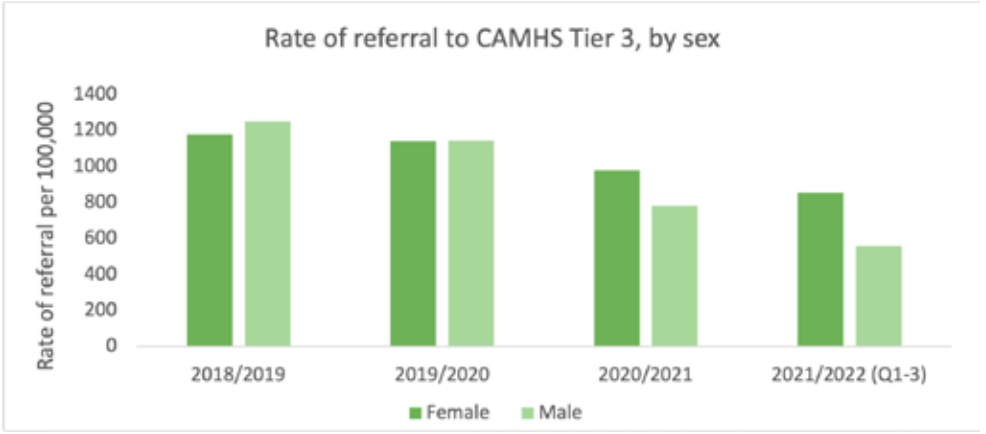


Source: CAMHS Tier 3. South West London St Georges Mental Health Trust. 2018-2022.

Sex of Referrals to CAMHS Tier 3 Services

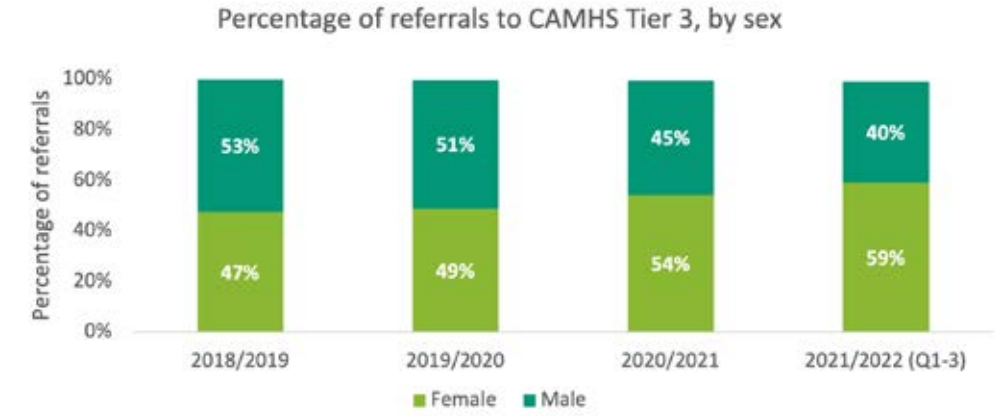
- In 2018/19 and 2019/20, the numbers of males and females referred to CAMHS tier 3 services were relatively equal.
- The rate of both female and male referral declined each year over the four-year period.
- However, there was a steeper decline in the rate of male referral than female across the period; the rate of male referral declined by 77% between 2018/19 and 2021/22 (Q1-3), whereas the rate of female referral only declined by 28.5% over the same period.
- This led to an imbalance in clients referred to the service in 2020/21 and 2021/22 (Q1-3); with only 45% and 40% of males referred to the service in these years, respectively.

Figure 36: Rate of referral to CAMHS Tier 3 by sex between 2018/19 and 2021/22



Source: CAMHS Tier 3. South West London St Georges Mental Health Trust. 2018-2022.

Figure 37: Percentage of referrals to CAMHS Tier 3 by sex between 2018/19 and 2021/22

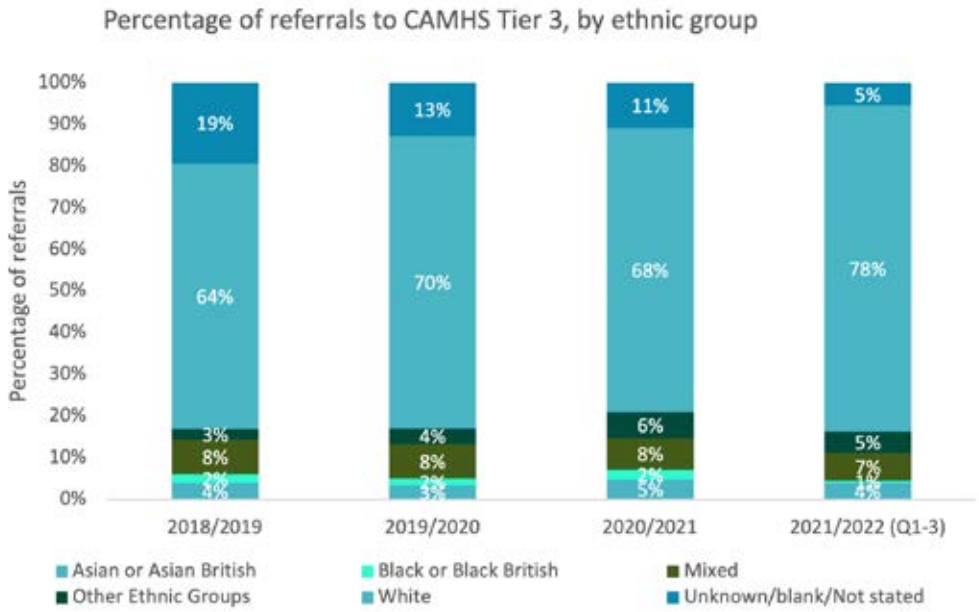


Source: CAMHS Tier 3. South West London St Georges Mental Health Trust. 2018-2022.

Ethnicity of Referrals to CAMHS Tier 3 Services

- Between 2018/19 and 2021/22, the majority of clients referred to CAMHS Tier 3 were from White ethnic groups (av. 70%).
- This was followed by clients from Mixed ethnic groups (av. 8%), Asian or Asian British ethnic groups and Other Ethnic groups (av. 4% each) and Black or Black British ethnic groups (av. 2%).
- The proportion of service users from White ethnic backgrounds increased over the period from 64% of referrals in 2018/19 to 78% in 2021/22 (Q1-3).
- Over the period, the percentage of clients referred to the service with an unknown ethnicity fell from 19% of referrals in 2018/19 to only 5% of referrals in 2021/22 (Q1-3). This decline corresponds to the growing percentage of referrals from White ethnic groups.

Figure 38: Percentage of referrals to CAMHS Tier 3 by ethnic group between 2018/19 and 2021/22



Source: CAMHS Tier 3. South West London St Georges Mental Health Trust. 2018-2022.

Adolescent Assertive Outreach Team

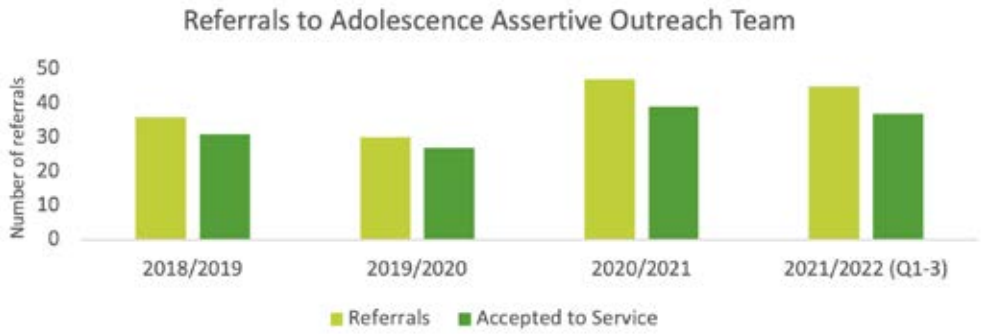
The Adolescent Outreach Team is a small multidisciplinary community team, working across South West London, with the aim of providing more intensive support in the community to young people aged 12-18-years-old who are experiencing an acute crisis in their mental health and who might be at risk of needing an inpatient admission owing to the severity of their illness or risk.

The service treats the following conditions: anxiety disorders, bipolar disorder, depression, obsessive compulsive disorder, post-traumatic stress disorder and psychosis.

Referrals to the Adolescent Assertive Outreach Team

- Overall, there were a low number of CYP referred to the Adolescent Assertive Outreach Team, averaging at 66 CYP per year.
- Most referrals to the service were aged 17-years-old and below. Across the four-year period there were only 7 referrals between the ages of 18-24 years.
- The number of CYP referred and accepted to the service increased from 2020. Whilst 36 and 30 CYP were referred into the service in 2018/19 and 2019/20 respectively, this increased to 47 and 45 CYP in 2020/21 and 2021/22 (Q1-3). This may have been caused by the impacts of the COVID-19 pandemic on CYP mental health, which has been recognised to have increased the number of CYP experiencing an acute crisis and requiring a greater level of support.[151]
- Whilst the number of CYP accepted into the service similarly increased in 2020/21 and 2021/22, there was also a growth in the percentage of CYP not accepted to the service, increasing from an average of 12% in 2018/19-2019/20 to an average of 17.5% in 2020/21-2021/22.

Figure 39: Referrals to the Adolescent Assertive Outreach Team between 2018/19 and 2021/22.

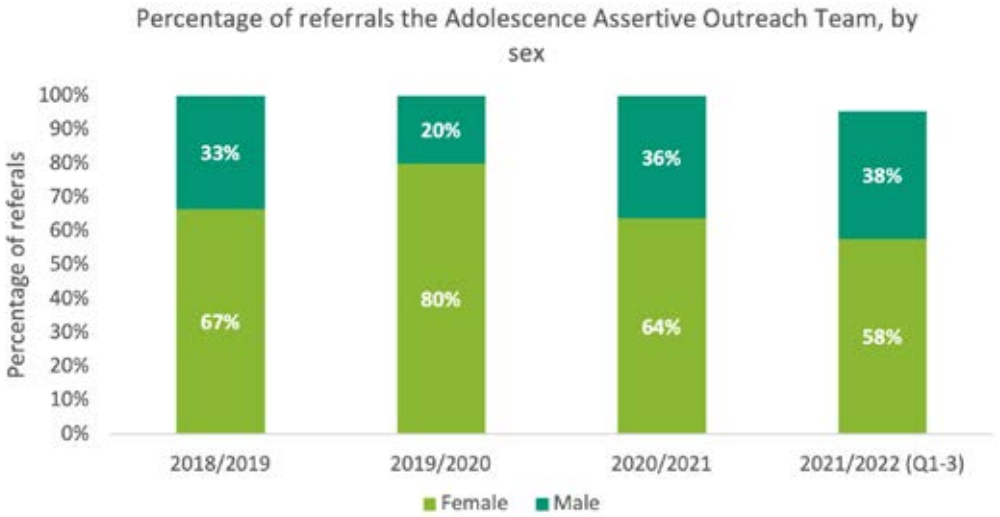


Source: Adolescence Assertive Outreach Team. South West London St George's NHS Trust. 2018-2022.

Sex of Referrals to the Adolescent Assertive Outreach Team

- Across the four-year period, there was a greater number of females (67.25%) referred to the service than males (32.75%).
- This imbalance was most pronounced in 2019/20 – 80% female and 20% male.
- However, the percentage of males in the service grew in 2020/21 and 2021/22 (Q1-3) to 36% and 38% of referrals respectively, which correlates with the growth in total referrals in these years.

Figure 40: Percentage of referrals to the Adolescence Assertive Outreach Team by sex between 2018/19 and 2021/22

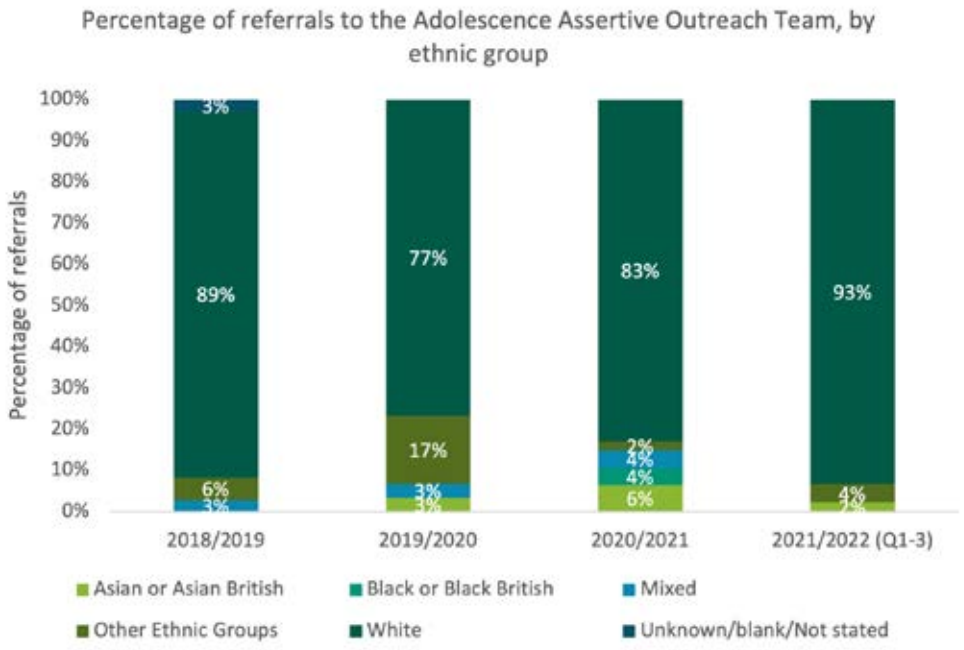


Source: Adolescence Assertive Outreach Team. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Referrals to the Adolescent Assertive Outreach Team

- Between 2018/19 and 2021/22 (Q1-3), the majority of referrals to the Adolescent Outreach Team were from White Ethnic Groups (av. 85.5%).
- There was a spike in the percentage of CYP from Other Ethnic Groups referred in 2019/20 to 17%.
- There were no Black or Black British CYP referred to the service in 2018/19, 2019/20 and 2021/22 (Q1-3).

Figure 41: Percentage of referrals to the Adolescence Assertive Outreach Team by ethnic group between 2018/19 and 2021/22



Source: Adolescence Assertive Outreach Team. South West London St George's NHS Trust. 2018-2022.

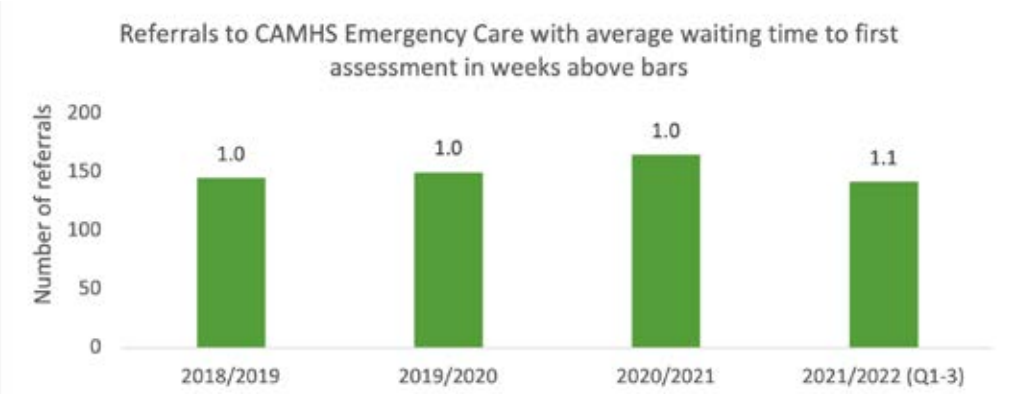
CAMHS Emergency Care Service

CECS is a specialist CAMHS nursing team which carries out mental health and self-harm assessments at A&E departments or on paediatric wards when a young person has required a brief inpatient stay following an episode of self-harm. CECS will carry out the initial assessment and then offer a follow up in 5-7 days. However, if the CYP is already known to local CAMHS they will provide the follow up.

Referrals to the CAMHS Emergency Care Service

- In 2018/19 and 2019/20 there were 1,450 and 150 young people referred to CECS.
- The number of referrals to CECS spiked in 2020/2021 to 165 young people.
- This may have been caused by the impacts of the COVID-19 pandemic on CYP mental health, as national studies have found that the pandemic escalated rates of self-harm behaviour and eating disorders, particularly among young females.[152]
- In Q1-3 of 2021/22 there were already 142 referrals to CECS.
- Wait times remained at a stable 1-1.1 weeks across the four-year period.

Figure 42: Referrals to CAMHS Emergency Care Services, with average waiting time to first assessment in weeks above bars, between 2018/19 and 2021/22

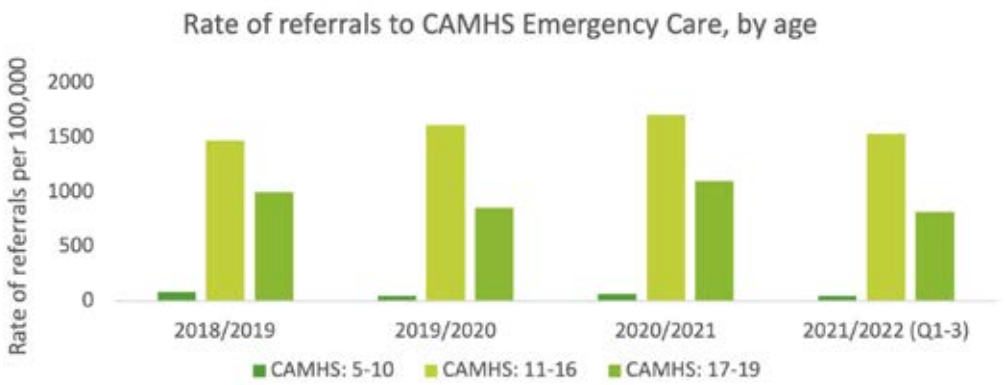


Source: CAMHS Emergency Care Service. South West London St George's NHS Trust. 2018-2022.

Age of Referrals to the CAMHS Emergency Care Service

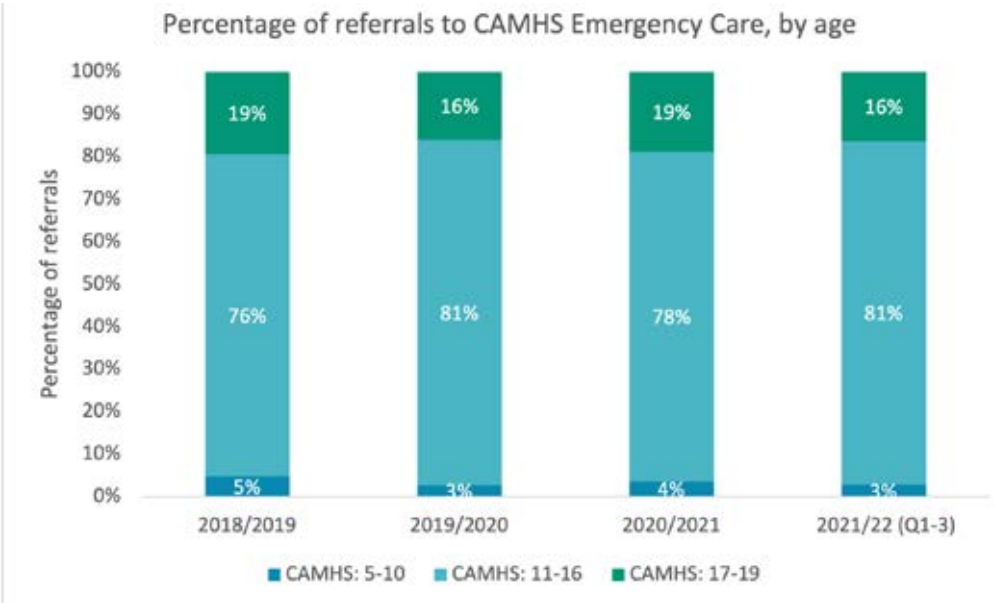
- Over the four-year period, the majority of referrals to CECS were in the 11-16-year-old age group (av. 79%), followed by the 17–19-year-old age group (av. 27%).
- The lowest rate of referrals was within the 5–10-year-olds age group (av. 3.75%).
- These percentages remained relatively stable across the period.
- Although the rate of referral for all age groups fluctuated over the period, it is noticeable that referrals of both 11-16-year-olds and 17-19-year-olds peaked at their highest point in 2020/21.
- This may have been due to the impacts of the COVID-19 pandemic, which has been noted to have increased self-harm and eating disorders, which are more prevalent in these age groups.[153]

Figure 43: Rate of referrals to the CAMHS Emergency Care Service by age between 2018/19 and 2021/22 (Q1-3)



Source: CAMHS Emergency Care Service. South West London St George's NHS Trust. 2018-2022.

Figure 44: Percentage of referrals to the CAMHS Emergency Care service by age between 2018/19 and 2021/22 (Q1-3)

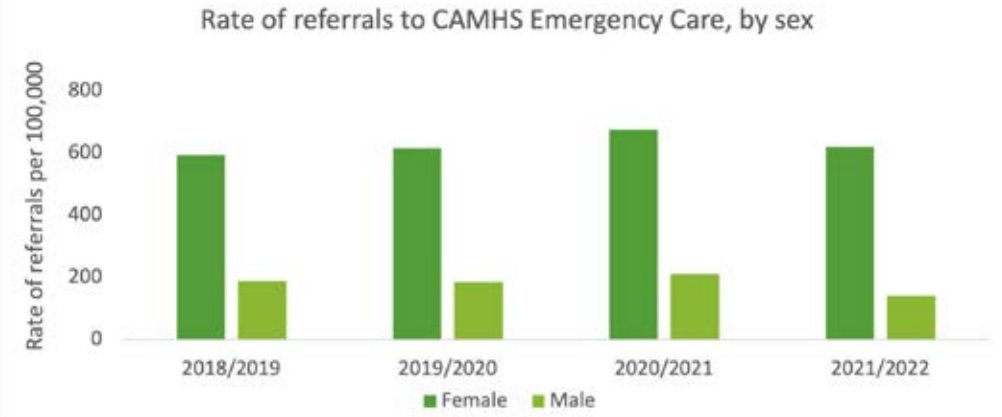


Source: CAMHS Emergency Care Service. South West London St George's NHS Trust. 2018-2022.

Sex of Referrals to the CAMHS Emergency Care Service

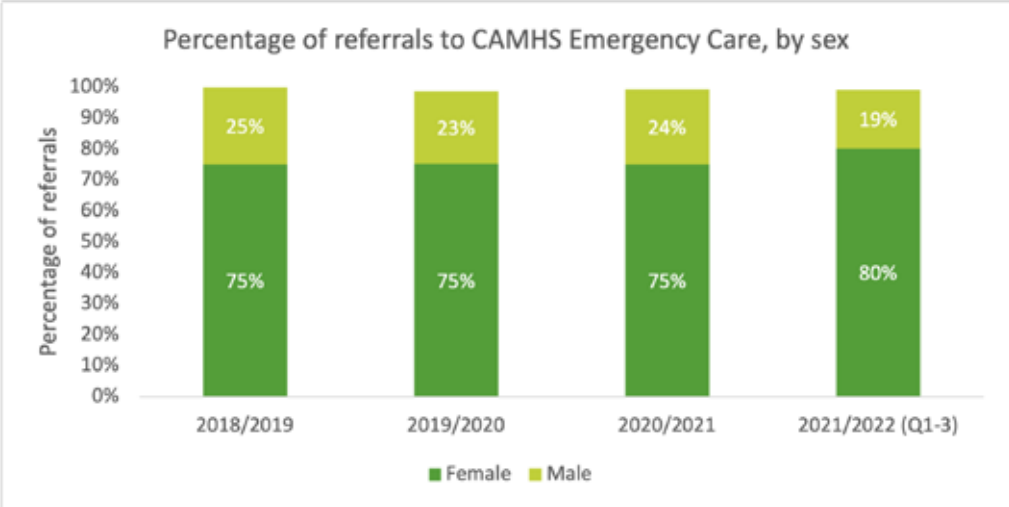
- Between 2018/19 and 2021/22 there was a higher percentage of females referred to CECS than males; av. 76.25% females and av. 23.75% males.
- The imbalance was most pronounced in 2021/22, wherein 80% of referrals were female and only 19% were male.
- This imbalance is in keeping with the higher prevalence rates of self-harm behaviour observed nationally among female CYP.[154]
- The rate of referral was highest for both males and females in 2020/21, which may have been caused by the COVID-19 pandemic, which has been recognised to have increased levels of acuity and risky behaviours among CYP. [155]

Figure 45: Rate of referrals to the CAMHS Emergency Care Service by sex between 2018/19 and 2021/22



Source: CAMHS Emergency Care Service. South West London St George's NHS Trust. 2018-2022.

Figure 46: Percentage of referrals to the CAMHS Emerency Care Service by sex between 2018/19 and 2021/22

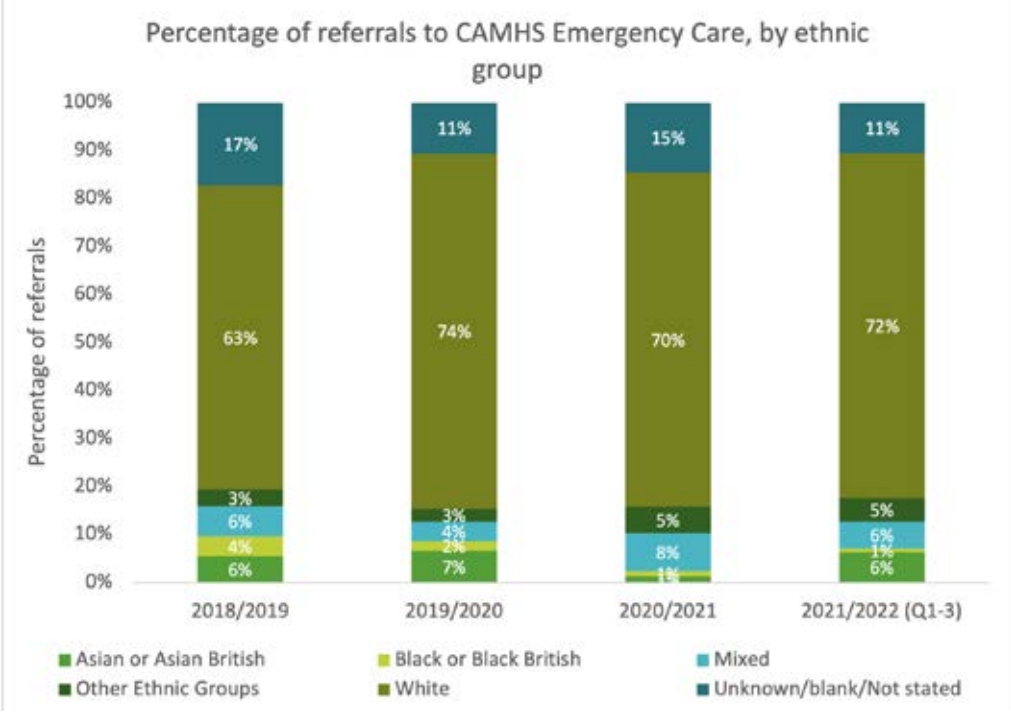


Source: CAMHS Emergency Care Service. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Referrals to the CAMHS Emergency Care Service

- Between 2018/19 and 2021/22 (Q1-3) most referrals to CECS were from White ethnic groups (av. 69.75%).
- The percentage of referrals from White ethnic groups increased over the period from 63% in 2018/19 to 72% in 2021/22.
- There was a sharp decline in the proportion of referrals from Asian and Asian British ethnic groups in 2020/21, falling from 6% and 7% in previous years to just 1% of referrals. This returned to 6% in 2021/22 (Q1-3).
- The percentage of referrals from Black or Black British ethnic groups to CECS decreased over the period from 4% in 2018/19 to 1% in 2020/21 and 2021/22 (Q1-3).
- There is a high percentage of referrals for which the ethnicity is unknown (av. 13.5%) across the period. This percentage has fluctuated over the period, with a trend toward declining, but remains relatively high. This indicates a need for improved data collection on ethnicity.

Figure 47: Percentage of referrals to the CAMHS Emergency Care Service by ethnic group between 2018/19 and 2021/22



Source: CAMHS Emergency Care Service. South West London St George's NHS Trust. 2018-2022.

CAMHS Eating Disorder Service

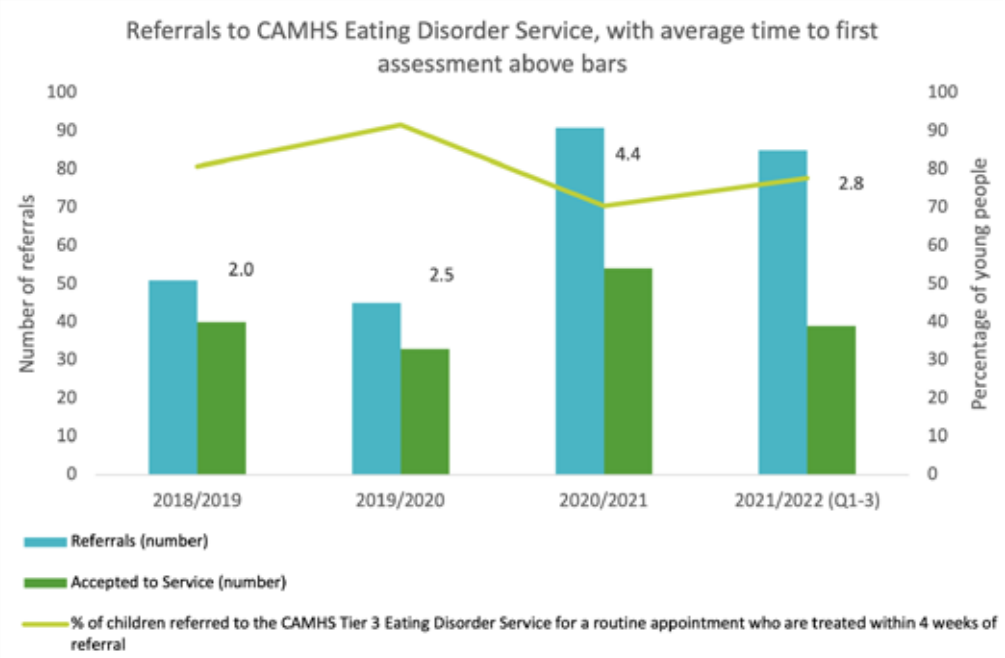
A young person diagnosed with an eating disorder will be referred from Tier 3 to CAMHS Eating Disorder Service at Springfield Hospital. The service treats binge eating, anorexia nervosa, bulimia and eating disorders.

Referrals to the CAMHS Eating Disorder Service and Use of the Service

- In 2018/19 and 2019/20, there were 51 and 45 referrals to the CAMHS Eating Disorder Service, respectively.
- In 2020/21 and 2021/22 (Q1-3), the number of referrals increased sizeably to 91 and 85 CYP, respectively.
- Given data for 2021/22 only covers Q1-3, it is likely that the total referrals for this year will exceed that in all previous years.

- This reflects nationally observed increases in eating disorders among CYP.[156]
- Despite the large increase in referrals, the number of children and young people accepted into CAMHS Eating Disorder Service has not followed the same trend, and so there has been a widening gap between those referred and those accepted into the service; the percentage of CYP not accepted to the service increased from 22% and 27% in 2018/19 and 2019/20, to 41% in 2020/21 and 54% in 2021/22 (Q1-3).
- In 2020/21, the wait time to access CAMHS Eating Disorder Service increased to an average of 4.4 weeks, which is 83% higher than the average wait times in all other years; 2 weeks in 2018/19, 2.5 weeks in 2019/20 and 2.8 weeks in 2021/22.
- Similarly, the % of CYP receiving treatment within 4 weeks of referral reached a low of 70% in 2020/2021, however this begun to return to previous levels, increasing to 78% in 2021/22 (Q1-3).

Figure 48: Referrals to the CAMHS Eating Disorder Service, with average wait time to first assessment, between 2018/19 and 2021/22 (Q1-3)

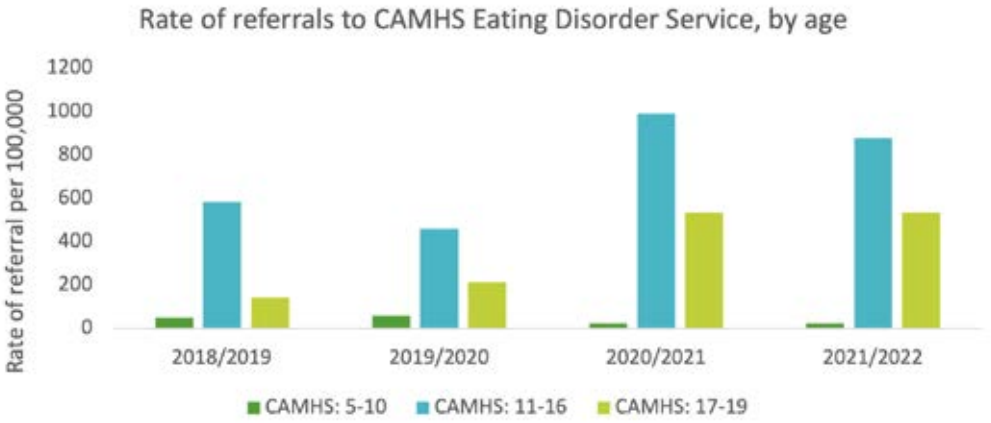


Source: CAMHS Eating Disorder Service. South West London St George's NHS Trust. 2018-2022.

Age of Referrals to CAMHS Eating Disorder Service

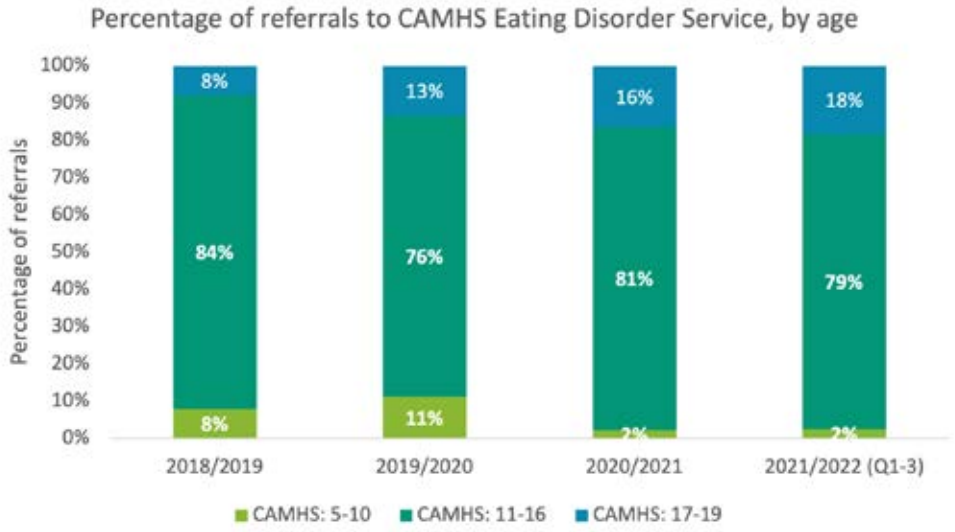
- Across the four-year period, the majority of referrals to CAMHS Eating Disorder Service were for 11–16-year-olds (av. 80%), followed by 17-19 year olds (av. 13.75%).
- The lowest referral rate was in 5–10-year-olds (av. 5.75%).
- The rates of referrals of the 11-16 and 17-19 age groups increased after 2020.
- The rate of referral of 11-16-year-olds rose from an average of 5.2 per 1,000 in 2018/19 and 2019/20 to an average of 9.35 per 1,000 in 2020/21 and 2021/22 – an 80% increase in referrals.
- The rate of referral of 17-19-year-olds increased from an average of 1.75 per 1,000 to 5.3 per 1,000 in the same period. This is a 203% increase in referrals.
- By contrast, there was a decline in the rate of 5–10-year-olds referred to the service after 2020. This led to a significant decline in the percentage of 5-10-year-olds referred to the service, falling from 8% and 11% of referrals in 2018/19 and 2019/20 respectively to only 2% of referrals in both 2020/21 and 2021/22.

Figure 49: Rate of referral to CAMHS Eating Disorder Service by age between 2018/19 and 2021/22



Source: CAMHS Eating Disorder Service. South West London St George's NHS Trust. 2018-2022.

Figure 50: Percentage of referrals to CAMHS Eating Disorder Service by age between 2018/19 and 2021/22

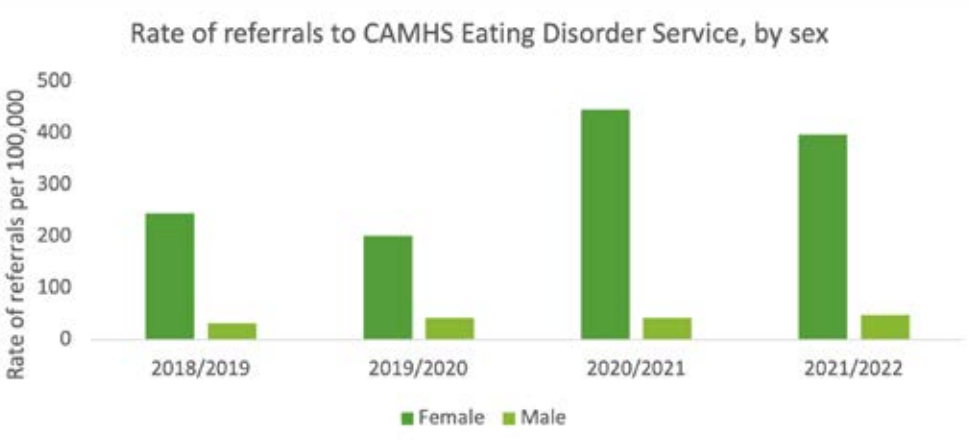


Source: CAMHS Eating Disorder Service. South West London St George's NHS Trust. 2018-2022.

Sex of Referrals to CAMHS Eating Disorder Service

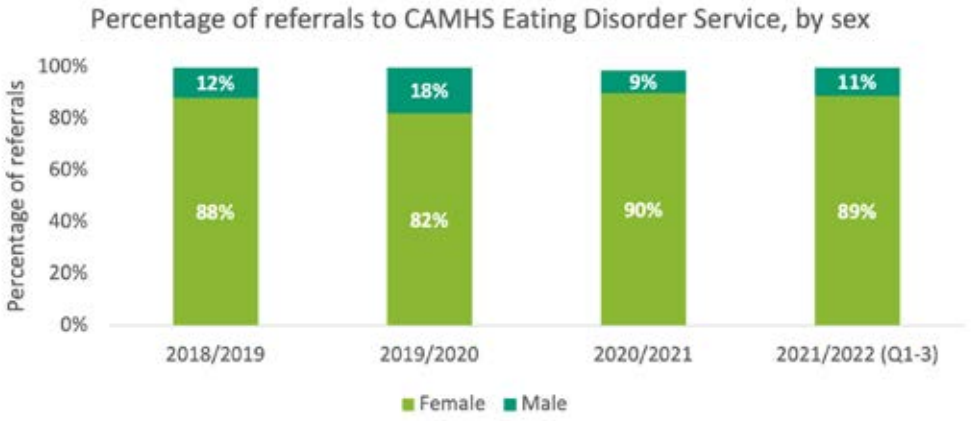
- Across all years the number of females referred to CAMHS Eating Disorder Service is higher than males; on average, females constituted 87.25% of referrals whereas males constituted just 12.25% of referrals.
- There was a large increase in referrals of females to the service in 2020/21 and 2021/22; this increased from rates of 245 and 201 per 100,000 CYP in 2018/19 and 2019/2020 respectively, to 446 and 397 per 100,000 in 2020/21 and 2021/22. This was a 93% increase in referrals.
- The number of boys in the service also increased over the period by 66.7% from a rate of 32 referrals per 100,000 in 2018/19 to 47 referrals per 100,000 in 2021/22 (Q1-3).
- These increases in referrals correlate with national increases in eating disorders among CYP following the COVID-19 pandemic.[157]

Figure 51: Rate of referrals to CAMHS Eating Disorder Service by sex between 2018/19 and 2021/22



Source: CAMHS Eating Disorder Service. South West London St George's NHS Trust. 2018-2022.

Figure 52: Percentage of referrals to CAMHS Eating Disorder Service by sex between 2018/19 and 2021/22

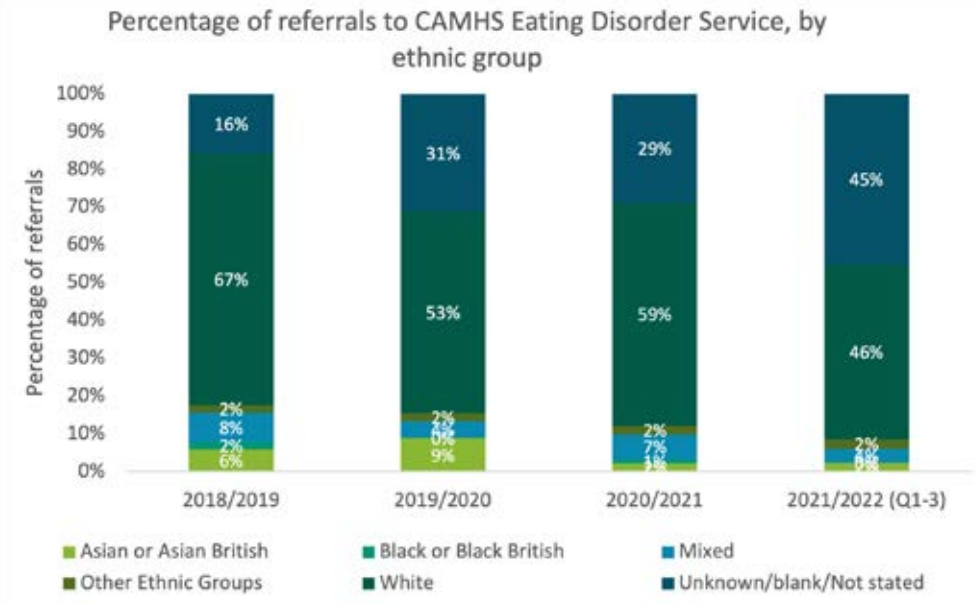


Source: CAMHS Eating Disorder Service. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Referrals to CAMHS Eating Disorder Service

- Between 2018/19 and 2021/22, the majority of referrals to CAMHS Eating Disorder Service were from White ethnic groups (av. 56.25%).
- White ethnic groups formed the highest percentage of referrals in 2018/19 (67%) but have steadily declined over the period to just 46% of referrals in 2021/22.
- There is a large and increasing percentage of referrals to CAMHS Eating Disorder Service whose ethnicity is unknown (av. 30.25%). This was highest in 2021/22, at 45% of referrals. This will have therefore skewed the ethnicity balance of referrals recorded in the graph above.
- There has been a decline in the percentage of Asian or Asian British service users referred to the service. This fell from a relative high of 6% and 9% in 2018/19 and 2019/20 respectively to just 2% in both 2020/21 and 2021/22 (Q1-3).

Figure 53: Percentage of clients referred to CAMHS Eating Disorder Service by ethnic group between 2018/19 and 2021/22



Source: CAMHS Eating Disorder Service. South West London St George's NHS Trust. 2018-2022.

Tier 4: Getting Risk Support

CAMHS Tier 4 provide specialised day and inpatient services for young people with mental disorders that are associated with significant impairment and/or significant risk to themselves or others, and whose needs cannot be safely and adequately met by CAMHS Tier 3 in the community.

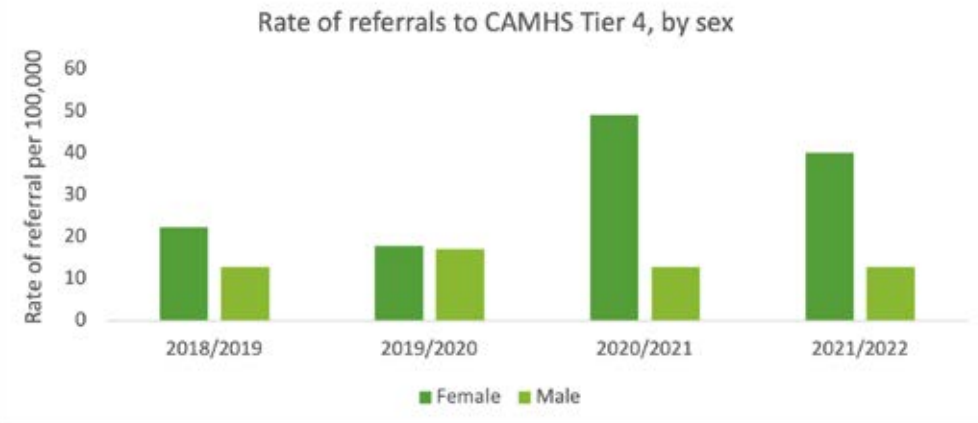
Referrals to CAMHS Tier 4 Services

There are a low number of CYP using CAMHS Tier 4 services in Richmond; across the four-year period just 42 CYP required Tier 4 services. In 2018/19 and 2019/20 there were 8 children in the service per year. This increased to 14 CYP in 2021/22 and there were 12 CYP referred in Q1-3 of2021/22.

Sex of Referrals to CAMHS Tier 4 Services

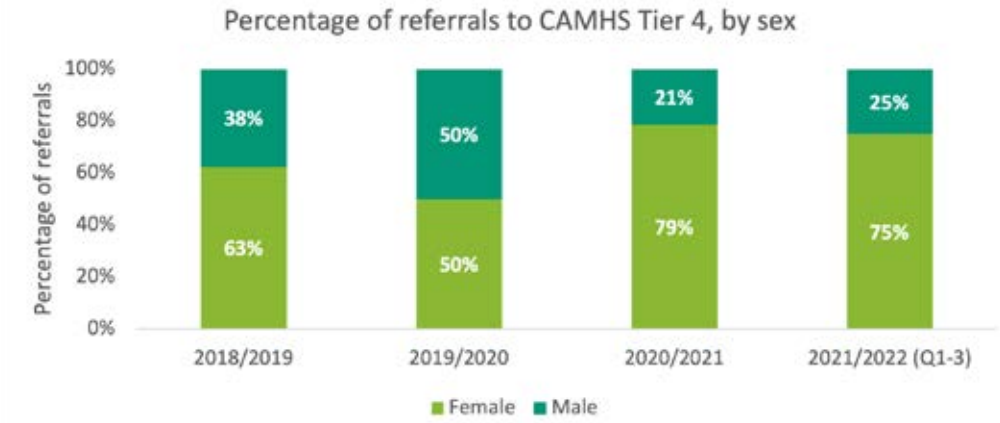
- With the exception of 2019/20, which had an equal number of males and females, there were more females referred to CAMHS Tier 4 services than males.
- This gap increased substantially from 2020; in 2020/21 and 2021/22 females constituted 79% and 75% of referrals respectively.
- This is due to a large increase in the number of females referred to the service since 2020. This increased from a rate of 22 and 18 per 100,000 in 2018/19 and 2019/20 respectively, to a rate of 49 and 40 per 100,000 in 2020/21 and 2021/22.
- By comparison, the rate of male referrals to CAMHS Tier 4 has remained relatively stable.
- This may reflect national observations that there has been an increase in severe mental health disorders among young females, particularly following the onset of the COVID-19 pandemic.[158] However, given the small numbers it is difficult to make any firm conclusions.

Figure 54: Rate of referrals to CAMHS Tier 4 by sex between 2018/19 and 2021/22



Source: CAMHS Tier 4. South West London St George's NHS Trust. 2018-2022.

Figure 55: Percentage of referrals to CAMHS Tier 4 by sex between 2018/19 and 2021/22



Source: CAMHS Tier 4. South West London St George's NHS Trust. 2018-2022.

Use of CAMHS Tier 4 Services

- There has been a reduction in the number of CYP spending extended periods of time on inpatient wards over the four-year period.
- Whilst in 2018/19, 60% of clients spent more than 90 days on the inpatient ward, this decreased to 43% in 2019/20, 12.5% in 2020/21 and reached a low of 0% in 2021/22 (Q1-3).
- Instead, more CYP are spending shorter periods in inpatient settings; the number of CYP staying for 0-60 days has increased from 30% in 2018/19 to 100% in 2021/22. For context, NHS Benchmarking in 2018/19 found that the average stay on CAMHS inpatient wards was 62 days for general admission.[159]
- Across the four-year period, the majority of referrals to CAMHS Tier 4 came from NHS wards for general patients and the usual place of residence.
- Upon discharge from CAMHS Tier 4 Services, CYP are primarily discharged back to their usual place of residence.

Service Activity: Key Findings

- Less boys are being referred to CAMHS SPA, falling from an average rate of 46 per 1,000 in 2018/19 and 2020/21 to 32 per 1,000 in 2020/21 and 2021/22.
- The most common referrals to CAMHS SPA are for anxiety (29%), neurodevelopmental conditions (19%) and self-harm behaviours (13%).
- The MHST programme is growing but does not have comprehensive coverage across all the borough's schools.
- The number of children supported by the MHST programme has increased over the last year but is still low compared to the numbers of children estimated to need support
- The number of referrals to the Emotional Health Service has declined in recent years, most referrals wait between 3 and 4 months for their first appointment.
- There has been a consistent decline in the number of children and young people referred and accepted into CAMHS Tier 3 services.
- In 2021/2022, there was an increase in the average wait time to first assessment in CAMHS Tier 3 services, rising from an average of 8.7 weeks from 2018-2021 to 13 weeks in 2021/2022.
- There was an increase in the number of children and young people referred and accepted into the Adolescent Assertive Outreach Team in 2020/21 and 2021/22.
- There was a noticeable increase in the number of referrals (165) to CAMHS Emergency Care Service in 2020/2021, higher than the average referred (145) across all other years.
- Referrals to the CAMHS Eating Disorder Service have increased over recent years. The numbers accepted to the service has also increased but not in proportion to the increase in referrals.
- Across all services, there are a large percentage of children and young people whose ethnicity is not recorded, which makes analysing the ethnicity balance of service users challenging. Effort should be made to improve recording of service users' ethnicity to ensure particular groups are not under- or over-represented within services.

Stakeholder Consultation

Focus Group Discussions

Focus groups were conducted with multiple stakeholders to provide detailed insight into the mental health needs of Richmond's population. A detailed list of the groups that participated in these discussions can be found in the introductory section.

Key Issues for Children and Young People's Mental Health in Richmond

The consultations identified the following key issues facing children and young people in Richmond:

Increased Prevalence of Mental Health Need

Stakeholders reported that mental health conditions among CYP in Richmond are increasing in prevalence, complexity, acuity, and longevity. Multiple stakeholders suggested that CYP in Richmond face a specific set of stressors, derived from the relative wealth of the borough and the phenomenon of 'affluent neglect'. This is a form of neglect experienced by children in wealthy families, which typically manifests emotionally.[160] Although a significant issue beforehand, the COVID-19 pandemic had dramatic adverse impacts on mental health needs and has led to a "total explosion of complexity in young people."

Concern was especially raised for the increased rates, pace and early onset of self-harm and suicidal ideation. Schools are seeing a "very high number of students with significant levels of anxiety which tend to escalate quickly into self-harm behaviour and suicidal ideation." One parent claimed that "they are all self-harming." Stakeholders identified that eating disorders are a particularly heightened issue in Richmond specifically, which, although presents highest among young girls, is also escalating among young boys and non-binary children.

Insufficient Accessibility to Services

Stakeholders reported that CYP are experiencing long waiting lists to access mental health services due to limited capacity within and increasing demands on services.

The wait time for CAMHS was identified as up to 18 months, which concerned stakeholders given that children requiring CAMHS "are actually the needier children but they just can't access anything". Accessing a referral to CAMHS 0-5 services was identified as particularly challenging.

The wait time for an initial assessment to the EHS was reported as 9 months, and, if accepted, CYP must, on average, wait an additional 11-12 months for an intervention. CYP and their parents/carers are resultantly forced to "go through private clinics or tolerate very long waiting lists".

Even when accepted into mental health services, service users felt that demands on capacity limited the extent of care they subsequently received. Service users suggested that services over-prescribed medication as an alternative to therapy, placed time limits on provision and discharged CYP prematurely from services. In addition, service users expressed frustration at the lack of flexibility they were offered to tailor their care to their needs; "with waiting times so long, there is no choice – you have to accept whoever you get".

Awareness of Services Available in Richmond

Stakeholders felt that there is a lack of awareness of the service provision available in Richmond and their thresholds for accessibility. It was suggested that up to date and accessible information should be provided to help signpost CYP and their parents/carers to services in the borough, such as through AFC, CAMHS SPA and/or schools.

Disconnect Between Services

Stakeholders reported that there continues to be significant disconnect between mental health services, which makes navigating the pathway between them challenging and inefficient. They felt that services continue to work in silos, and partnership working is stymied by the competitive tendering of service providers. For example, one stakeholder raised that children must see their GP to obtain a referral to CAMHS, rather than being directly signposted to MHSTs. Inefficient communication between services was also frequently identified as an issue, with services continuing to utilise different client information systems.

The service disjuncture seen as particularly significant was the transition between children and adult mental health services. One stakeholder identified a 27% fall in activity between the 15-19 and 20-24 age groups. The disjuncture between child and adult services needs to be properly addressed to ensure continuity of care and prevent service users being lost in the transition.

Lack of Specialised Services for Children and Young People with Neurodiversity and/or Learning Disabilities

Stakeholders reported a lack of specialised mental health services and professionals for CYP with neurodiversity and/or LD in Richmond. It was felt that SEND-related services are struggling to complete timely assessments, and there is a serious need to expand complex SEND therapies and the CAMHS workforce. Although SWL LD CAMHS and local LD psychology/Positive Behaviour Support (PBS) received additional funding in 2021, stakeholders emphasised that more funding will be required to establish a place-based psychological and PBS team to deliver consultation and tiered help locally.

Stakeholders identified the COVID-19 pandemic as having had significant adverse impacts on the mental health of CYP with neurodiversity and/or LD, who were disproportionally affected by shielding and lockdown regulations. This has placed immense pressure on parents and carers. Additionally, stakeholders suggested that CYP with neurodiversity and/or LD accessing mental health services are presenting with highly complex and acute needs post-pandemic. Stakeholders expressed particular concern for the significantly high and disproportionate number of CYP with neurodiversity and/or LD in mental health inpatient services. Adult mental health hospitals are not considered to be the right place to support the needs of these CYP, but stakeholders questioned whether a more suitable place exists to support their needs.

The high numbers of CYP with neurodiversity and/or LD in crisis suggests a significant need to develop preventative services tailored to those that struggle to process and understand their emotions.

Schools Struggling to Cope with Students' Mental Health Needs

The limited capacity and lengthy wait times for mental health services was identified as posing significant challenges for schools, who are resultantly "left in the holding position to support and carry the child and the parent", including writing safety plans for high-risk children. This is placing significant pressure on staff who are "at breaking point when it comes to supporting students and parents with mental health". The sustainability of this pressure on staff is highly concerning to schools, especially as staff members are increasingly seeking to step back from pastoral responsibilities.

Services that are available to support schools with students' mental health are perceived as limited and inconsistent. There are not enough school nurses to cover all schools in Richmond, meaning their availability and time within schools is limited. In addition, although the work of Mental Health Support Teams (MHSTs) in schools was frequently praised by stakeholders, their provision is variable across schools in the borough, particularly private schools, and their support does not extend to children with autistic spectrum disorders.

LGBTQ+ Children and Young People

It was highlighted that LGBTQ+ CYP experience heightened mental health needs, and that these needs were further exacerbated by the COVID-19 pandemic.

Stakeholders felt that LGBTQ+ CYP face additional challenges within mental health services. Stakeholders commonly reported feeling that their mental health needs were not believed when they presented to mental health services, which they felt prevented them from getting the support they required. Stakeholders also felt that the mental health workforce lacked diversity, which means that LBGTQ+ CYP "do not feel they can relate to their therapist." Stakeholders suggested that it would be beneficial to be able to be given a choice of therapist but recognised that this was highly challenging with current demands on the mental health system.

Beneficial Services to Support Children and Young People's Mental Health in Richmond

Stakeholders identified the following support and/or treatment approaches as beneficial to supporting CYP mental health in Richmond:

- As the place where CYP are already present, it was considered beneficial to utilise schools as a key venue for CYP to access mental health support and services. For this approach to be successful, mental health services must be readily accessible within schools. This includes ensuring that mental health provision is consistent across schools in the borough, and that work is concurrently carried out to "create a school culture where it is normal to go and see a school counsellor".
- Stakeholders recognised the importance of targeting interventions at primary age children and their parents/carers. This cohort was identified as "the place to get in early" and prevent mental health need across the life course. For example, it was suggested that workshops should be delivered to parents/carers to develop parenting and mental health skills.
- Community groups and activities. Stakeholders specifically identified the following groups and activities as beneficial to CYP's mental health: art therapy, Jigsaw for You bereavement work, Pave the Way autism support, young carers group, sports, Girl Guiding/Cadets.
- For LGBTQ+ young people, Free2B and Spectra were identified as beneficial.

Children and Young People's Voice: Findings from the 2022 Richmond Young People's Survey.[161]

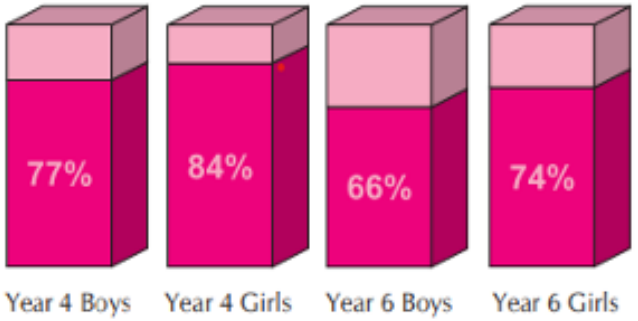
The Richmond Young People's Survey was developed by the Schools Health Education Unit in partnership with the London Borough of Richmond Upon Thames Public Health Team to obtain pupils' views on aspects of health and wellbeing.

All primary and secondary schools were invited to participate in the survey during the spring and summer terms 2022, with the focus on Years 4, 5, 6, 8 and 10 pupils. A total of 4,883 pupils took part from 18 primary and junior schools and 7 secondary schools.

A selection of key themes identified within the survey have been summarised below. The summary and topical reports can be read online here.

Richmond Primary School Pupils in Years 4–6 (ages 8–11)

Worrying



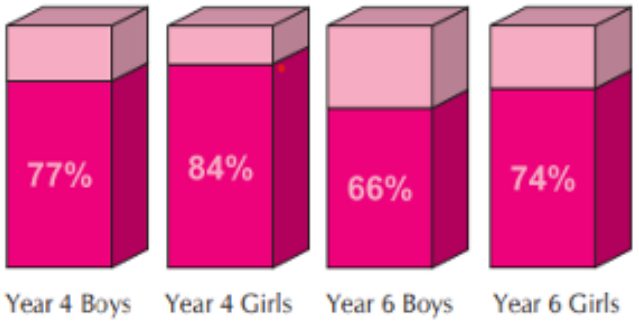
Source: Richmond Young People's Survey. 2022.

- 75% of pupils worry 'quite a lot' or 'a lot' about at least one issue:
- 16% of boys and 23% of girls worry about more than 5 issues 'quite a lot' or 'a lot'.
- 19% of pupils worry about their mental health, 23% worried about the mental health of someone in their family and 13% worried about having enough food to eat.
- Year 6 pupils worried 'quite a lot' or 'a lot' about the following issues (top 5):

Year 6	Boys		Girls
The environment	39%	The environment	36%
COVID-19	18%	School work	30%
School work	17%	Problems with friends	26%
The mental health of someone in their family	14%	The way they look	22%
Terrorism	14%	Puberty and growing up	21%

Source: Richmond Young People's Survey. 2022.

- 77% of pupils have at least one negative feeling/ experience 'often' or 'everyday':



Source: Richmond Young People's Survey. 2022.

Problem-solving

- When they are struggling/feel bad or are stressed/worried, 80% of pupils responded that they at least 'sometimes' keep it to themselves, 34% at least 'sometimes' deal with things by hurting themselves in some way and 45% get into trouble at home or school.

Resilience

Year 6	Boys		Girls
I learn from it for next time	58%	I learn from it for next time	54%
I'm calm and can carry on	41%	I'm calm and can carry on	35%
I might feel a bit bad but soon forget it	40%	I might feel a bit bad but soon forget it	33%
I get upset and feel bad for ages	11%	I get upset and feel bad for ages	20%
I might feel something else	6%	I might feel something else	7%

Source: Richmond Young People's Survey. 2022.

- 18% of year 5+ pupils (13% of year 6 boys and 21% of year 6 girls) had a low measure of resilience.
- Pupils were asked what they do if something goes wrong:

Inequalities

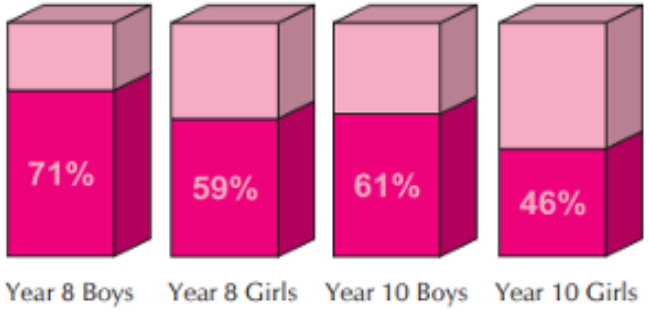
Significant differences between potentially vulnerable groups and 'all year 6 pupils' are as follows:

- Pupils entitled to free school meals are more likely to worry about at least one issue (86% vs 70%).
- Pupils with SEND are more likely to have hurt themselves when worried or stressed (46% vs 30%).
- Pupils from single parent families and pupils with SEND are less likely to have an adult they can go to for support for worries (75% and 72% vs 81%).
- Pupils entitled to free school meals and pupils with SEND are more likely to have negative emotions/experiences every day (56% and 57% vs 36%).

Richmond Secondary School Pupils in Years 8 and 10 (ages 12–15)

Happiness

- 56% of pupils responded that they are 'quite' or 'very' happy with their life at the moment:

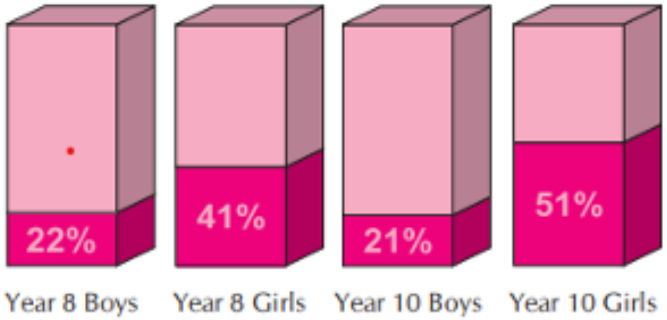


Source: Richmond Young People's Survey. 2022.

- 16% of boys and 23% of girls said they are 'quite' or 'very' unhappy with their life at the moment.

Worrying

- 81% of pupils responded that they worry about at least one issue 'quite a lot' or 'a lot'.
- 21% of boys and 47% of girls responded that they worry about more than 5 issues 'quite a lot' or 'a lot':



Source: Richmond Young People's Survey. 2022.

- 31% of Year 8 pupils responded that they worry 'quite a lot' or 'a lot' about their mental health; 23% worry about the mental health of someone in their family.
- Pupils worry 'quite a lot' or 'a lot' about the following (top 5):

	Boys		Girls
My future	45%	School work	67%
School work	39%	My future	63%
Getting a job	31%	The way you look	54%
Their mental health	19%	Getting a job	51%
The way they look	18%	Their mental health	47%

Source: Richmond Young People's Survey. 2022.

Problem Solving

- 32% of girls (and 14% of boys) 'at least sometimes' deal with problems by hurting themselves in some way.
- 16% of pupils said they at least 'sometimes' get help from online advice websites/ helplines e.g. Kooth/Childline etc. and 9% said they get help from a charity, e.g. Samaritans, Young Minds etc.
- Pupils said they at least 'sometimes' deal with problems by doing the following (top 5):

	Boys		Girls
Spending time on the computer/ gaming etc.	88%	Relaxing	90%
Relaxing	86%	Crying	88%
Playing sport, being active etc.	80%	Playing sport, being active etc.	65%
Speaking to/confronting the person who is causing you to worry	48%	Spending time on the computer/ gaming etc.	63%
Crying	41%	Eating less	59%

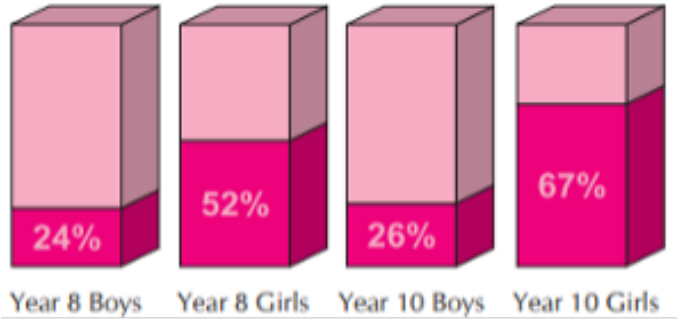
Source: Richmond Young People's Survey. 2022.

Resilience

- 35% of pupils had a low measure of resilience.
- 45% of pupils responded that if something goes wrong, they learn from it for next time, while 28% are 'usually' or 'always' calm and can carry on and 28% get upset and feel bad for ages.

Thoughts and Feelings

- 46% of pupils said they felt anxiety 'often' or 'every day':



Source: Richmond Young People's Survey. 2022.

- 10% of pupils (16% of year 10 girls) said they experience suicidal thoughts 'often' or 'every day'.
- 84% of pupils have at least one negative feeling/experience 'often' or 'every day'; 46% of boys and 76% of girls experience at 3 negative feelings/experiences 'often' or 'every day'.

Inequalities

Significant differences between potentially vulnerable groups and 'all year 8 or 10 pupils' are as follows:

- Year 8 pupils entitled to free school meals are more likely to have negative emotions/experiences every day (65% vs 47%).
- Year 10 LGBTQ+ pupils and young carers are more likely to have self-harmed when stressed (50% and 39% vs 25%).
- Year 10 LGBTQ+ pupils are more likely to have negative emotions/experiences every day (74% vs 55%).

Stakeholder Consultation: Key Findings

- Stakeholders reported that mental health conditions among CYP in Richmond were increasing in prevalence, complexity, acuity, and longevity, and expressed particular concern for increasing rates of eating disorders, self-harm and suicidal ideation.
- Although a significant issue beforehand, the COVID-19 pandemic was felt to have had dramatic adverse impacts on mental health needs.
- Stakeholders reported that CYP are experiencing long waiting lists to access mental health services.
- The long wait times for mental health services was identified as placing significant pressure on schools and teachers, who are operating as a holding space for high-risk children and their parents/carers.
- Stakeholders felt that there is a lack of comprehension of the service provision available in Richmond and the thresholds to accessing each service.
- It was felt that there are significant disconnects between mental health services in the borough, particularly during the transition from children to adult mental health services, and that services continue to work in silos.
- Stakeholders reported there to be a lack of specialised mental health services and professionals for CYP with neurodiversity and/or LD in Richmond. This was felt to be particularly pertinent given the significant adverse impacts of the COVID-19 pandemic on the mental health of these CYP.
- It was felt that LGBTQ+ CYP experience heightened mental health needs and face additional challenges to receiving support when in mental health services.
- Stakeholders felt that it would be beneficial to build on the capacity of schools and the community to provide mental health support, and that interventions should be targeted an early stage to prevent mental health need across the life course.
- The SHEU survey of Richmond pupils' views on health and wellbeing found that:
  - 75% of primary school pupils and 81% of secondary school pupils worry quite a lot or a lot about one listed issue, and this is higher for girls than boys.
  - 34% of primary school pupils at least 'sometimes' deal with things by hurting themselves in some way when they are struggling/feel bad or feel stressed/worried.
  - 46% of secondary school pupils felt anxiety 'often' or 'every day', and this was significantly higher for girls than boys.
  - 10% of pupils said they experience suicidal thoughts 'often' or 'every day'.
  - There are significant differences between the mental health of potentially vulnerable groups and all pupils.

Transition from Children and Young People to Adult Services

Young people face a 'cliff edge' when trying to access mental health care after reaching the upper age limit of CAMHS. If they still require support, care should be transferred to an adult mental health service (AMHS), through a process known as transition.[162] Transition to AMHS should be part of the therapeutic process, considering the young person's preferences, current circumstances and developmental maturity.[163] Research identifies that in most cases a successful transition does not occur, leaving young people to try to manage their illness on their own. A recent systematic review identified that only 25% of young people were successfully transitioned to AMHS, with another 25% remaining in CAMHS even after crossing the age boundary. There were no records for what happened to the remaining 50%. [164]

When young people do make the transition to AMHS, it is rarely well managed. Previous research exploring transition in the UK found that only 4% of young people experienced all four features of optimum transition: [165]

- the young person is fully involved in the decision for care to move to a new service
- at least one joint meeting between members of both services and the young person
- a period of handover or joint care between both services
- full transfer of the young person's information to the new service

Poor experiences of transition can be due to different approaches between the two services. Children's services are generally viewed as more nurturing, with a focus on treating developmental and emotional disorders.[166] In contrast, adult services focus on treating severe and enduring mental illnesses, such as psychosis or bipolar disorder, meaning young people without these diagnoses are less likely to be accepted.[167] If their care does move to the AMHS, young people can also struggle to adapt to a different model of care.

Another factor which makes the transition to adult services more challenging is that they often have strict criteria in place when assessing whether a young person is suitable for that service. These high entry thresholds can mean that all but the most severely ill are denied treatment. Young people are often told they are not ill enough for services.[168] Although these entry thresholds are in part to do with the care philosophy of adult services to treat those with severe and enduring mental illness, they are also thought to be caused by resource pressures and staffing shortages.[169]

As well as problems between the services, there are also cases where there are simply no appropriate services for a young person to transition to. This is especially common if they have a diagnosis such as autism or ADHD. These conditions were previously regarded as being 'childhood illnesses', therefore there is little service provision for adults, even though young people can still need support after they have turned 18. [170]

Key Messages for Transition[171]

- Adolescence is a period of intense change for young people and a time when mental health problems may emerge or become more severe.
- It is important that young people understand and are given information about their mental health problems. Staff should be able to offer information about treatment and support options.
- The transition from child to adult mental health services should consider the young person's whole life, including their family, friends, housing, school, college, and work. Services need to be age-appropriate and flexible.
- It is vital that young people fully participate in planning their transition. Planning should start at least six months in advance.
- Staff need to work collaboratively with other services (health, social care and voluntary services) in order to support young people throughout the transition process.
- Young people need access to a consistent, pro-active key worker and peer support from other young people.
- It is important to consider the needs of groups who may have difficulty accessing transition services.
- Managers should commission training for staff on use of the Child Assessment Framework and Care Planning Approach and monitor service performance.
- The voice of young people, parents and carers must be fully factored into routine monitoring indicators.
- Monitoring young people's outcomes, including those who do not go to AMHS, is critical to capture whether needs and resources were matched and to evaluate all unmet need.

Adults and Older Adults: Live Well and Age Well

The Live Well and Age Well chapter focuses on those above the age of 18 living in Richmond, providing an overview of the mental health needs from early adulthood, through working age to older adults. The chapter will start with estimated prevalence of mental disorders, then consider vulnerable groups before looking at service activity.

Working-age Adults

One in four adults in England will have a mental health disorder in any given year.[172] Mental health disorders affect people from all walks of life, and anyone can be affected at any point. Richmond has one of the highest proportions of adults aged 40+ in London, and by 2029 will see the largest increase in its population among those aged 55+ years.[173] Understanding the mental health needs of this demographic is therefore vital to ensure that services are configured to meet current and future needs.

Individuals with severe and enduring mental illness are at greater risk of poor physical health and have a reduced live expectancy compared to the general population. They face particular challenges including being less likely to live in safe areas in appropriate housing; having less opportunity to be involved in healthy activities; having complex and urgent social care needs; and finding it difficult to gain and maintain employment.[174] Addressing these factors are therefore key to reducing these inequalities faced by those with mental ill health.[175]

Older Adults

Older adults' mental health has been increasingly recognised as a significant health and wellbeing issue; it is increasingly noted how ageing will impact an individual, as well as the interconnections between physical and mental health. For example, depression occurs in higher rates among older people with physical health conditions, such as heart disease, than those without such conditions.

Older adults may experience certain stressors that are more common during this stage of life, all of which place a strain on mental health.[176] These include:

- Physical health conditions, which present older adults with challenges such as chronic pain and impaired functionality, and may lead to reductions in independence and social activity.
- Loneliness, which older adults are more likely to experience due to the loss of a loved one or the onset of disability and illness.
- Dementia, which can trigger mental health problems. Estimates suggest that 20-40% of people living with dementia are depressed. Dementia can also make treatment of mental health conditions more challenging.
- Elder abuse, including physical or psychological abuse which can result in long-term adverse psychological impacts such as depression and anxiety.[177]

With the growing proportion of older adults within the population of Richmond, it is vital the needs of older people are recognised and integrated into local mental health services.

Overview of Local Need: Estimated National Prevalence of Mental Health Conditions

Assessing the prevalence of mental health disorders among adults in Richmond is challenging due to incomplete data sets and unavailable data for some groups. It has therefore been necessary to apply national data from the Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing 2014 (APMS) to the local population to estimate the level of need.

The Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, 2014

The 2014 APMS provides data on prevalence of both treated and untreated psychiatric disorders in the adult population of England (aged 16 and over).[178] The survey is conducted every seven years and was previously carried out in 1993, 2000 and 2007. The findings of the 2021 survey have yet to be released; therefore, this report relies on the 2014 survey.

Caution on figures: the national survey only looked at those who were aged 16 and over and lived in private housing. People who were in hospital, in prison, in sheltered housing, were homeless or rough sleeping were excluded from the survey.[179]

The 2014 APMS found that:[180]

- One in six adults met the criteria for a CMD in 2014.
- Women were more likely than men to have reported symptoms of a CMD – 1 in 5 women compared to 1 in 8 men.
- Women were also more likely to report severe symptoms of a CMD – 10% of women compared to 6% of men.
- Reported rates of self-harm have increased in both men and women across age groups since 2007. This may be due to greater awareness of the behaviour.

- Young women have emerged as a high-risk group with higher rates of CMD and self-harm, and more positive screens for PTSD and bipolar disorder.
- The gap between young women and young men has increased.
- Most mental disorders were more common in people living alone, in poor physical health or with a disability, and not employed.

The survey also reported the following trends in treatment and service use:[181]

- One in three people with a CMD reported current use of mental health treatment; an increase from one in four reported in the 2000 and 2007 surveys.
- Demographic inequalities exist for those who receive treatment. Those in Black ethnic groups had particularly low treatment rates, whereas those who were White British, female or in mid-life (35 – 54 years) were more likely to receive treatment.
- People in lower income households were more likely to request but not receive mental health treatment.
- People with a CMD were more likely to use community services and discuss their mental health with a GP than in 2007.[182]

Using the 2014 Adult Psychiatric Morbidity Survey to Estimate the Prevalence of Mental Health Disorders in Richmond

The prevalence rates from the 2014 APMS have been applied to the borough population. The figures below are estimates and should be interpreted with caution. When applying national level surveys to smaller geographical areas local factors are more likely to have an effect and should be considered when interpreting these estimates.

Common Mental Disorder

CMDs are a group of disorders that cause marked emotional distress and interfere with daily function, though usually they do not affect insight or cognition.[183] They are regarded as 'common' because these mental health problems affect more people than any other mental health disorder; reducing their prevalence is therefore a major public health challenge.[184] Despite usually being less disabling than other psychiatric disorders, their higher prevalence means that the cost of CMD to society is significant.[185]

CMDs range in their severity from mild to severe:

- **Mild:** when a person has a mental health problem with a small number of symptoms that have a limited effect on their daily life.[186]
- **Moderate:** when a person experiences a mental health problem with a greater number of symptoms that makes their daily life more difficult.[187]
- **Severe:** when a person experiences a mental health problem with a lot of symptoms that makes their daily life very difficult.[188]

CMDs include the following:

- **Depression:** Symptoms of depression include low mood, feelings of sadness and loss of interest and enjoyment in things that were once pleasurable.[189] People can experience negative thoughts and feelings of worthlessness. All these symptoms can impact on emotional and physical wellbeing as well as behaviour.[190] Depression can have a lifelong course of relapse and remission.
- **Generalised Anxiety Disorder:** Symptoms of GAD include experiencing a number of worries that are in excess and out of proportion to a particular situation.[191] People with GAD also have difficulty in controlling their worries.[192]

Symptoms of depression and anxiety frequently co-exist; therefore, many people meet the criteria for more than one CMD.[193]

Estimated Prevalence of Common Mental Disorders in Richmond

When the prevalence rates from the 2014 APMS were applied to the Richmond borough population it was estimated that:

- 26,655 adults in Richmond have a CMD.
- The most common type of CMD experienced is GAD, followed by depressive episodes and phobias.

Estimated Prevalence of Common Mental Disorders by Age

- For all CMDs except panic disorders, it is estimated that the prevalence will be highest in the 35-44- and 45-54-year age groups.
- The lowest numbers of all types of CMD are expected to be in those over the age of 75 years.

Table 56: Estimated number of people in Richmond with a CMD in the past week, by type of CMD and age, based on national prevalence

For further detailed breakdown of CMD in terms of sex please refer to appendix.

Type of Common Mental Disorder	Age							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Generalised Anxiety Disorder	1,001	1,292	2,220	2,323	1,521	699	363	9,251
Depressive Episode	365	741	1,319	1,432	1,022	367	189	5,174
Phobias	524	699	965	859	547	105	73	3,763
Obsessive Compulsive Disorder	286	296	515	509	356	52	44	2,038
Panic Disorder	191	106	97	159	119	122	87	941
Common Mental Disorder - Not Otherwise Specified	1,34	1,927	2,638	2,769	1,925	908	711	12,230
Any Common Mental Disorder	3,002	4,024	6,208	6,078	4,277	2,008	1,278	26,655

Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014. Table 2.3 CMD in past week, by age and sex. Using ONS Mid-year population estimates, UK, June 2020

Estimated Prevalence of Common Mental Disorder by Sex

- More females than males will experience any type of CMD over the life course.
- Both females and males experience a declining prevalence of CMD symptoms in later life.
- Females consistently experience higher numbers of GAD across the life course.
- It is estimated that between the ages of 25 – 34 and 65 – 74, more males than females will experience a depressive episode.

Table 57: Estimated number of people in Richmond with a CMD in the past week, by type of CMD and sex, based on national prevalence

Type of Common Mental Disorder	Sex	
	Males	Females
Generalised Anxiety Disorder	3,694	5,536
Depressive Episode	2,186	3,012
Phobias	1,357	2,443
Obsessive Compulsive Disorder	829	1,221
Panic Disorder	226	651
Common Mental Disorder - Not Otherwise Specified	4,372	7,816
Any Common Mental Disorder	9,950	16,853

Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014. Table 2.3 CMD in past week, by age and sex. Using ONS Mid-year population estimates, UK, June 2020

Estimated Prevalence of Common Mental Disorder by Ethnicity

- It is estimated that most adults with a CMD in Richmond will be from White British or White Other ethnic groups.
- Across all ethnic groups, it is estimated that more females than males will experience any type of CMD.

Table 58: Estimated number of people in Richmond with a CMD in the past week, by ethnic group and sex, based on national prevalence

Sex	Ethnic Group				
	White British	White Other	Black/ Black British	Asian/ Asian British	Mixed, multiple and other
Males	7,041	1,340	144	626	410
Females	11,106	1,968	368	1,292	798
All Adults	18,215	3,296	530	1,840	1,192

Source: Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014. Table 2.7 CMD in past week, by ethnic group and sex. Using ONS Mid-year population estimates, UK, June 2020

Primary Care Data for Common Mental Disorders in Richmond

Primary Care data was supplied in May 2022 for depression, anxiety and mental health in adults registered with a GP in Richmond. The depression and mental health indicators were extracted from QOF Long Term Condition indicators; and the anxiety indicator was extracted from GP databases. The data has been used to provide another estimate of prevalence for CMDs in the population.

QOF covers four domains, and each domain consists of a set of measures of achievement against which General Practices accrue points. Ultimately the aim of QOF is to improve standards of care. It is acknowledged that not all service users who present to their GP with a mental health problem will be captured under these indicators. There are multiple reasons for this. Not all patients who present to their GP with symptoms of mental ill health will receive a diagnosis and, as QOF is a voluntary programme, not all practices will participate. Consequently, these figures may not be representative of the true prevalence in the population.

The primary care data suggests that:

- Similar to the national prevalence estimates, depression and anxiety tail off in later life, with the lowest rates among those over 65.
- There is a similar prevalence of anxiety and depression among adults in Richmond. This contrasts our prevalence estimates which predict there to be higher levels of GAD in the population.

Table 59: shows the number adults with depression and anxiety who are registered with a GP in Richmond by age in May 2022

Number of Adults Registered with a GP in Richmond	Age 19-49	Age 50-64	Age 65+	Total	Prevalence
QOF Depression	10,393	6,860	5,163	22,416	100.78 per 1,000
Anxiety	9,220	8,349	4,308	21,877	98.28 per 1,000

Source: South West London Health & Care Partnership. Depression and mental health data extracted from Long Term Conditions and QOF indicators; anxiety data extracted from GP database

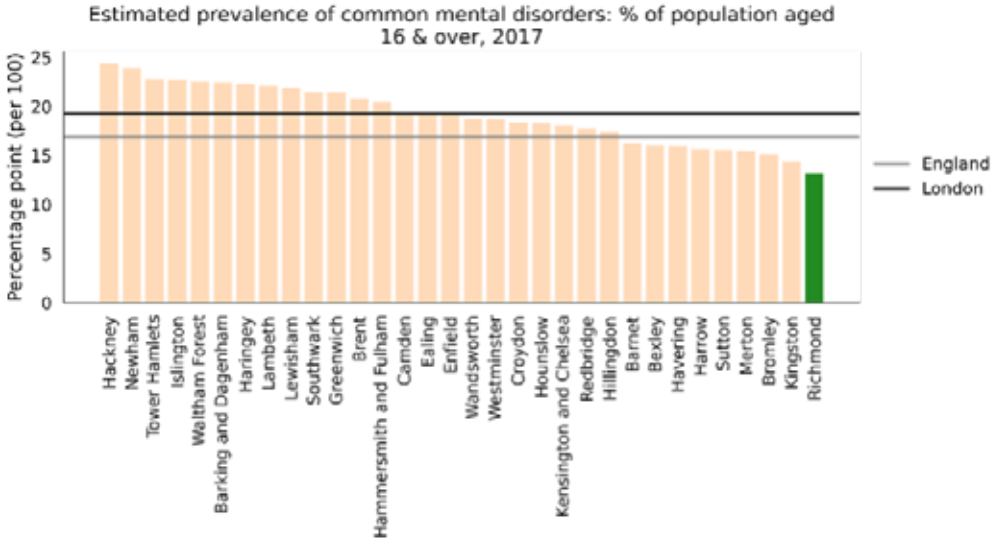
Office for Health Improvement and Disparities Data on Common Mental Disorders in Richmond

The OHID Fingertips profiles provide up-to-date local data for Richmond across a range of mental health themes, and allow for the benchmarking against regional or England averages.

OHID data shows that:

- The recorded prevalence of depression in Richmond has steadily increased year-on-year over the last decade, rising from 4% (7,076) of the population in 2013/14 to 9.3% (17,560) in 2020/21.[194]
- The incident rate remained fairly stable over the same period, consistently between 0.5% (944) and 0.8% (1,551).
- The only exception to this was a doubling of the rate in 2020/21 1.6% (3,020). This is in keeping with the effect of the pandemic on mental health.
- Data from 2017 suggests that the prevalence of CMD for those aged 16 and over in Richmond is 13.2% (20,430) of the borough population. This was the lowest rate of any borough in London.[195] The Richmond rate is 21.9% lower than the England average and 31.4% lower than the London average.
- For those aged 65 years and over, the estimated prevalence of CMD in Richmond was 8.3% of the population (2,514). This is the second lowest rate of all the London Boroughs.
- It is noted that these figures are much lower than the GP data which records 9,471 adults aged 65+ to have anxiety and depression in Richmond.

Figure 60: Estimated prevalence of common mental disorders by Local Authority, 2017



Source: Richmond Joint Strategic Needs Assessment. 2021.

Severe Mental Illness

A SMI refers to a group of mental disorders that cause psychological problems which are of a severe enough nature to seriously impair a person's ability to engage in usual life activities.[196] They include schizophrenia and bipolar disorder.

People with SMIs are at greater risk of poor physical health and premature mortality than the general population.[197] In England people with SMIs have a 3.7 times higher death rate for ages under 75 compared to the general population, and on average die 15-20 years earlier than the general population.[198]

It is estimated that 2 in 3 deaths among people with SMI are preventable. Major causes of death in people with SMIs are hypertension, respiratory disease, cardiovascular disease and diabetes. [199] In addition to these chronic physical health conditions, suicide is also a heightened cause of death in the SMI population. For people with SMI, suicide risk is particularly high following acute psychotic episodes and psychiatric hospitalisation.[200]

Psychotic Disorders

People with a psychotic disorder experience disturbances in their thinking and perception that distort their perception of reality.[201] Symptoms include auditory hallucinations, disorganised thinking and delusional beliefs.[202]

Schizophrenia and affective psychosis are the most common types of psychotic disorders.[203]

People with psychotic disorders can make a full recovery, although some will have persisting difficulties and remain at risk of future episodes.[204] Psychotic disorders are also associated with considerable stigma, which can contribute to social exclusion and distress endured by those who have the condition. [205]

Key Findings on Psychotic Disorders in the 2007 and 2014 Adult Psychiatric Morbidity Surveys:[206]

- There was no significant difference in the rate of psychotic disorders in men and women.
- The rate was highest in those aged 35–44.
- Rates were also higher in Black men (3.2%) than men from other ethnic groups.
- Certain socioeconomic factors were strongly linked with psychotic disorder – it was more common in those who were economically inactive and in those who live alone.

Estimated Number of People with a Psychotic Disorder in Richmond

Table 61: Estimated number of people in Richmond with a psychotic disorder by sex in 2014, based on national prevalence

Sex	Estimated Number of Adults with a Psychotic Disorder
Men	528
Women	570
All Adults	1,098

Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014. Table 5.1 psychotic disorder in the past year in 2007 and 2014 by sex. Using ONS Mid-year population estimates, UK, June 2020

Bipolar Disorder

Bipolar disorder is a common lifelong mental health condition, previously known as manic depression.[207] It is characterised by recurring episodes of depression and mania.[208]

Key Findings on Bipolar Disorder in the 2014 Adult Psychiatric Morbidity Survey:[209]

- There was no significant difference in the rates of bipolar disorder in men and women.
- Bipolar disorder was more common in younger age groups; 3.4% of 16-24 year olds compared to 0.4% of 65-74 year olds.
- Screening positive for bipolar disorder did not vary by ethnic group.

Primary Care Data on Severe Mental Illness in Richmond

Primary Care Data was supplied in May 2022 for those who are registered with a GP in Richmond. The SMI indicators were extracted from QOF Long Term Conditions. The QOF Mental Health was also supplied, which includes the number of adults on GP clinical registers with a diagnosis of schizophrenia, bipolar affective disorder, other psychoses and patients on lithium therapy for other reasons.[210]

The primary care data suggests that:

- Adults registered with an SMI or with a diagnosis of schizophrenia, bipolar affective disorder and/or other psychoses are higher than predicted by the national estimates.
- These disorders are highest among 19–49-year-olds in Richmond, which is in line with expectations.
- Those aged 65+ years have the lowest rates of SMI.

Table 62: Prevalence of SMI and QOF mental health among adults registered with a GP in Richmond by age in May 2022

Primary Care Data Indictor	Age			Grand Total	Prevalence
	19-49	50-64	65+		
SMI Prevalence	754	534	415	1,703	7.63 per 1,000
QOF Mental Health	854	591	474	1,919	8.6 per 1,000

Source: South West London Health & Care Partnership. SMI and mental health data extracted from Long Term Conditions and QOF indicators.

Office for Health Improvement and Disparities Data on Severe Mental Illness in Richmond

The OHID fingertips profiles provide up-to-date local data for Richmond across a range of mental health themes, and allow for the benchmarking against regional or England averages.

OHID data suggests that:

- The rate of premature mortality in adults with SMI in Richmond between 2018-20 was 62.8 per 100,00, which is the lowest in London and lower than the England average of 103.6 per 100,000. [211]
- The excess under-75 mortality rate in adults with SMI in Richmond between 2018-20 was 446.3 per 100,000, which is the 9th highest rate in London and higher than the England average.[212]

Suicide, Suicidal Thoughts, Suicide Attempts and Self-harm

Suicidal thoughts and behaviours are associated with high levels of distress for those affected. They are often associated with mental illness and are important in identifying those at risk of taking their own life in the future.[213]

Key Findings on Self-harm and Suicide in the 2014 Adult Psychiatric Morbidity Survey:

- The proportion of adults who reported self-harm behaviour increased between 2007 and 2014 from 3.8% to 6.4%.[214]
- The gap between the prevalence of self-harm in young men and women has widened; one in four women between the ages of 16–24 years reported to have self-harmed at some point, which is almost twice the rate for men who reported to have self-harmed.[215]

Estimated Number of People Experiencing Suicidal Thoughts, Suicide Attempts and Self-harm in Richmond

- Self-harm is estimated to be most prevalent among those between 16-24 years, and primarily in young women.
- Suicidal thoughts are estimated to be most prevalent among those aged 45-54 years.
- Suicide attempts are estimated to be most prevalent among those between 35-44 years.
- The prevalence of self-harm and suicidal thoughts and attempts is lowest in those aged 75+, which fits to expectations.

Table 63: Estimated number of people in Richmond experiencing suicidal thoughts, self-harm, suicidal attempts in terms of age, based on national prevalence

Estimated Number of Adults in Richmond	Age							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Suicidal Thoughts	4,257	4,786	7,045	7,542	5,394	2,061	1,176	32,300
Suicidal Attempts	1,430	1,800	2,573	2,164	1,663	629	247	10,505
Self-harm	2,780	2,562	2,541	1,305	974	332	44	11,446

Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014. Table 12.1 prevalence and recency of lifetime suicidal thoughts, suicide attempts and self-harm, by age and sex. Using ONS Mid-year population estimates, UK, June 2020

Office for Health Improvement and Disparities Data on Self-harm and Suicide in Richmond

- Between 2012-2014 there was a reduction in the number of suicides in Richmond.
- However recently there has been an increase to pre-2012 levels.
- Due to relatively low numbers of suicide, data is aggregated over three years.
- During the period of 2017-2019, there were 46 suicides in Richmond (36 of which were males), which is the highest number recorded in the past two decades.[216]
- The suicide rate for 2017-2019 was 15.1 per 100,000, which is almost triple the rate in 2012-2014 (5.2 per 100,000).[217]
- This rate of increase in is contrast to the stationary trends of England and London.
- Richmond had the second highest rate of emergency hospital admissions for intentional self-harm in 2020/21 for London with a rate of 151.5 per 100,000.[218]
- In 2019 self-harm was the leading cause of death for males and females between the ages of 15-49 years.[219]

Post-Traumatic Stress Disorder

Many people experience traumatic events in their lives, during and after which people will commonly feel distressed and anxious. Sometimes these symptoms persist, and individuals go on to develop PTSD.

Around a third of adults in England report having experienced at least one traumatic event.[220]

Estimated Numbers of People with Post-Traumatic Stress Disorder in Richmond

- Younger people are more likely to experience PTSD than older people.
- For women, those between 16-24 years were more likely to screen positive for PTSD.
- For men, the rate to screen positive for PTSD remained stable from 16 – 65 years, but declined in older age.

Table 64: Estimated number of people in Richmond with a positive PTSD screen by age, based on national prevalence

Estimated number of adults in Richmond	Age							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
PTSD screen positive	1,271	1,144	1,480	1,432	879	279	87	6,899

Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014. Table 4.1 Domain, screen positive for probable PTDS in last month and whether experienced trauma, by age and sex. Using ONS Mid-year population estimates, UK, June 2020

Personality Disorder

Personality disorders are longstanding distortions of personality that affect a person's ability to build and maintain relationships. Impairment in relational functioning is an enduring feature of personality disorders, along with substantial social difficulties.[221]

Individuals with personality disorders are also at higher risk of poor general health and reduced life expectancy, and the disorder places a substantial burden on the affected individual, their families and wider society.[222]

There are two primary types of personality disorder:

- **Antisocial personality disorder:** characterised by a disregard for and violation of others' rights.[223]
- **Borderline personality disorder** (also known as emotionally unstable personality disorder: characterised by high levels of personal and emotional instability associated with significant impairment.[224]

Estimated Numbers of People with Personality Disorder in Richmond

- It is estimated that more men than women in Richmond have an antisocial personality disorder, while more women than men have a borderline personality disorder.
- The rates of those with any personality disorder declines by age.
- The estimated number of people with a personality disorder is highest among those between the ages of 35–54.

Table 65: Estimated number of people in Richmond with a personality disorder by age and sex, based on national prevalence

Screen for type of personality disorder	Age				
	16/18-24	25-34	35-54	55-64	All
All adults					
Antisocial	778	3,675	1536	523	4119
Borderline	906	1,838	960	238	2996
Men					
Antisocial	516	2,379	1122	479	2992
Borderline	338	324	530	129	1160
Women					
Antisocial	258	1,184	427	48	1147
Borderline	572	1,623	459	97	1849

Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014. Table 7.1: Screen positive for antisocial & borderline personality disorder (SCID-II), by age and sex. Using ONS Mid-year population estimates, UK, June 2020

Co-occurring Mental Health and Alcohol and Drug Use

It is common for people who experience problems with their mental health to also experience issues with drug and/or alcohol use at the same time (co-occurring). For example, it is acknowledged that the majority of those in community substance misuse treatment for alcohol and drug use experience a mental health problem.[225]

Those with co-occurring conditions have a greater risk of further health problems and premature death. In is notable that 54% of suicides in those experiencing a mental health problem will also have a history of alcohol or drug use.[226]

Alcohol Use

Alcohol problems and mental ill health are closely linked. Research shows that those who have severe mental health problems are more likely to have problems with alcohol and those who consume high levels of alcohol are more likely to develop mental health problems.24

For example:[227]

- Regular heavy drinking is linked to symptoms of depression.
- Alcohol consumption can worsen anxiety.
- Regular and excess consumption of alcohol can be associated with psychosis.
- Excess alcohol consumption is often implicated in episodes of self-harm and suicide.
- Long-term excessive alcohol consumption can lead to brain damage and may increase the risk of developing dementia.[228]
- Korsakoff syndrome is a chronic memory disorder commonly caused by the misuse of alcohol.[229]

Alcohol Consumption in Richmond

- Alcohol consumption is high in Richmond and therefore a key concern for mental health and well-being.
- The borough has the seventh highest rate of litres of alcohol sold per adult through the off-trade in London, with one in three adults drinking over 14 units of alcohol a week.[230] This is higher than in London and England.
- Admission episodes for alcohol-specific conditions in 2020/21 was 553 per 100,000 (1,030), and this has seen an increasing trend since 2014/15.[231]

Estimated Number of People with Hazardous or Harmful Drinking Habits in Richmond

- Those between 35-44 years are more likely to drink at hazardous and harmful levels.
- Hazardous and harmful drinking declines with age.
- White British men and women were more likely to drink at hazardous, harmful or dependent levels than other ethnic groups.
- In women, drinking at hazardous levels and above was most common in those aged 16-24.

Table 66: Estimated number of people with hazardous or harmful alcohol use in Richmond terms of age, based on national prevalence. Using the Alcohol use disorders identification test (AUDIT)

Estimated Number of Adults in Richmond	Age							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Hazardous Drinking (AUDIT Score 8 or More)	4,591	4,977	6,723	6,078	5,109	2,096	682	30,889
Harmful Drinking (Audit Score 16 or More)	667	932	1,383	891	665	192	44	4,861

Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014.
Table 10.1: Harmful and dependent drinking in the past year, by age and sex.
Using ONS Mid-year population estimates, UK, June 2020

Drug Use

NICE defines drug misuse as 'dependence on, or regular excessive consumption of, psychoactive substances, leading to psychical, mental or social problems.'[232] In the UK, the most common illicit drug is cannabis, followed by cocaine and ecstasy.[233]

A substance use disorder can also have serious long-term health risks including increasing blood pressure, stroke, pancreatitis, liver disease, cancer, depression, dementia, sexual problems, mental / emotional health needs and infertility.[234]

According to the 2021 census an estimated 1 in 11 adults aged 16-59 year had taken an illicit drug in the last year.[235]

Estimated Number of People Who Have Used Illicit Drugs in Richmond

- It is estimated that illicit drug use is highest among 35–44-year-olds.
- Illicit drug use reduces by age, with particularly low use among older adults.

Table 67: Estimated number of people who have used illicit drugs in Richmond of age, based on national prevalence

Estimated number of adults in Richmond	Age							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Use of Any Illicit Drug	5,910	9,297	13,221	8,942	5,132	1,537	436	45,314

Source: NHS Digital Adult Psychiatric Morbidity Survey, 2014. Table 11.1: Lifetime experience of illicit drug use, by age and sex. Using ONS Mid-year population estimates, UK, June 2020

Gambling and Mental Health

In recent years there has been increasing concern about harms associated with gambling. The harms associated with gambling are wide-ranging, though there is a clear link with mental health. For example:[236]

- Gambling can increase the likelihood of some people thinking about, attempting or dying from suicide.
- People with mental health issues were twice as likely to participate in harmful gambling compared to those without a mental health issue.
- Those with a mental health issue who gambled were 2.4 times more likely to experience gambling-related harms.

There is limited regional data about problem gambling due to its occurrence in such small numbers. However national evidence estimates that 0.5% of the adult population have a problem with gambling.[237]

Perinatal Mental Health

Perinatal mental health problems are those that happen during pregnancy and the year following the birth of a child. The perinatal period can lead women to develop mental ill health for the first time or exacerbate pre-existing mental health conditions. It is expected that perinatal mental health problems affect up to 20% of new or expectant mothers.[238]

Perinatal mental health problems can have long-lasting effects on the affected woman and her family, as well as on the development of the child.

The general fertility rate (number of live births per 1,000 women of child-bearing age) in Richmond in 2020 was 55 per 1,000, which means that up to 404 women in Richmond in 2020 were at risk of a mental health problem during and after pregnancy.[239]

Dementia

Dementia refers to a group of cognitive and behavioural symptoms associated with a progressive decline in brain functioning. Symptoms include problems with memory, thinking or language, and changes in mood, emotions, perception and behaviour, and therefore impacts an individual's ability to live independently. Dementia predominantly affects people over the age of 65, however around 1 in 20 people with dementia are younger than 65 – this is often called young-onset dementia.[240]

The most common forms of dementia are:[241]

- **Alzheimer's Disease:** typically starting with impairment of episodic memory, the disease progresses to affect other brain functions. This is the most common form of dementia, accounting for approximately 60% of cases.
- **Vascular Dementia:** typically presents with a progressive deterioration in brain function, occasionally with localised weakness or reduction in vision. This is the second most common form of dementia, accounting for approximately 20% of cases.
- **Dementia with Lewy Bodies:** often associated with delusions, hallucinations and transient loss of consciousness. This is the third most common form of dementia, accounting for approximately 15% of cases.

Estimated Prevalence of Dementia in Richmond

A Dementia Needs Assessment was carried out in Richmond in 2019 to assess health needs related to dementia in the population to inform ASC commissioning activities in the borough.[242] Please refer to this document for the detailed needs of the population in Richmond.

The key findings of the 2019 Dementia Needs Assessment were:

- A higher proportion of Richmond's population are living with a diagnosis of dementia (0.6%) than average across the rest of London (0.5%). This is in part due to the higher proportion of people aged 65+ in the borough (15.4%). This amounts to 1,447 people in 2020/21.[243] 1,412 of those are aged over 65.[244]
- It is anticipated that there will be a 74% increase in the number of people aged 65+ living in Richmond between 2018 and 2035, which is expected to increase the number of people living with a diagnosis of dementia.

Overview of Local Need: Key Findings

- There are an estimated 26,655 of adults in Richmond with a CMD.
- It is estimated that 1,703 adults in Richmond have a SMI.
- It is estimated that one in six adults in Richmond has a mental disorder.
- The prevalence of depression has increased year on year over the last decade in Richmo nd from an estimated 7,076 people in 2013/14 to 17,560 in 2020/21.
- There was an increase in the incidence of depression during the pandemic 2020/21.
- Women in Richmond are more likely to have CMD than men.
- Young women in Richmond have emerged as a high-risk group.
- In 2019 self-harm was the leading cause of death for males and females between the ages of 15-49 in Richmond.
- Richmond had the second highest rate of emergency hospital admissions for intentional self-harm in 2020/21 in the whole of London.
- In 2017-19 there were 46 suicides in Richmond, the highest annual figures in the past two decades.
- The prevalence of most CMDs and SMIs diminish with age.
- A higher proportion of Richmond's population are living with a diagnosis of dementia (0.6%) than average across the rest of London (0.5%).

Vulnerable Groups and Mental Disorders

Mental health problems in adults can have a wide range of causes. For many, there is likely to be a combination of factors that make an individual more susceptible to poor mental health outcomes, particularly in relation to social context. Adverse childhood experiences increase risk. Other risks include poverty, discrimination, inaccessibility to good quality support services and overall lack of awareness about mental health.[245]

The following section highlights groups of adults who are more vulnerable to mental health disorders due to adversity, setting out the evidence of increased vulnerability and providing estimates, using local data, to identify need relating to each group. Estimates of local need have been calculated by applying local population data to relevant prevalence studies for each vulnerable group. Population estimates were identified through GLA 2020-based population projections unless otherwise indicated.

It is important to recognise that when applying estimated prevalence from national level surveys to the local population, the smaller the geographical area the more likely it is that local factors come into play, making the estimates used less reliable. This must be taken into consideration when interpreting the estimates in the table below. Examples of local factors include socioeconomic deprivation, access to services, levels of crime, the extent of community cohesion etc.

Note: There are inconsistencies in the terminology relating to mental health disorder, psychiatric disorder, and psychological symptoms. Where limited availability of evidence has prevented local estimates from being calculated, relevant proxy-indicators have been included.

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Individuals dependent on alcohol and/or drugs	Risk factors for mental health disorders in alcohol and drug dependent individuals.[246] • Common risk factors can contribute to both mental illness and substance use and addiction • Substance use and addiction can contribute to the development of mental illness • Mental illness may contribute to substance use and addiction • Genetic predisposition • Adverse childhood experiences • Exposure to trauma. • Chronic stress	76.1% alcohol dependent outpatients in Madrid had a current dual diagnosis.[247] Co-occurring conditions in substance misuse and community mental health services study:[248] • 44% CMHT patients reported drug use and/or harmful alcohol. • 75% of drug and alcohol service patients (n=161) rated positive for at least one psychiatric disorder: - 37% personality disorder - 27% severe depression - 8% psychotic disorder was present.	1,376 out of 151,379 residents (0.9%) in Richmond are estimated to be alcohol dependent.[249] 636 people are in drug and alcohol treatment in Richmond.[250] There were 300 new presentations to drug and alcohol services in 2021-22:[251] • 190 (63%) of drug and alcohol treatment clients identified as having a mental health treatment need. • Estimated 477 with at least one co-occurring psychiatric disorder. • Estimated 235 with a co-occurring personality disorder. • Estimated 172 with co-occurring severe depression. • Estimated 51 with a co-occurring psychotic disorder. • Estimated 54 (30.5%) with concurrent contact with mental health services and substance misuse services for drug misuse. • Estimated 37 (28.2%) concurrent contact with mental health services and substance misuse services for alcohol misuse.
Carers	Risk factors for poor mental health in Carers:[252] • Poor physical health. • High stress levels. • Poor sleep. • Loneliness. • Lack of awareness from professionals.	English national survey into the health of caregivers identified:[253] • 18.72% of individuals caring for 0-19 hrs per week had a CMD. • 28.53% of individuals caring more than 20 hrs per week had a CMD.	Estimated 13,377 residents (16-90 yrs. old) identified as carers.[254] Estimated 10,005 residents (16-90 years) providing up to 20 hours informal care per week:[255] • Estimated 1,873 with a CMD. Estimated 3,372 residents (16-90 years) providing more than 20hrs informal care per week: • Estimated 962 with a CMD.

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Ethnic Minority Groups	Risk factors for poor mental health in ethnic minority groups:[256] • Deprivation. • Poor educational outcomes. • Structural Racism. • Discrimination. • Stigmatisation. • Poor access to services.	The adult Psychiatric Morbidity Survey 2014 identifies:[257] Prevalence of CMD (all adults) • Black/ Black British 24.0% • Mixed/Multiple/Other 19.8% • Asian/Asian British 16.5% Prevalence of CMD (Women) • Black/ Black British 31.9% • Mixed/ Multiple/Other 26.0% • Asian/ Asian British 21.3% Prevalence of PTSD (all adults) • Black/ Black British 10.0% • Mixed/ Multiple/ Others 8.0% • Asian/ Asian British 6.6% Prevalence of psychotic disorder (all adults) • Black/ Black British 1.4% • Asian 0.9% Prevalence of psychotic disorder (Men) • Black 3.2% • Asian 1.3% Prevalence of Bipolar disorder (all adults) • 4.3% Black/ Black British • 1.4% Asian/ Asian British	Estimates based upon age standardised rates: Estimated number with a common mental disorder (all adults): • Estimated 530 Black/ Black British • Estimated 1192 Mixed/ Multiple/ Other • Estimated 1840 Asian / Asian British Estimated number with a common mental disorder (women): • Estimated 368 Black/Black British women • Estimated 798 Mixed/Multiple/Other women • Estimated 1292 Asian/Asian British women Estimated number with PTSD (all adults): • Estimated 221 Black/Black British • Estimated 482 Mixed/Multiple/ Others • Estimated 736 Asian/ Asian British Estimated number with psychotic disorder (all adults) • Estimated 29 Black/Black British • Estimated 91 Asian Estimated number with a psychotic disorder (men) • Estimated 32 Black men • Estimated 60 Asian men Estimated number with bipolar disorder (all adults) • Estimated 95 Black/Black British • Estimated 156 Asian/Asian British

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Gypsy, Roma and Traveller	Risk factors for poor mental health in Gypsy, Roma and Traveller:[258] • Poverty. • Economic instability. • Social exclusion. • Stigma and discrimination. • Racism and racial discrimination. • Low educational achievement. • High rates of school exclusion. • Poorer physical health. • Poor access to services. • Poor awareness of mental health. • Distrust of support services.	Research identifies that the Gypsy, Roma and Traveller communities experience 2.5 times higher rates of poor mental health compared to samples of the general population.[259]	Limited evidence available.
Learning Disabilities	Risk Factors for poor mental health in people with learning disabilities:[260] • Pain. • Physical ill health. • Taking multiple types of medication. • Genetic syndromes associated with specific mental health problems. • Experience of deprivation, poverty, abuse, and other negative life events earlier on in life. • Lack of social support and reduced coping skills. • Stigma and discrimination.	Data from census studies shows: [261] • 23.4% adults (16-64 years) with an intellectual disability had a mental health disorder (excluding problem behaviours and autism). • 27.2% older adults (65+ years) with an intellectual disability had a disorder (excluding problem behaviours and autism).	Estimated 704 people with learning disabilities (16-64 years) with a mental health disorder. Estimated 180 people with learning disabilities (65+ years) with a mental health disorder.

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
LGBTQ+	Risk factors for poor mental health in LGBTQ+ people: [262] • Negative experience of healthcare • Discrimination and bullying in school • Victimisation and violence • Loneliness and isolation • Gender dysphoria • Higher levels of drug and alcohol use	Mental health of the non-heterosexual population of England:[263] • 22.2% had any neurotic disorder in the past week • 6.3% had GAD • 4.1% had a depressive episode in the past week • 20.6% experienced suicidal thoughts in their lifetime • 8.9% experienced suicidal attempts in their lifetime	Estimated LGB population (aged 18–90 years) in England in mid-2014 was 4.26%.[264] Estimated 6,540 LGB persons in Richmond: • Estimated 1,439 LGB persons with a neurotic disorder in the past week • Estimated 412 LGB persons with GAD • Estimated 268 LGB persons experiencing a depressive episode in the last week • Estimated 1,347 LGB persons have experienced suicidal thoughts • Estimated 582 LGB persons attempting suicide
Co-morbid Physical and Mental Health Issues	Risk Factors for co-morbid Physical and mental health: [265] • Unhealthy diet: high in salt, sugar, or unhealthy fats • Tobacco use • Air pollution • Harmful use of alcohol. • Physical inactivity	Evidence suggests that at least 30% of all people with a long-term condition also have a mental health problem.[266] People with three or more long-term conditions living in highly deprived areas, more than half had signs of significant psychological distress[267]	The number of Richmond residents with a long-term condition is 91,529 (41% of the population):[268] • Estimated that at least 27,500 of residents with a long-term condition will have a mental health problem. • 22,778 residents with a long-term condition are on the depression QOF register.
Unemployed / Low Income	Risk factors for poor mental health in low-income groups:[269] • Poverty • High crime rates • Poor housing • Lower educational attainment • Stigmatisation • Discrimination • Debt • Poor physical health • Poor access to services	The Adult Psychiatric Morbidity Survey shows:[270] • 34.6% of unemployed women (16-64) and 24.5% of unemployed men had a CMD • 47.4% of adults (16-64 years) in receipt of some kind of out-of-work benefit had a CMD • 35.1% of adults (16-64 years) in receipt of housing benefit had a CMD	Estimates below are based on age standardised prevalence rates (16-64 years): • Estimated 657 unemployed women with a CMD • Estimated 956 unemployed men with a CMD • Estimated 1,507 benefit claimants with a CMD

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Homelessness[271]	Risk factors for poor mental health in homeless people:[272] • Adverse childhood experiences • Victim of violence • Family conflict • Relationship breakdown • Poor physical health • Poor mental health • Learning difficulties • Domestic abuse • Drug and alcohol dependencies • Housing instability • Poverty • Debt	Prevalence of mental disorder in people experiencing homelessness: [273] • 12.7% Psychotic illness • 11.4% Major depression • 23.1% Personality Disorder • Severe depression 17% • Self-harm 14% • Suicidal thoughts 19% • Bipolar disorder 5% • Schizophrenia 4% • Personality disorder 60%	In Richmond in 2017/18 there were 207 households who were homeless and in priority need:[274] • Estimated 26 with a psychotic illness • Estimated 24 with major depression • Estimated 48 with a personality disorder In Richmond in June 2022 there were 35 rough sleepers recorded.[275] • Estimated 6 with severe depression • Estimated 5 self-harming • Estimated 7 experiencing suicidal thoughts • Estimated 21 with a personality disorder
Refugees and asylum seekers	Risk factors for poor mental health in refugees and asylum seekers:[276] • Poverty • Poor physical health • Trauma • Family breakdown and separation • Bereavement • Victims of violence and abuse • Imprisonment • Unstable living conditions • Poor access to healthcare	Prevalence of common mental disorder in refugees and asylum-seekers:[277] • Depression 44% • Anxiety 40% • PTSD 36%	Richmond has received 354 adults as part of the 'Homes for Ukraine' scheme:[278] • Estimated 156 with depression • Estimated 142 with anxiety • Estimated 127 with PTSD

Vulnerable Group	Risk factors for a mental health disorder	Evidence	Local context and identified need
Young Women	Young women have emerged as a high-risk group, with high rates of CMD and self-harm, and positive screens for PTSD and bipolar disorder. The gap between young women and young men increased markedly over the last 20 years. The evidence is under-developed, but there are several theories including:[279] • Intimate partner violence • Physical and sexual abuse • Gender discrimination • Misogyny • Social media consumption • Physiological differences including hormonal influence	Females (17-19 years):[280] • 23.9% had any mental disorder. • 52.7% with a mental disorder had self-harmed or made a suicide attempt. Females (16-24 years):[281] • 26.0% had a CMD • 12.6% had PTSD • 25.7% ever self-harmed	In 2022, there are 3,237, females (17-19 years) in Richmond: [282] • Estimated 774 with a mental disorder • Estimated 408 with a mental health disorder had self-harmed or made a suicide attempt In 2022, there are 8,015 Females (16-24 years) in Richmond: [283] • Estimated 2,084 with a CMD • Estimated 1,010 with PTSD • Estimated 2,060 ever self-harmed
Criminal Justice	Risk factors for involvement in the criminal justice system: [284] • Homelessness • Inconsistent and erratic parenting • Over harsh discipline • Hyperactivity • Learning difficulties • Numeracy and literacy problems • Risk taking behaviours • Drug and alcohol dependency • History of abuse • Interactions with the criminal justice system	From a survey of one region in England, of people on probation:[285] • 39% had a mental illness • 60% had substance misuse problems • 48% had personality disorders Recent prevalence rates of mental disorder among prisoners from one London prison were: [286] • 53.8% had depressive disorders • 26.8% had anxiety disorders • 12% had psychosis • 34.2% had some form of personality disorder • 33.1% had alcohol dependence. • 57.1% had dependence on illegal drugs	245 Richmond residents are currently in contact with the probation service:[287] • Estimated 96 with a mental illness • Estimated 147 with a substance misuse problem • Estimated 118 with a personality disorder 83 Richmond residents are currently in prison: [288] • Estimated 45 with a depressive disorder • Estimated 22 with an anxiety disorder • Estimated 29 with a personality disorder • Estimated 10 with psychosis • Estimated 47 with dependence on illegal drugs • Estimated 27 with alcohol dependence

Vulnerable Groups and Mental Disorders: Key Findings

- Over half of adults in drug and alcohol treatment have a co-occurring substance misuse and mental health disorder.
- It is estimated that there are almost 1,873 carers with a CMD in Richmond.
- It is estimated that there are 900 adults with a learning disability who also have a CMD in Richmond.
- It is estimated that almost 600 lesbian, gay and bisexual adults have attempted suicide in their lifetime in Richmond.
- There are an estimated 27,500 adults with a long-term condition and a mental health disorder in Richmond.
- It is estimated that almost half of adults in receipt of out of work benefits have a CMD in Richmond.
- Almost half of adults housed through the 'Homes for Ukraine' scheme experience anxiety and depression, up to a third may have PTSD.
- Young women are emerging as a high-risk group for mental disorder. It is estimated that:
  - One in four (2,084), females aged 16-24 years have a CMD in Richmond.
  - One in four (2,060), females aged 16-24 years have self-harmed in Richmond.
  - 1,010 females aged 16-24 years have PTSD in Richmond.

Autism

Autism spectrum disorders are developmental disorders characterised by impaired social interaction and communication, severely restricted interests, and highly repetitive behaviours.[289]

Key Findings from the Adult Psychiatric Morbidity Survey related to Autism:

- The estimated prevalence of autism in 2014 was 0.7% of the adult population.[290]
- There was no clear pattern in the distribution of autism by age. Rates were higher in men than women although it is acknowledged that assessments for autism may rely more on how the condition presents in men, thus leading to an under identification in women.[291]

Attention Deficit Hyperactivity Disorder

ADHD is a complex neurodevelopmental disorder which starts in childhood and often persists into adulthood.[292]

Key Findings from the Adult Psychiatric Morbidity Survey related to ADHD:

- One in ten adults screened positive for ADHD.
- The rates were similar for men and women.

Mental Health Service Utilisation in Richmond

This section presents data on mental health service activity in Richmond with the aim of using it to understand levels of unmet need.

It will first outline the how services are commissioned; then it will look at the effect of COVID-19 on service provision; before outlining the local system of care and how adults and older adults with differing mental health needs access the services from the NHS Trust and the voluntary sector.

South West London Context

In 2020, the South West London Health and Care Partnership was formally designated as an Integrated Care Board (ICB). The South West London ICB brings health and care partners closer together to improve local health and care services. The South West London ICB is made up of six boroughs – Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.[293]

As a system the ICB is reviewing the mental health needs of the community to effectively meet local demand. This includes working with mental health partners to focus on prevention and early intervention and develop the capacity to support people.[294]

Several areas have been prioritised by the South West London ICB for the improvement of mental health, including: [295]

- Developing a three-year mental health strategy.
- Improving crisis care provision.
- Transforming community mental health.
- Developing the health workforce.
- Preventing suicide and self-harm.
- Developing a new maternal mental health service.

In Richmond, mental health services are provided by South West London and St George's NHS Trust.[296]

The Local System of Care

This section will look at a particular selection of mental health services in Richmond that were identified by the steering groups. There is a focus on the demographics of those referred to service, to see if these are in keeping with the expected prevalence in the population; on waiting times; reasons for referral; and sources of referral, to understand how adults and older adults are accessing mental health services in Richmond.

For most services outlined below, data provided for 2021/22 is only Q1-3. This has been noted where applicable. Where Q1-3 is not specified you can assume the data provided is for the full year.

Improving Access to Psychological Therapies Programme

The IAPT programme in Richmond is delivered by the Richmond Wellbeing Service, which also delivers primary care liaison psychiatry. The service is for adults over 18 who are registered with a Richmond GP. IAPT is an evidence based talking therapies programme that began nationally in 2008 and has transformed the treatment of common mental disorders, especially adult anxiety disorders and depression, in England.[297] It is run by the East London NHS Trust and Richmond Mind.

Expected national service standards include:

- Waiting times: 75% of people referred to IAPT services should start treatment within 6 weeks of referral.
- Recovery standard: at least 50% of people who complete treatment should recover.

Referrals to IAPT and Service Use

- The annual number of referrals increased each year between 2018/19 and 2020/21.
- The final figure for 2021/22 is not yet available.
- The IAPT recovery rate for each year since 2018 exceeds the 50% recovery rate standard.
- The percentage of IAPT appointments where people did not attend remained around 12% each year.
- Around a quarter of referrals do not enter treatment.
- Only approximately half of those who enter treatment finish the course.

Table 68: Number of service users referred to IAPT and use of the service in Richmond between 2018/19 and 2021/22

IAPT Richmond Service Use	Year			
	2018/19	2019/20	2020/21	2021/22 (Q1-3only)
Number of Referrals Received	5,586	5,816	6,411	4,951
Average Waiting Time from Referral to Starting Treatment	8.8 weeks	7.1 weeks	3.7 weeks	5.2 weeks
Number of Referrals Entering Treatment (% of referrals)	4,129 (73.95%)	4,638 (79.74%)	4,862 (75.84%)	3,920 (79.18%)
Number of Referrals Finishing a Course of Treatment	2,126	2,445	2,902	2,061
IAPT Recovery Rate	55.7%	54.7%	59.7%	55.6%
Percentage of IAPT Appointments Not Attended	12.9%	11.9%	12.8%	12.0%

Source: Improving Access to Psychological Therapies. Richmond Wellbeing Service. 2018-2022.

Age of Service Users Referred to IAPT

- Those between 25-34 are most represented amongst those entering treatment.
- Demand increased the most for those aged 25–34 years between 2018/19 and 2020/21.
- Older adults aged 65+ are the least represented in the service.

Table 69: Age of service users referred to IAPT between 2018/19 and 2021/22

Age group of referrals	Year			
	2018/19	2019/20	2020/21	2021/22 (Q1-Q3)
16-24	632	724	830	656
25-34	1,097	1,284	1,356	1,024
35-44	1,014	1,055	1,092	920
45-54	673	742	750	606
55-64	424	469	539	425
65-74	214	249	216	205
75+	103	117	86	94

Source: Improving Access to Psychological Therapies. Richmond Wellbeing Service. 2018-2022.

Sex of Service Users Referred to IAPT

- More females than males enter treatment for IAPT at a rate of almost 2:1.

Table 70: Sex of service users referred to IAPT between 2018/19 and 2021/22

Sex of referrals	Year			
	2018/19	2019/20	2020/21	2021/22 (Q1-Q3)
Female	2,782	3,087	3,402	2,647
Male	1,368	1,559	1,452	1,269
Not Known	<5	<5	<5	<5
Indeterminate	<5	<5	11	11

Source: Improving Access to Psychological Therapies. Richmond Wellbeing Service. 2018-2022.

Ethnicity of Service Users Referred to IAPT

- Those that identify as British are most represented among service users entering treatment.
- Between 2018/19 and 2020/21, the biggest increases in those entering treatment have been in those that identify as African, White and Black African and Indian.

Table 71: Ethnicity of service users referred to IAPT between 2018/19 and 2021/22

Ethnic Group of referrals	Year			
	2018/19	2019/20	2020/21	2021/22 (Q1-Q3)
Asian or Asian British Total	**269**	**306**	**378**	**283**
Bangladeshi	14	13	24	11
Chinese	22	20	25	25
Indian	119	137	179	125
Pakistani	28	32	45	34
Any Other Asian Background	86	104	105	88
Black or Black British Total	**82**	**107**	**122**	**89**
African	31	51	62	54
Caribbean	35	34	41	26
Any Other Black Background	16	22	19	9
Mixed Total	**187**	**244**	**289**	**200**
White and Asian	41	50	69	59
White and Black African	14	18	35	19
White and Black Caribbean	37	52	48	43
Any Other Mixed Background	95	124	137	79
Other Ethnic Groups	**117**	**110**	**143**	**112**
White Total	**3,406**	**3,752**	**3,810**	**3,086**
British	2,843	3,132	3,066	2,492
Irish	68	76	105	71
Any Other White Background	495	544	639	523
Blank	14	9	<5	<5
Not known	12	15	21	33
Not stated	70	107	102	125

Source: Improving Access to Psychological Therapies. Richmond Wellbeing Service. 2018-2022.

Voluntary Sector Services

Richmond Mind

Richmond Borough Mind exists to meet the local mental health needs of the community.[298] Their vision is to see people who experience mental health issues and their carers enjoy a good quality of life within their local communities.[299]

Richmond Mind offers a number of services, including Richmond Wellbeing Service (as described in detail above), Peer Group Network, Journey Recovery Hubs, Carers in Mind, Young Wellbeing Projects and the Wellbeing Centre which is for adults with severe and enduring mental health issues and focusses on recovery and crisis prevention.

Referrals to Richmond Mind and Service Use

- Demand for Richmond Mind services increased year-on-year.
- The age group most represented in Richmond Mind services is adults aged 55-64 years.
- There are more women than men attending the service, with approximately twice as many women as men.
- The number of men remained fairly consistent across the period, with only a small increase from 2018/19 to 2021/22.
- By contrast, the number of women using the service increased steadily each year.
- The ethnicity of most that attend the service are White British

Table 72: Demographics of service users referred to and use of Richmond Mind services between 2018/19 and 2021/22

Use of Richmond Mind Services		Year			
		2018/19	2019/20	2020/21	2021/22
Total Number of Service Users in the Service (All Referrals Accepted)		772	821	893	1,022
Age	16-24	11	14	18	34
	25-34	70	77	82	91
	35-44	86	104	99	121
	45-54	145	143	157	189
	55-64	177	199	195	227
	65-74	128	139	156	150
	75+	85	85	84	104
	Not Specified	70	60	102	106
Sex	Female	491	514	543	623
	Male	258	282	257	285
	Not Specified	21	17	87	105
	Other	<5	8	6	9
Ethnicity	Asian/Asian British	38	39	41	52
	Black/Black British	18	17	14	17
	Mixed	20	18	12	19
	Other	5	14	17	19
	White Other	102	97	83	103
	White British	467	528	489	533
	White Irish	21	20	10	13
	Did Not Respond	100	75	215	260
	Not Recorded	<5	<5	<5	<5
Source of Referral	Unknown	754	768	799	855
	Other Most Common Sources (In Order of Frequency)	Self	Self; Richmond Home Treatment Team (RHTT)	Self; Wellbeing Service	Self; Link worker; RHTT Wellbeing service

Source: Richmond Mind. 2018-2022.

RUILS Social Prescribing Richmond

RUILS, in partnership with the Richmond GP Alliance, delivers social prescribing across Richmond. Social prescribing supports individuals to take control of their health and wellbeing by connecting them with activities and support in the local community.[300]

Referrals to RUILS Social Prescribing and Service Use

- The number of those using the service increased by 1.8 times between 2020/21 and 2021/22.
- More females than males use the service.
- However, it is noted that the number of men has almost doubled.
- The age group most represented in the service is the over 75s.

Table 73: Demographics of service users referred to and use of RUILS Social Prescribing Richmond services between 2020/21 and 2021/22

Use of RUILS Social Prescribing Services		Year	
		2020/21	2021/22
Total Number of Services Users in the Service		1,693 Referrals	3,103 Referrals
Gender	Female	1,087	1,990
	Male	603	1109
	Not Specified	<5	<5
	Other	0	<5
Age	19-24	53	96
	25-34	147	294
	35-44	179	452
	45-54	237	477
	55-64	241	455
	65-74	227	356
	75-84	309	393
	85+	293	563
Reasons	Mental Health	719	1,035
	Social Isolation	588	632
Source of Referral	GP	97.8%	97.6%
	Hounslow and Richmond Community Healthcare	1.7%	1.5%
	Self	0.5%	0.9%
Number of Service Users Accepted to Service (Exclusion criteria – under-18s and those in mental health or social crisis)		All	All
Waiting Times for First Assessment		Avg of 1 week	Avg of 1 week
Number of Service Users' Appointments where Patients DNA (it is not possible to ascertain how many DNAs were for mental health reasons)		436	469

Source: RUILS Social Prescribing. 2020-2022.

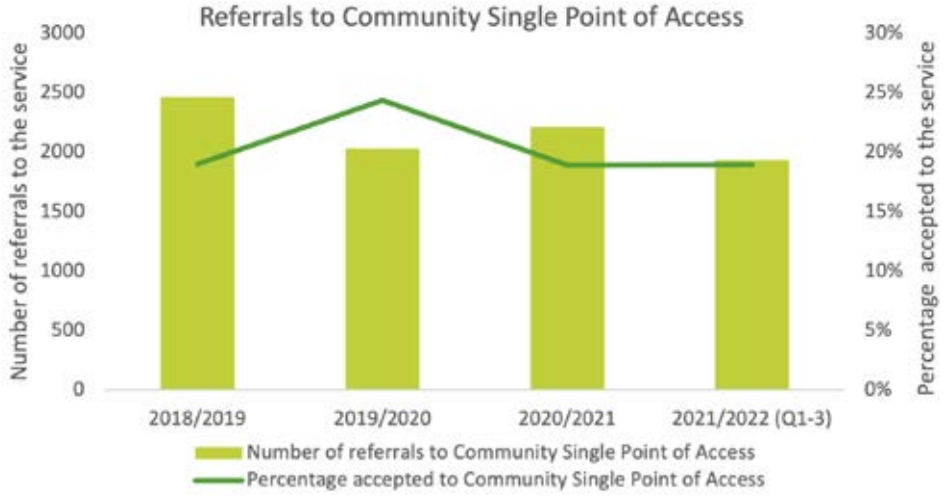
Community Single Point of Access

The Community SPA is used by healthcare professionals to refer adults registered with a GP into community-based services. The SPA will triage all referrals to direct them to the appropriate service.[301]

Referrals to the Community Single Point of Access

- The number of service users referred to Community SPA between 2018/19 and 2021/22 fluctuated, however shows an overall decline in the number of referrals. Referrals peaked in 2018/19 at 2467, fell to 2037 in 2019/20, increased to 2215 in 2020/21 but then declined to their lowest figure of 1937 in 2021/22.
- The number of service users accepted to the Community SPA also shows a general trend of decline. In 2018/19 470 service users were accepted into the service, which increased to 497 in 2019/20, but then fell to 420 in 2020/21 and further to 368 in 2021/22.
- Although the numbers of service users accepted has declined, the percentage of service users accepted to Community SPA has remained steady at 19% across all years, except for 2019/20 when it increased to 24%.

Figure 74: Number of service users referred and accepted to the Community SPA between 2018/19 and 2021/22

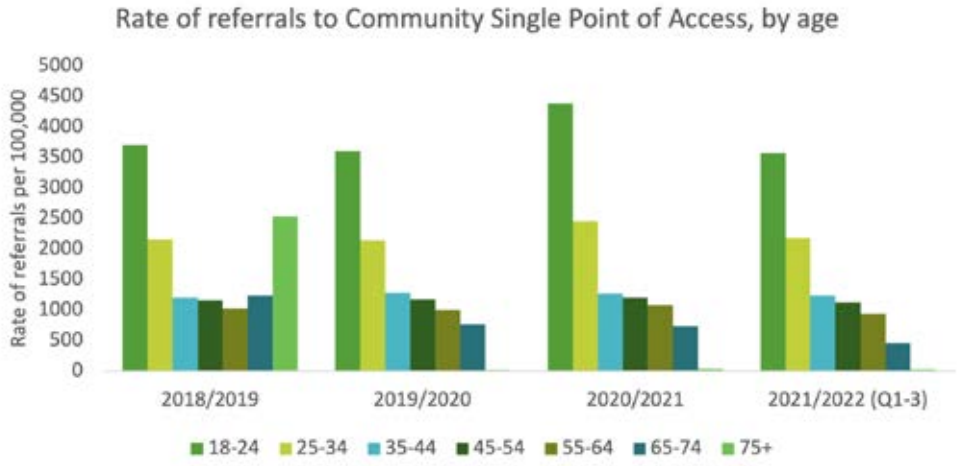


Source: Community Single Point of Access. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Community Single Point of Access

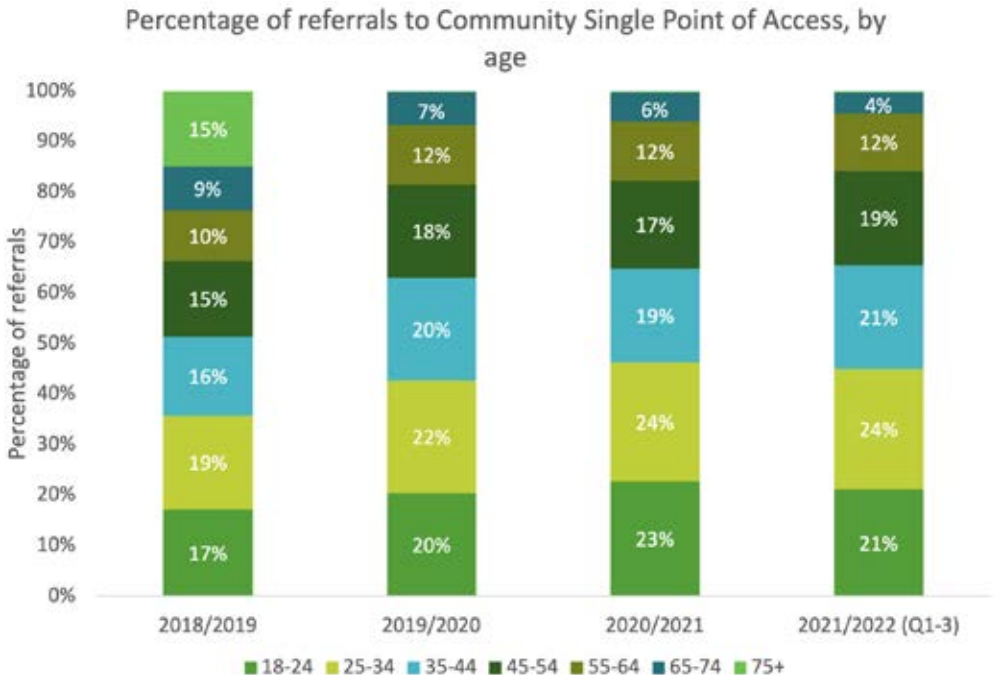
- Most referrals to the Community SPA are aged 18 to 44. Collectively, these groups constituted 52% of referrals in 2018/19, 62% in 2019/20 and 66% in 2020/21 and 2021/22 (Q1-3).
- There is a general trend towards a decline in the rate of referrals with increasing age. The referral rate is highest among the 18-24 age group (av. 3821 per 100,000), and incrementally declines across the life course to a low of 656.08 per 100,000 (av.) among the 75+ age group.
- There was a large drop in the number of older adults aged 65+ referred to Community SPA after 2018/19.

Figure 75: Rate of referrals to the Community SPA by age between 2018/19 and 2021/22, using ONS mid-2020 population



Source: Community Single Point of Access. South West London St George's NHS Trust. 2018-2022.

Figure 76: Percentage of service users referred to the Community SPA by Age between 2018/19 and 2021/22

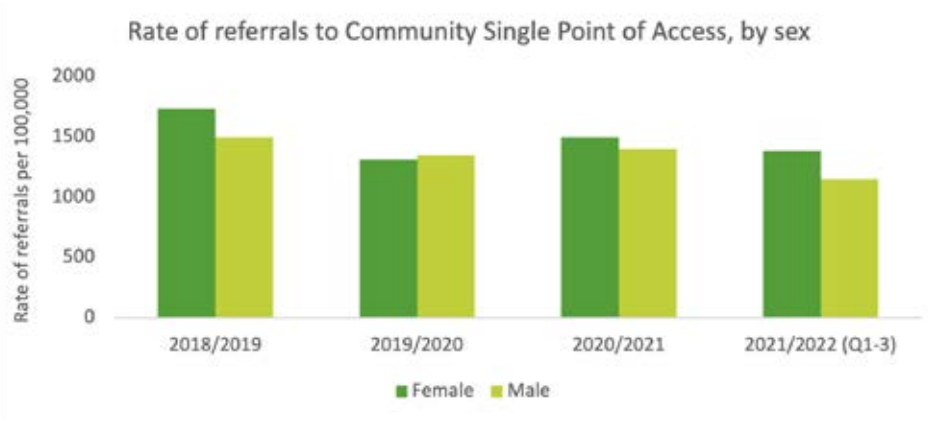


Source: Community Single Point of Access. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Community Single Point of Access

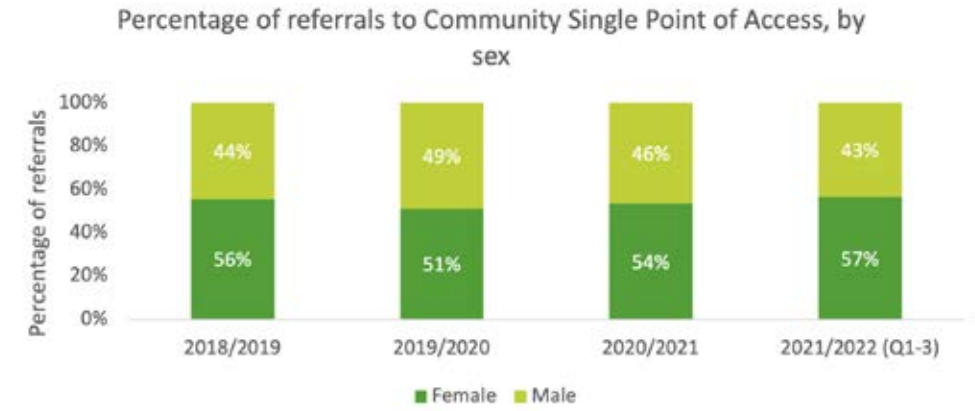
- Across the four-year period, there were more females referred to Community SPA than males; 54% female and 46% male.
- Between 2018/19 and 2019/20, both genders saw a decrease in their rate of referral. However, this reduction was more sizeable for females than for males; the female rate fell by 28% whereas the male rate only fell by 10%.
- The balance of males and females was most equitable in 2019/20, and males had a slightly higher rate of referral than females in this year.
- In 2020/21, both males and females saw increased rates of referral from the previous year. This increase was greatest among females; the rate of female referral increased by 13% and the rate of male referral increased by 4%.
- In Q1-3 of 2021/22, the rate of female referral had reached 93% of its rate in the previous year, whereas the rate of male referral had reached 82% of its rate in the previous year.

Figure 77: Rate of referrals to the Community SPA by sex between 2018/19 and 2021/22, using ONS mid-2020 population



Source: Community Single Point of Access. South West London St George's NHS Trust. 2018-2022.

Figure 78: Percentage of service users referred to Community SPA by sex between 2018/19 and 2021/22

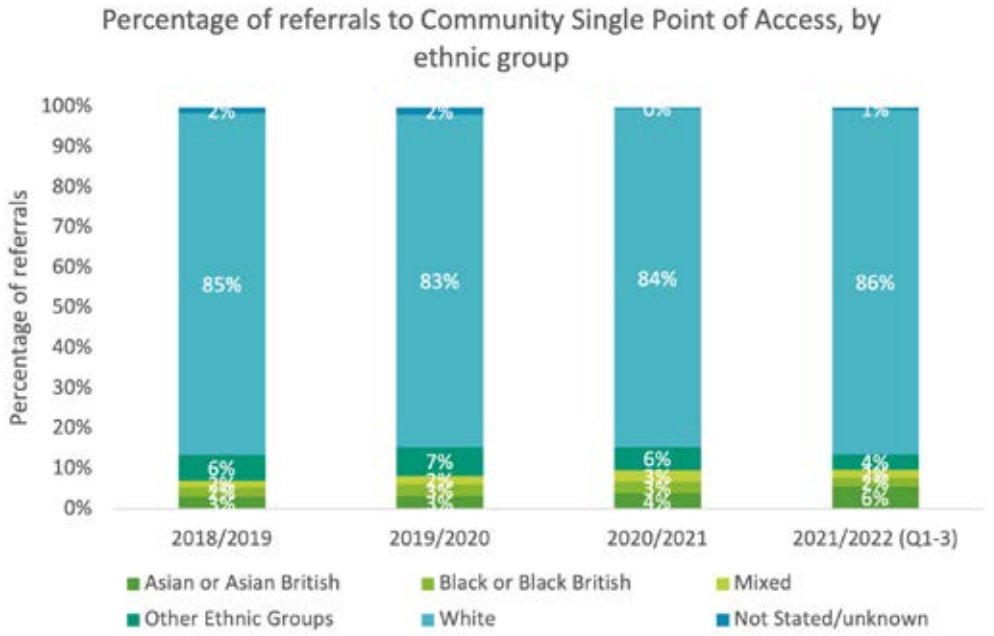


Source: Community Single Point of Access. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Community Single Point of Access

- Across the four-year period, the majority of referrals to Community SPA identified as White (av. 84.5%).
- This was followed by Asian or Asian British (av. 6%), Other Ethnic Groups (av. 5.75%), Black or Black British (av. 2.5%) and Mixed (av. 2.25%).
- All ethnic groups saw reduced numbers of referrals over the period except Asian or Asian British, which saw an increased number of referrals over the period, rising from 64 referrals in 2019/20 to 87 referrals in 2020/21 and to 108 referrals in 2021/22 (Q1-3).

Figure 79: Percentage of service users referred to Community SPA by ethnic group between 2018/19 and 2021/22



Source: Community Single Point of Access. South West London St George's NHS Trust. 2018-2022.

Source of Referrals to the Community Single Point of Access

- Between 2018/19-2021/22, the majority of referrals to the SPA were from a GP (4,856 referrals) followed by the police (1,943 referrals), other primary health care (830 referrals) and Social Services (365 referrals).
- The number of service users referred from GPs and social services declined between 2018 and 2022.
- There were 1,554 referrals from GPs to the SPA in 2018/19, and this fell to 1,213 in 2019/20, 998 in 2020/21 and 1091 in 2021/22 (Q1-3).
- Similarly, there were 145 referrals from social services in 2018/19, which fell to 73 in 2019/20, 84 in 2020/21 and 63 in 2021/22 (Q1-3).
- It is noticeable that referrals from the police rose in 2020/21, increasing from 358 and 417 referrals in 2018/19 and 2019/20 respectively to 711 referrals in 2020/21.This fits with national observations that there have been increasing levels of demand on the police, especially since the COVID-19 pandemic, to respond to incidents related to mental health, and a growing culture of using the police as a first port of call when someone is in a mental health crisis.[302]

Table 80: Source of referrals to the Community SPA by percentage and number between 2018/19 and 2021/22

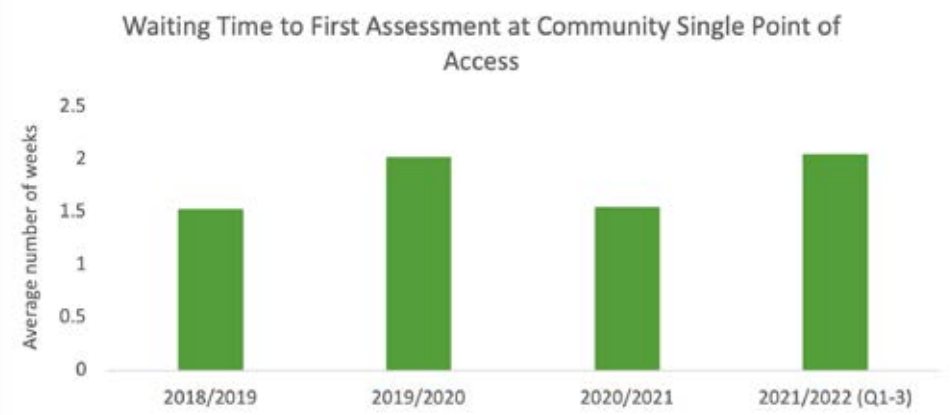
Source of Referral - % and (no.)	Year			
	2018/2019	2019/2020	2020/2021	2021/2022 (Q1-3)
General Medical Practitioner	63% (1,554)	60% (1,213)	45% (998)	56% (1,091)
Justice System: Police	15% (358)	20% (417)	32% (711)	24% (457)
Other Primary Health Care	8% (198)	10% (197)	11% (248)	10% (187)
Local Authority and Other Public Services: Social Services	6% (145)	4% (73)	4% (84)	3% (63)
Other service or agency	3% (69)	3% (57)	3% (69)	3% (57)
Other secondary care specialty	3% (79)	2% (35)	2% (47)	2% (35)
Self-Referral	2% (43)	1% (27)	1% (17)	1% (10)

Source: Community Single Point of Access. South West London St George's NHS Trust. 2018-2022.

Wait to First Assessment at the Community Single Point of Access

- Between 2018/19-2021/22, the length of time that service users had to wait to access Community SPA services ranged between 1.5 and 2 weeks, with the longest wait times seen in 2019/20 and 2021/22 (Q1-3).

Figure 81: Average number of weeks that service users waited for a first assessment by the Community SPA between 2018/19 and 2021/22



Source: Community Single Point of Access. South West London St George's NHS Trust. 2018-2022.

Contact Medium to Access the Community Single Point of Access

- Between 2018/19-2021/22 (Q1-3), most service users accessed the SPA by telephone (av. 77%), followed by face-to-face consultation (av. 18%).
- Prior to 2020/21, these were the only contact mediums available to access the SPA.
- In 2020/21, the percentage of service users accessing the SPA through face-to-face consultation fell from 21% to 11% of referrals, which is likely due to limitations on health service operation posed by the COVID-19 pandemic.[303]
- Instead, in 2020/21 and 2021/22 (Q1-3) a number of service users began to access the service through alternate means, such as eConsultations (7%), text (2%) and email (1%).
- It is important to note that this may create barriers to access for some groups such as those who do not speak English as a first language or who experience digital poverty.
- The percentage of service users accessing the SPA by telephone consultation remained stable during the pandemic.

Community Mental Health Services

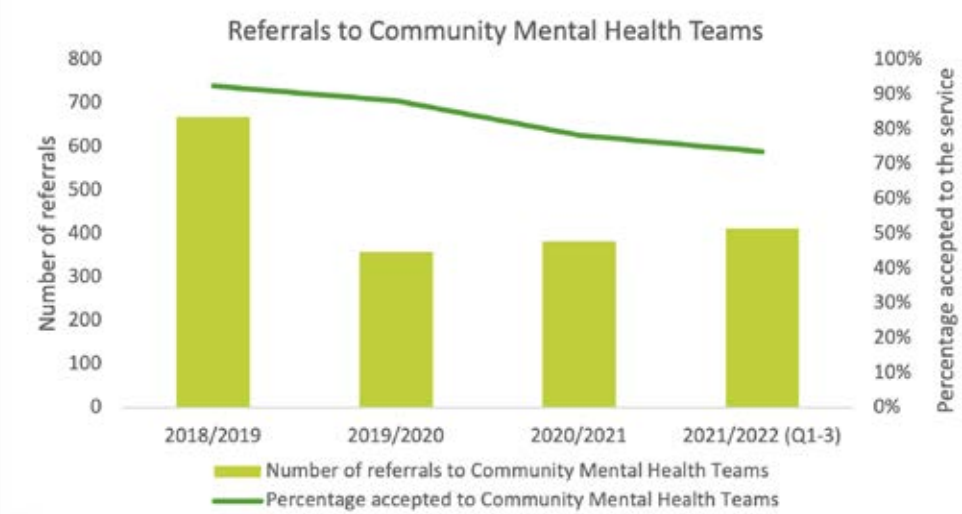
Community Mental Health Teams

The CMHT is a community based, multi-disciplinary mental health service which provides assessment and evidence-based treatment for patients with suspected or diagnosed moderate to severe mental illness/ mental disorder who for reasons of complexity, severity or lack of treatment response require specialist secondary care input.

Referrals to Community Mental Health Teams

- Between 2018/19 and 2019/20, there was a sharp decline in the number of service users referred to CMHTs, falling from 669 to 359 referrals.
- In 2020/21, the number of referrals increased slightly to 383, and in Q1-3 of 2021/22 this had already increased to 413 referrals.
- The percentage of service users accepted to CMHTs from those referred declined each year over this period. The acceptance rate fell from 92.5% in 2018/19 to 73% in 2021/22 (Q1-3).

Figure 82: Number of service users referred and accepted to CMHTs between 2018/19 and 2021/22

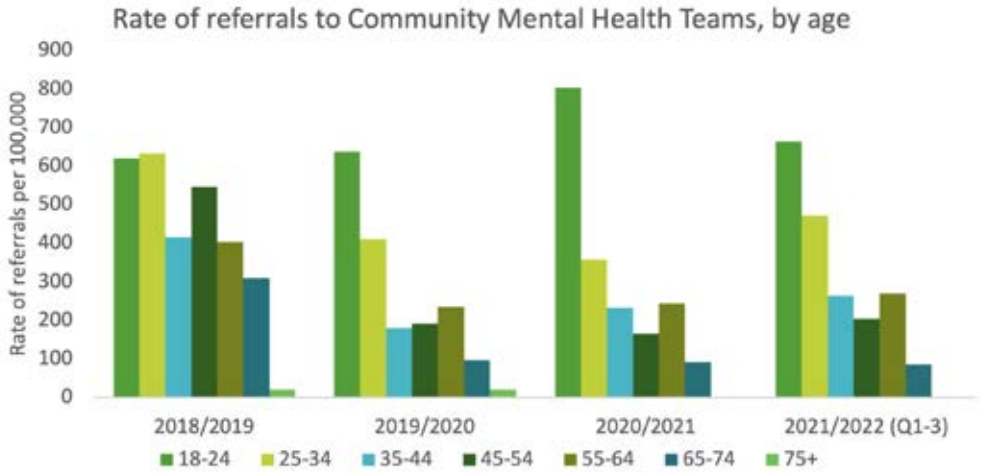


Source: Community Mental Health Teams. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to Community Mental Health Teams

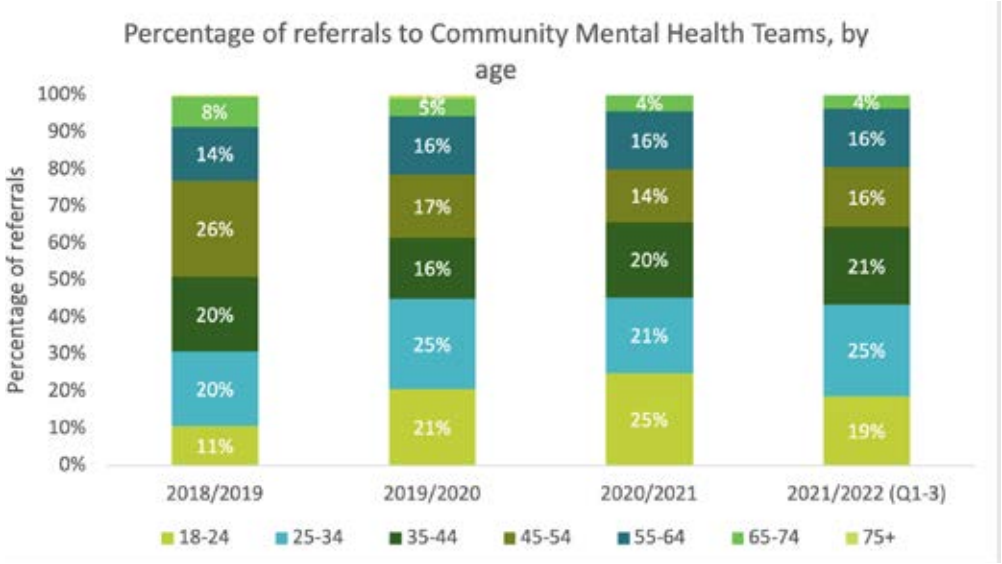
- There is a general trend of a decreasing number of referrals with increasing age, with a particularly steep decline above the age of 65.
- Most referrals to the CMHT were within the 25-34 age group (av. 22%), followed by the 18-24 and 35-44 age groups (av. 19%).
- The fewest referrals came from the 65-74 (av. 5%) and 75+ (av. 0.32%) age groups.
- It is notable that there was a drop in the number of older adults aged 65+ referred to CMHT after 2018/19:
- Referrals of 65-74's fell from a rate of 309 per 100,000 in 2018/19, to 97, 92 and 86 per 100,000 in 2019/20, 2020/21 and 2021/22 respectively.
- Referrals of older adults aged 75+ fell from a rate of 20.66 per 100,00 in 2018/19 and 2019/20, to 0 per 100,000 in 2020/21 and 2021/22.
- The decline in total referrals in 2019/20 onwards led to reduced rates of referral for all age groups except 18-24 year olds, whose rate of referrals increased. This led the 18-24 age group to constitute an increased percentage of total referrals from 2019/20 onwards.

Figure 83: Rate of referrals to CMHTs by age between 2018/19 and 2021/22, using ONS mid-2020 population data.



Source: Community Mental Health Teams. South West London St George's NHS Trust. 2018-2022.

Figure 84: Percentage of service users referred to CMHTs by age between 2018/19 and 2021/22

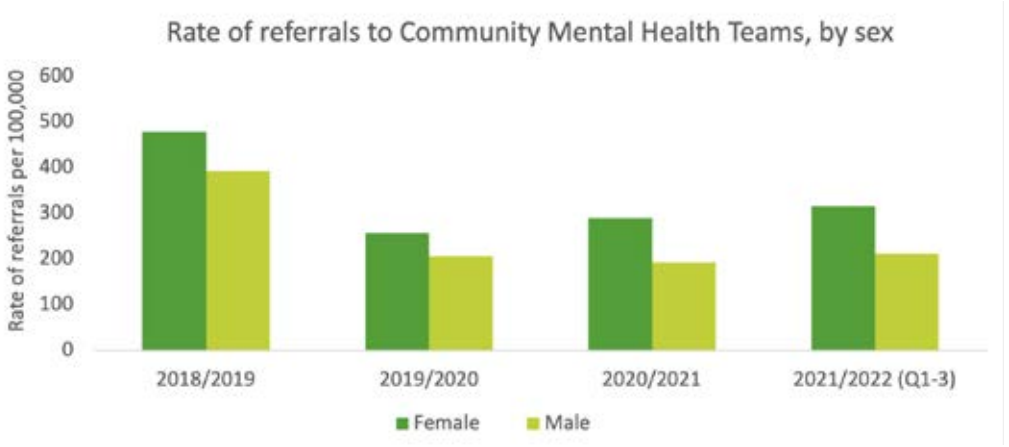


Source: Community Mental Health Teams. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to Community Mental Health Teams

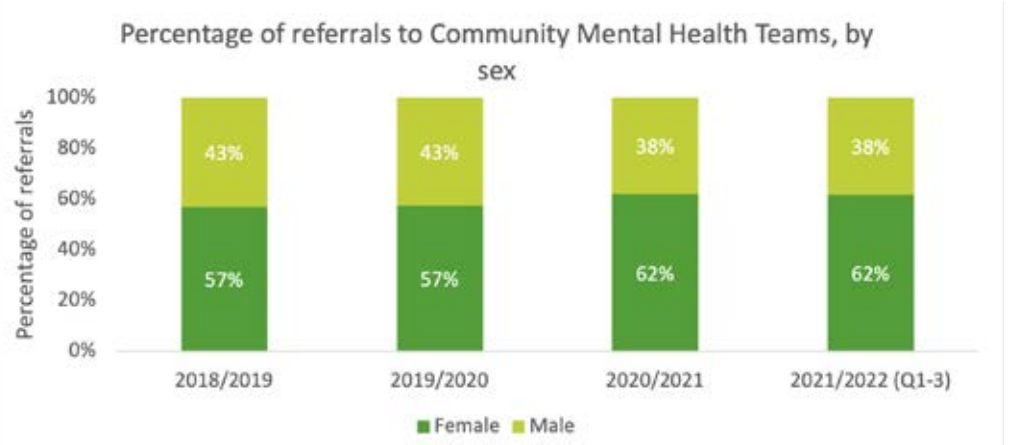
- Across the four-year period, there were more females referred to the CMHT than males; 54% were female and 46% were male.
- The decline in total referrals in 2019/20 was experienced evenly by both male and female service users; both genders saw their total referrals fall by 60% between 2018/19 and 2019/20.
- However, whilst the rate of male referrals declined in 2020/21, the rate of female referrals increased in the same period. This increased the imbalance in males and females referred to the service to 62% female and 38% male.
- This proportion of referrals was maintained in 2021/22 (Q1-3), although it must be noted that this does not constitute a full year's data.
- In Q1-3 of 2021/22, the referral rate of both males and females increased from the previous year by 9%.

Figure 85: Rate of referrals to CMHTs by sex between 2018/19 and 2021/22, using ONS mid-2020 population data.



Source: Community Mental Health Teams. South West London St George's NHS Trust. 2018-2022.

Figure 86: Percentage of service users referred to CMHTs by sex between 2018/19 and 2021/22

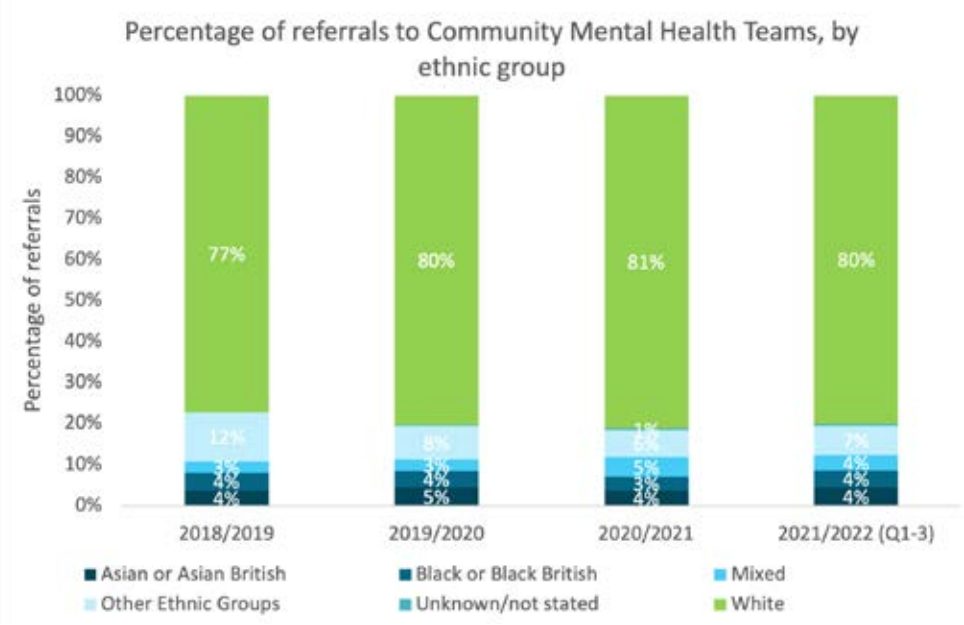


Source: Community Mental Health Teams. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to Community Mental Health Teams

- Most service users referred to CMHTs between 2018/19-2021/22 were from White ethnic groups (av. 79.5%).
- This was followed by service users from Other (av. 8.25%), Asian or Asian British (4.12%), Black or Black British (3.93%) and Mixed ethnic groups (3.52%).
- The percentage of service users from each ethnic group remained relatively consistent over the four-year period.

Figure 87: Percentage of service users referred to CMHTs by ethnic group between 2018/19 and 2021/22

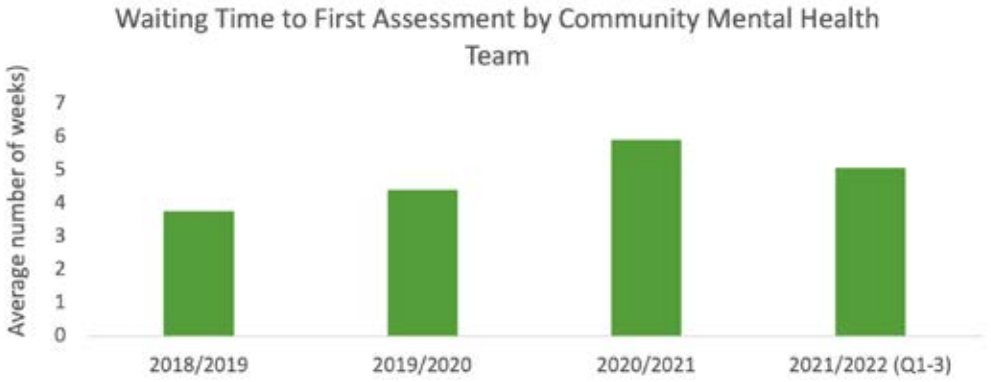


Source: Community Mental Health Teams. South West London St George's NHS Trust. 2018-2022.

Waiting Time to Access Community Mental Health Teams

- The average wait time to access CMHTs increased between 2018 and 2022.
- In 2018/19, service users waited an average of 3.8 weeks to access the service.
- This peaked at 5.9 weeks in 2020/21 before falling slightly to 5.1 weeks in 2021/22 (Q1-3).

Figure 88: Average number of weeks service users waited to access CMHTs between 2018/19 and 2021/22



Source: Community Mental Health Teams. South West London St George's NHS Trust. 2018-2022.

Source of Referral to Community Mental Health Teams

- Between 2018/19 and 2021/22, most referrals to CMHTs came from GPs (788 referrals).
- This was followed by the Adult CMHT (397 referrals), Other Primary Health Care (215 referrals), the Adult Inpatient Service (93 referrals) and Other secondary care speciality (58 referrals).

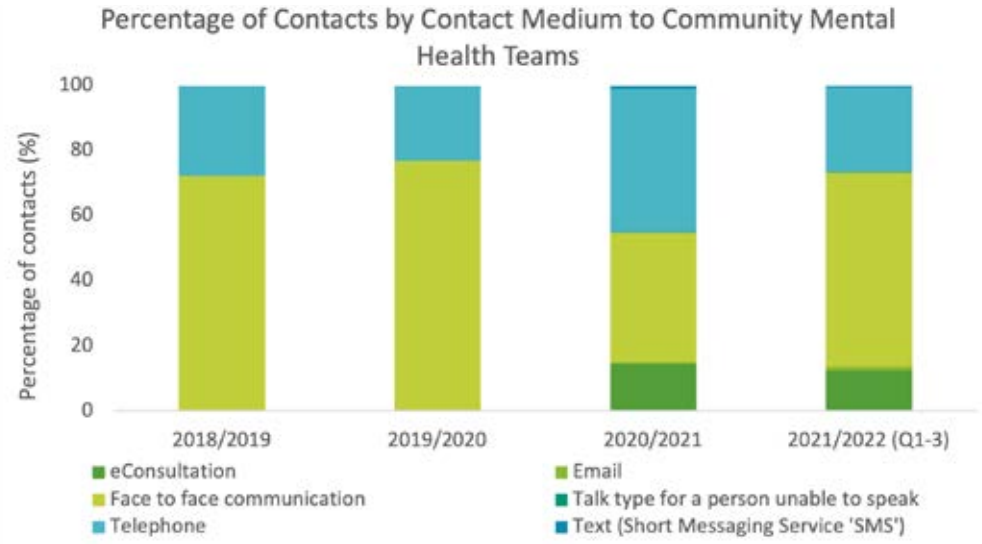
Contacts Not Attended

- Between 2018/19 and 2019/20 the percentage of DNAs increased from 14.9% to 17.6%.
- This fell to 10% in 2020/21 before increasing to 12% in 2021/22 (Q1-3).

Contact Medium to Access Community Mental Health Teams

- In 2018/19 and 2019/20, most service users accessed CMHT services by face-to-face communication (74.5%) or telephone consultation (25.4%).
- The number of service users accessing CMHT services through face-to-face consultation fell to 40% in 2020/21. This is likely to have been caused by the restrictions on health services operating through face-to-face appointments during the COVID-19 pandemic.
- Although the percentage of service users having face-to-face consultations increased again in 2021/22 (Q1-3) to 60%, this remained lower than pre-pandemic levels.
- Instead, in 2020/21 and 2021/22 (Q1-3) a number of service users began to access the service through new means, such as eConsultations (av. 13.5%), email (av. 1%) and text (av. 1%) .
- The declining percentage of face-to-face contacts, alongside the introduction of new communication methods, may have contributed to the decrease in DNAs seen in 2020/21. The rise in DNAs in 2021/22 (Q1-3) corresponds with an increased proportion of face-to-face contacts.

Figure 89: Percentage of contacts by contact medium used to access CMHT between 2018/19 and 2021/22



Source: Community Mental Health Teams. South West London St George's NHS Trust. 018-2022.

Early Intervention Services

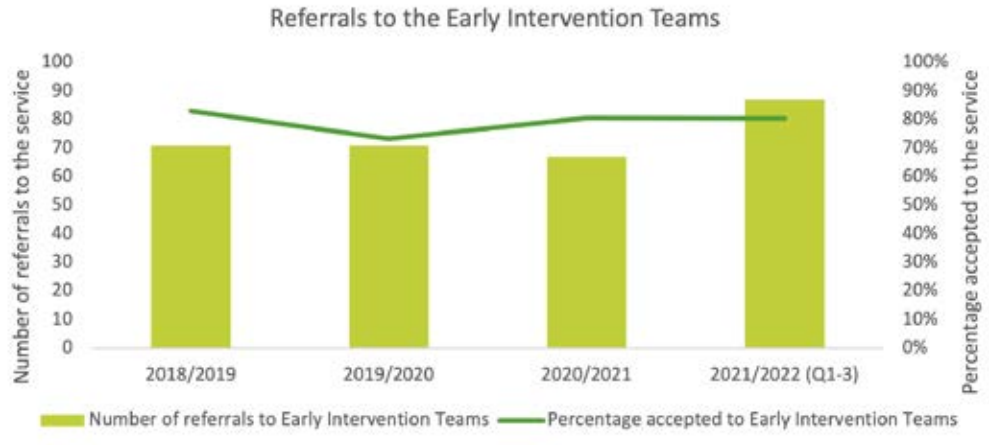
Early Intervention Teams

The Early Intervention Teams offer comprehensive professional help to adults as soon as possible after the onset of psychosis to minimise the impact their life.[304]

Referrals to the Early Intervention Teams

- In 2018/19 and 2019/20, there were 71 referrals to the Early Intervention Teams each year. In contrast, in Q1-3 of 2021/22, there had already been 87 referrals to the service, indicating an increase in the number of referrals during that year.
- It should be noted that the overall numbers referred into and accepted by the service are low and are subject to random variation.
- Changes to the number of service users accepted by Early Intervention Teams did not correspond to changes in the numbers referred, leading to fluctuations in the percentage of service users accepted.
- The percentage of service users accepted peaked in 2018/19 at 83%. This fell to a low of 73% in 2019/20, and then increased to 80.6% and 80.5% in 2020/21 and 2021/22 respectively.

Figure 90: Number of service users referred, and the percentage accepted to the Early Intervention Teams between 2018/19 and 2021/22



Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Early Intervention Teams

- Between 2018 and 2022, most service users referred to the Early Intervention Teams were between the ages of 18-34 years.
- In 2018/19 and 2019/20, service users between the ages of 18-34 made up 72% and 71% of total referrals in each year, respectively.
- The proportion of these age groups dropped slightly in 2020/21 and 2021/22 to 63% and 59% of total referrals respectively, however these remained the largest groups of referrals.
- Across the period, 18–24-year-olds made up the largest single age group among total referrals (av. 34%).
- However, the rate of referrals of 18–24-year-olds fluctuated sizeably over the 4-year period. In 2018/19, they were referred at a rate of 174.8 per 100,000. This increased to 227.2 per 100,000 in 2019/20 before falling to a low of 166.1 per 100,000 in 2020/21. In 2021/22 (Q1-3) this increased to a high of 288.4 per 100,000.
- The rate of referrals of service users aged 25-34 declined each year over the four-year period. This fell from a high of 141.7 per 100,000 in 2018/19, to a low of 80.3 per 100,000 in 2021/22 (Q1-3).
- The rate of referrals of 35–44-year-olds increased from 2020. This rose from a rate of 24.9 per 100,000 and 28 per 100,000 in 2018/19 and 2019/20 respectively, to 46.6 per 100,000 and 43.5 per 100,000 in 2020/21 and 2021/22 (Q1-3).
- The rate of referrals of 45–54- and 55–64-year-olds saw increases in 2021/22 (Q1-3).

Figure 91: Rate of referral to the Early Intervention eams by age between 2018/19 and 2021/22, using the ONS mid-2020 population

Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Early Intervention Teams

- Between 2018 and 2022, most service users referred to the Early Intervention Teams were between the ages of 18-34 years.
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- The rate of referrals of service users aged 25-34 declined each year over the four-year period. This fell from a high of 141.7 per 100,000 in 2018/19, to a low of 80.3 per 100,000 in 2021/22 (Q1-3).
- The rate of referrals of 35–44-year-olds increased from 2020. This rose from a rate of 24.9 per 100,000 and 28 per 100,000 in 2018/19 and 2019/20 respectively, to 46.6 per 100,000 and 43.5 per 100,000 in 2020/21 and 2021/22 (Q1-3).
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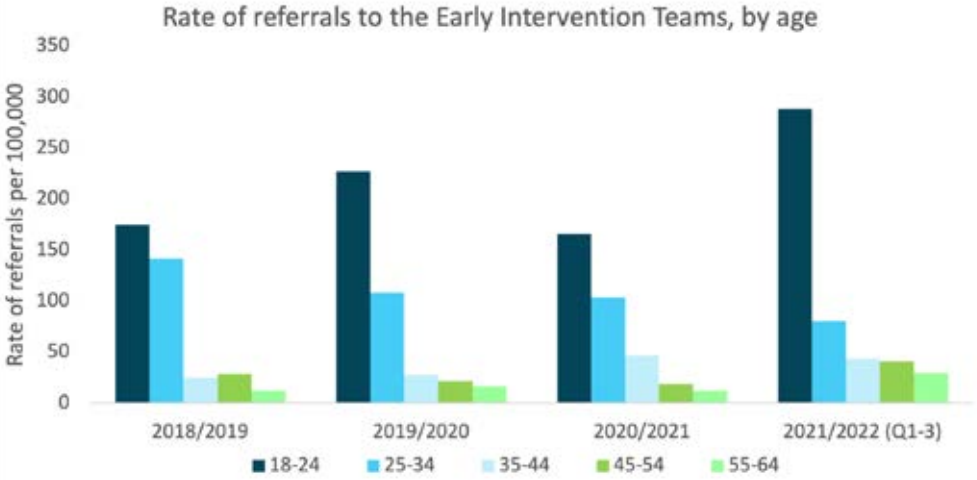
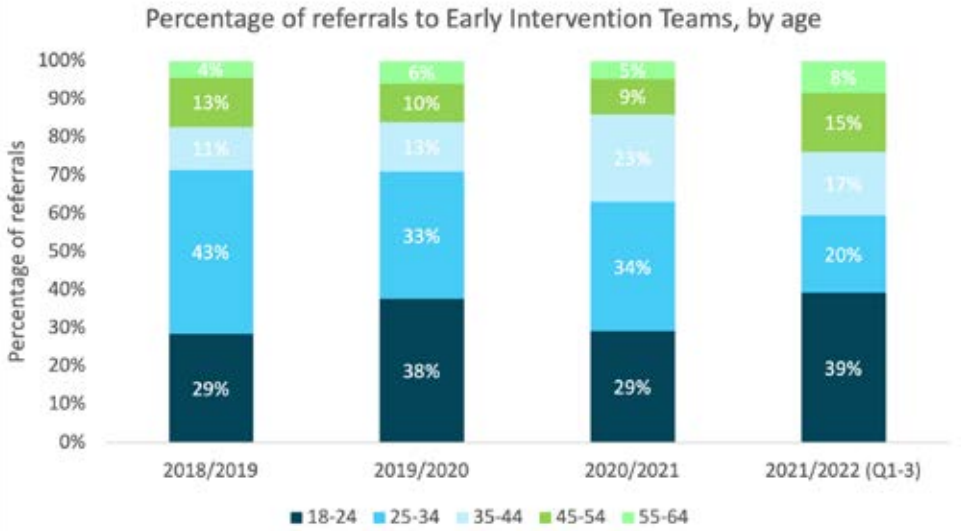
Figure 92: Rate of referral to the Early Intervention eams by age between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Figure 93: Percentage of service users referred to the Early Intervention Teams by age between 2018/19 and 2021/22

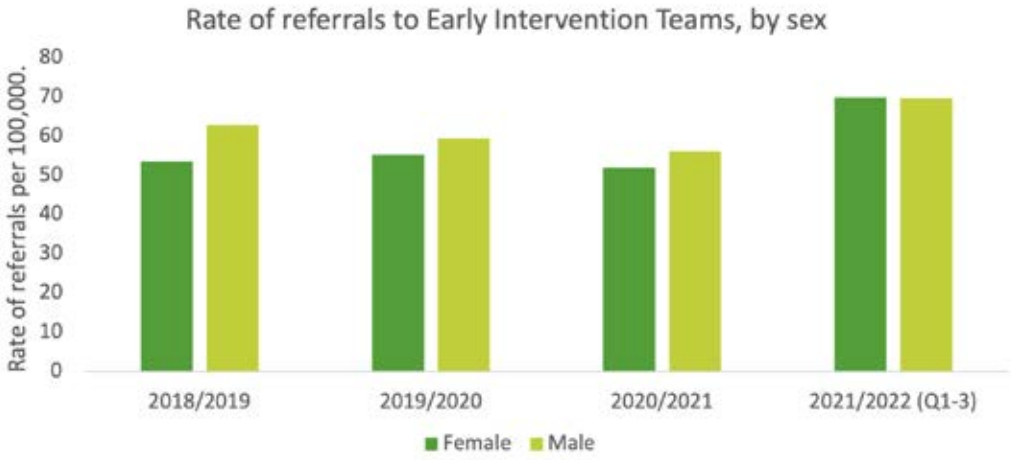


Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Early Intervention Teams

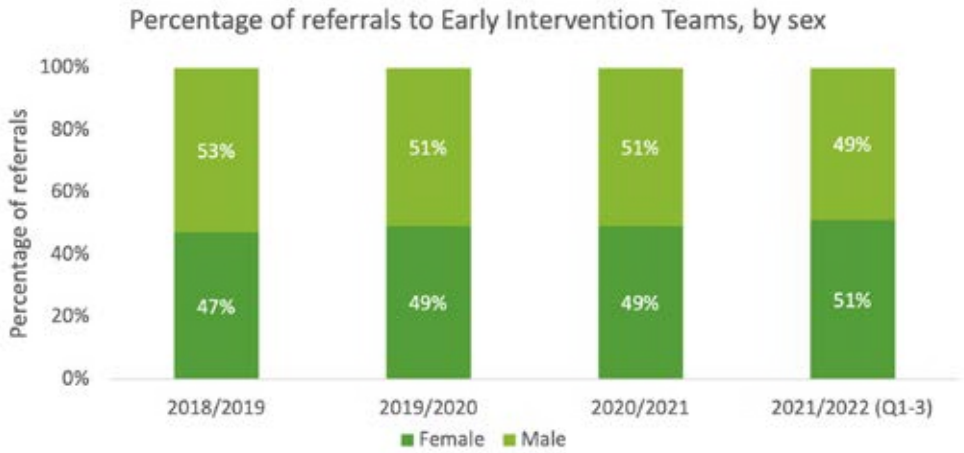
- Between 2018/19 and 2021/22, the balance between male (51%) and female (49%) service users referred to the Early Intervention Teams was relatively equal.
- There was a slightly higher rate of referrals to the service for males compared with females in 2018/19, 2019/20 and 2020/21.
- The gap between rates of male and female referrals was greatest in 2018/19, however, small declines to the rates of male referrals to the service over the following two years reduced the gap in 2019/20 and 2020/21.
- The rate of referrals of both males and females peaked in 2021/22 (Q1-3) to a high of 69.69 and 69.88 per 100,000 respectively.

Figure 94: Rate of referral to the Early Intervention Teams by sex between 2018/19 and 2021/22, using the ONS mid-2020 population data.



Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Figure 95: Percentage of service users referred to the Early Intervention Teams by sex between 2018/19 and 2021/22

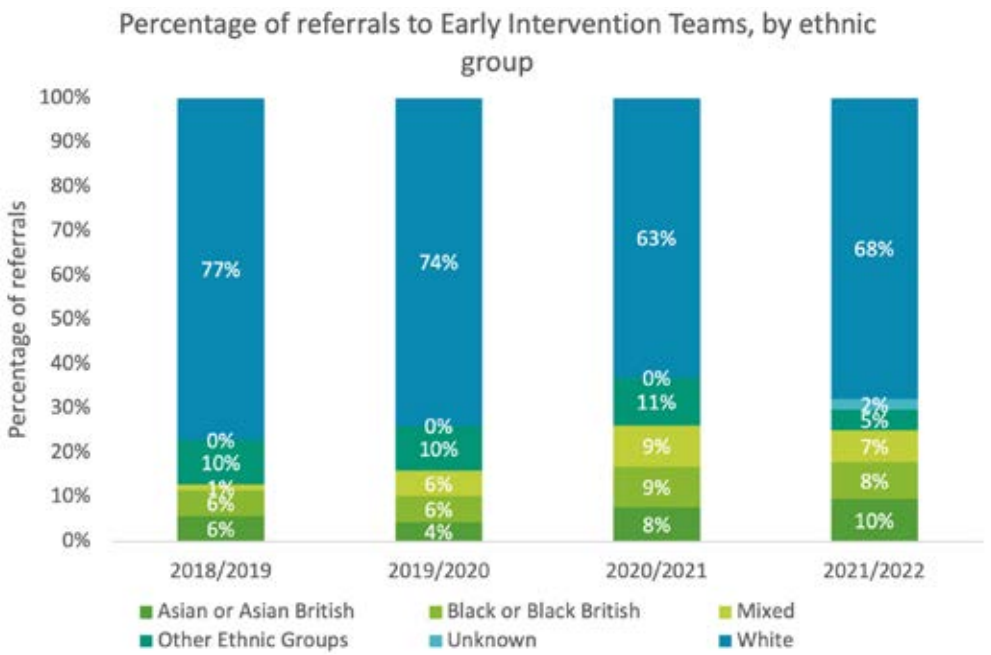


Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Early Intervention Teams

- Between 2018 and 2022, most referrals to the Early Intervention Teams were from White ethnic groups (av. 70.5%).
- However, this percentage declined from a high of 77% in 2018/19, to 74% in 2019/20, 63% in 2020/21 and 68% in 2021/22 (Q1-3).
- Black or Black British, Mixed and Asian or Asian British ethnic groups saw increased rates of referrals in 2020/21 and 2021/22 (Q1-3).
- Black or Black British and Mixed ethnic groups peaked at 9% of total referrals in 2020/21.
- Asian or Asian British ethnic groups peaked at 10% of total referrals in 2021/22 (Q1-3).

Figure 96: Percentage of service users referred to the Early Intervention Teams by ethnic group between 2018/19 and 2021/22

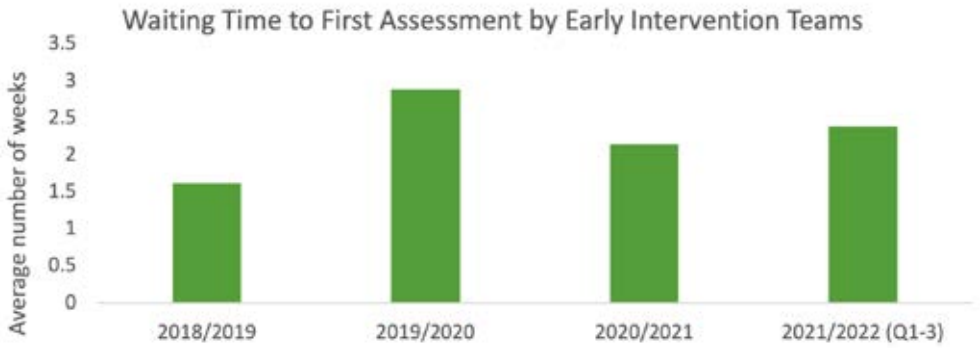


Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Waiting Time for the Early Intervention Teams

- The average wait time for a first assessment by the Early Intervention Team increased over the 4-year period.
- The average wait time was at its lowest point at 1.6 weeks in 2018/19.
- After this it peaked at 2.9 weeks in 2019/20.
- The average wait time then fell to 2.4 weeks in 2021/22 (Q1-3), although it should be noted that this is not a full year of data.

Figure 97: Average number of weeks service users waited for a first assessment with the Early Intervention Teams between 2018/19 and 2021/22

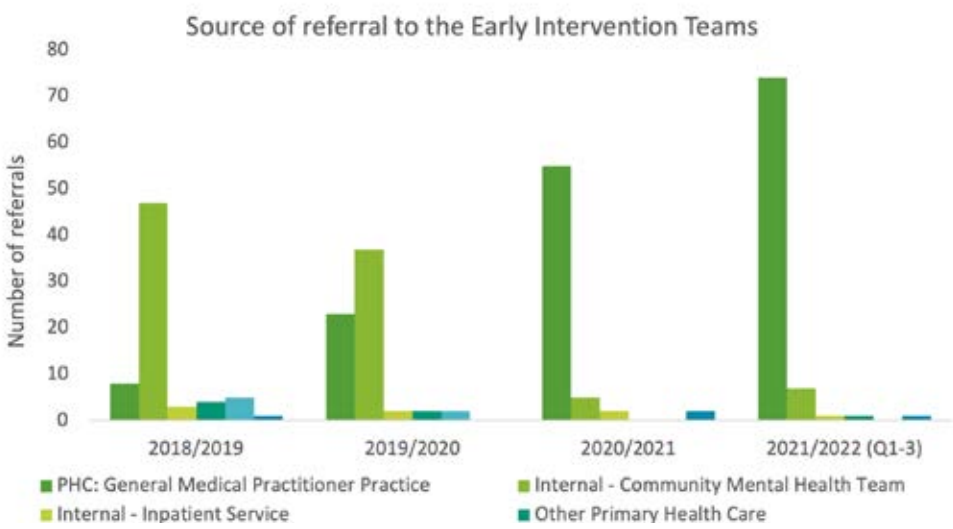


Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Source of Referral to the Early Intervention Teams

- Between 2018 and 2022, there was a notable shift in the primary referral source of service users to early intervention services from CMHTs to GPs.
- Whilst in 2018/19, the majority of referrals came from CMHTs (47 referrals), by 2020/21 and 2021/22 (Q1-3) this had declined to be the source of just 5 and 7 referrals respectively.
- By contrast, in 2020/21 and 2021/22 (Q1-3) GPs were the source of 55 and 74 referrals to the service respectively. This increased from 8 and 23 referrals from GPs in 2018/19 and 2019/20 respectively.

Figure 98: Source of referral to the early intervention teams between 2018/19 and 2021/22

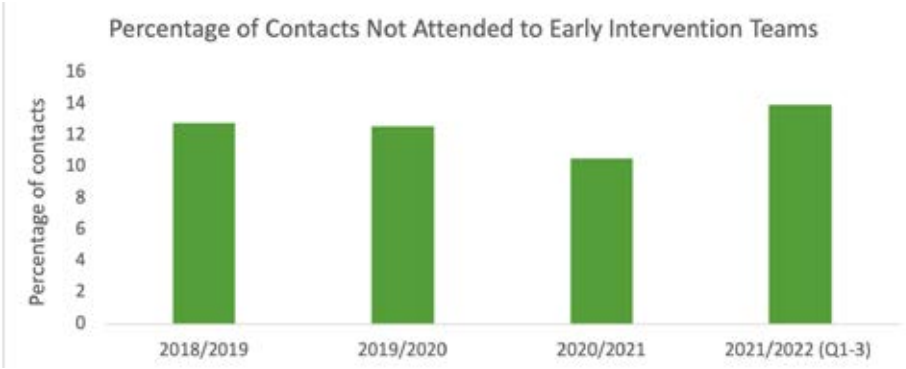


Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Contacts Not Attended to Early Intervention Services

- In 2018/19 and 2019/20, the percentage of DNAs to early intervention services averaged 12.6%.
- In 2020/21 this fell to 10.5%, corresponding with national data showing reduced numbers of DNAs across health services during the COVID-19 pandemic.[305]
- The percentage of DNAs increased again in 2021/22 (Q1-3) to 13.9%.

Figure 99: Percentage of service users who DNA to the Early Intervention Teams between 2018/19 and 2021/22

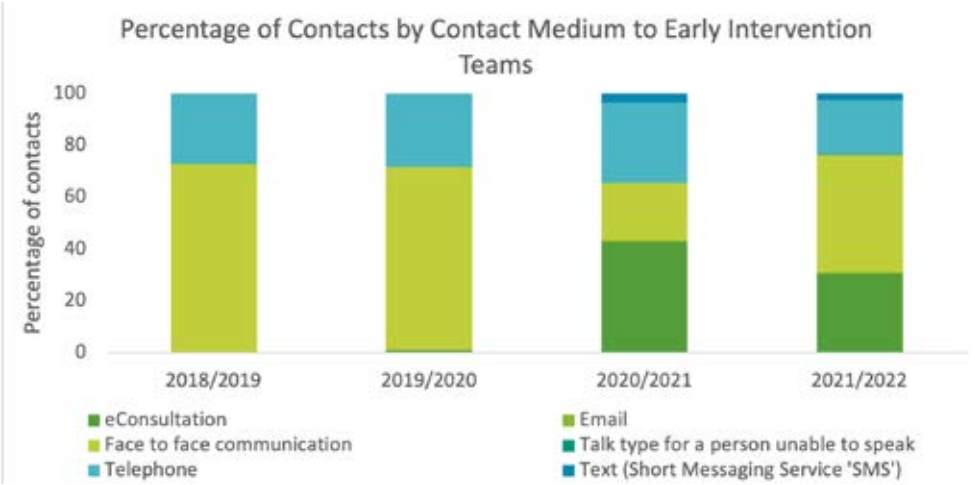


Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

Contact Medium to Access Early Intervention Teams

- In 2018/19 and 2019/20, most service users accessed Early Intervention Teams through face-to-face (71.6%) or telephone consultation (27.5%).
- In 2020/21, there was a large reduction in the percentage of service users accessing the service through face-to-face consultation, falling to just 22%. This is likely to have been caused by restrictions on health services operating face-to-face appointments during the COVID-19 pandemic.
- It is noted that the reduced percentage of face-to-face consultations coincided with a decrease in the rate of DNAs, although not to the same extent.
- In 2020/21, there was an increase in the percentage of service users accessing the service through telephone consultation (31%) and eConsultation (43%).
- Although the percentage of service users accessing the service through face-to-face consultation increased again in 2021/22 (Q1-3) to 45%, this remained lower than pre-pandemic levels, as did the percentage of telephone consultations (21%).

Figure 100: Contact medium used to access early intervention services by percentage between 2018/19 and 2021/22



Source: Early Intervention Teams. South West London St George's NHS Trust. 2018-2022.

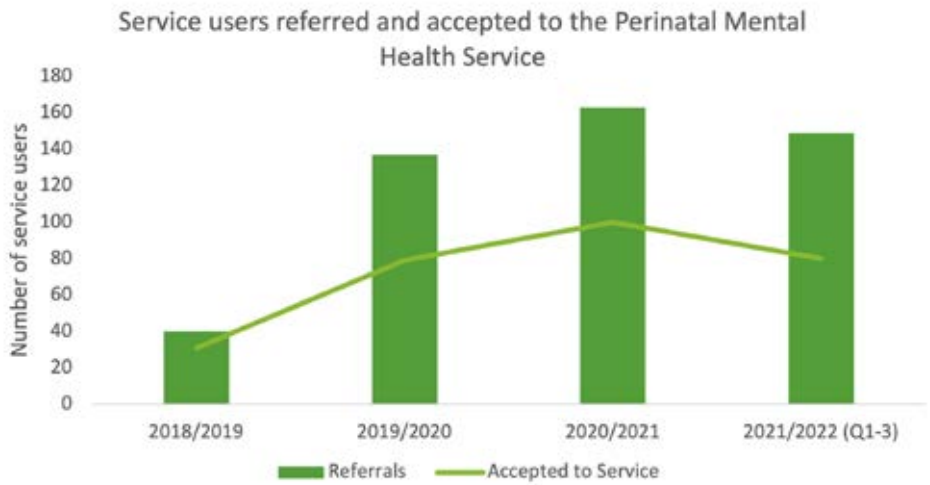
Perinatal Mental Health Service

The Perinatal Mental Health Service consists of a multidisciplinary team of clinicians with specialist training and expertise working in the community to address complex mental health needs of women in the perinatal period. The primary aims of the service are to improve the health and wellbeing of women, their babies and their wider families through increased awareness of mental illness in women during pregnancy and after childbirth, early identification of those women who have, or are at risk of, mental health problems and provision of effective and evidence-based interventions.[306]

Referrals to the Perinatal Mental Health Service

- Referrals to the Perinatal Mental Health Service increased over the four-year period.
- The increase in referrals was particularly notable between 2018/19 and 2019/20, growing from 41 referrals to 137 referrals.
- Referrals to the service continued to increase in 2020/21 to 163, and there had been 149 service users referred in Q1-3 of 2021/22.
- The number of service users accepted to the service also increased, however, not at the same rate as those referred to the service.
- The percentage of service users accepted to the Perinatal Mental Health Service therefore declined over the 4-year period. The percentage was highest in 2018/19 at 77.5% and fell overall to 53.7% in 2021/22 (Q1-3).

Figure 101: Number of service users referred and accepted into the Perinatal Mental Health Service between 2018/19 and 2021/22

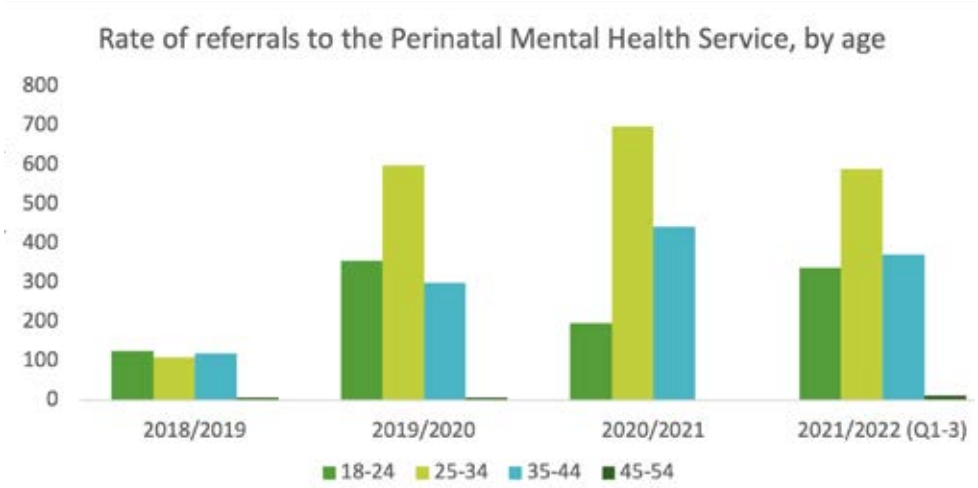


Source: Perinatal Mental Health Service. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Perinatal Mental Health Service

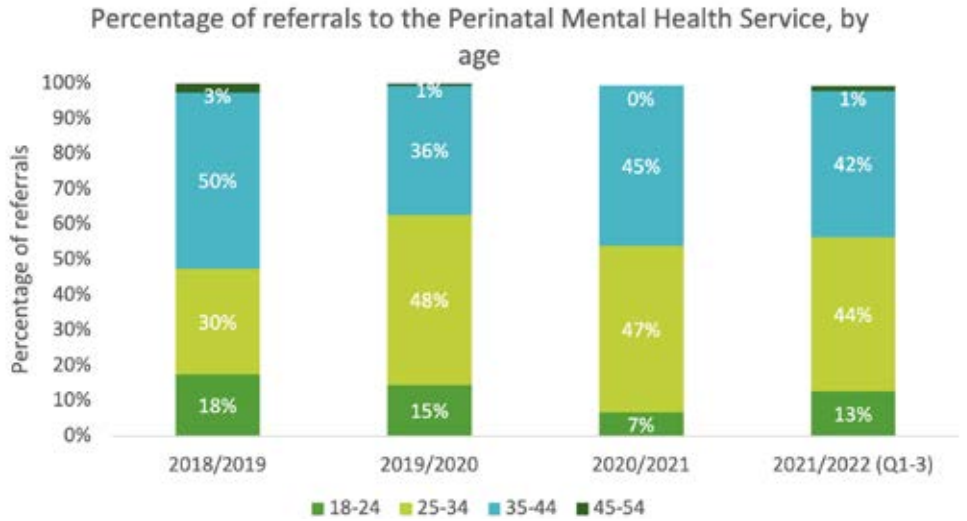
- Most referrals to the perinatal mental health team were between the ages of 25 and 44 years; across the four years, making up 85.5% of referrals.
- This was followed by 18–24-year-olds, who constituted 13.25% of referrals.

Figure 102: Rate of referrals to the Perinatal Mental Health Service by age between 2018/19 and 2021/22, using the ONS mid-2020 population data.



Source: Perinatal Mental Health Service. South West London St George's NHS Trust. 2018-2022.

Figure 103: Percentage of referrals to the Perinatal Mental Health Service by age between 2018/19 and 2021/22

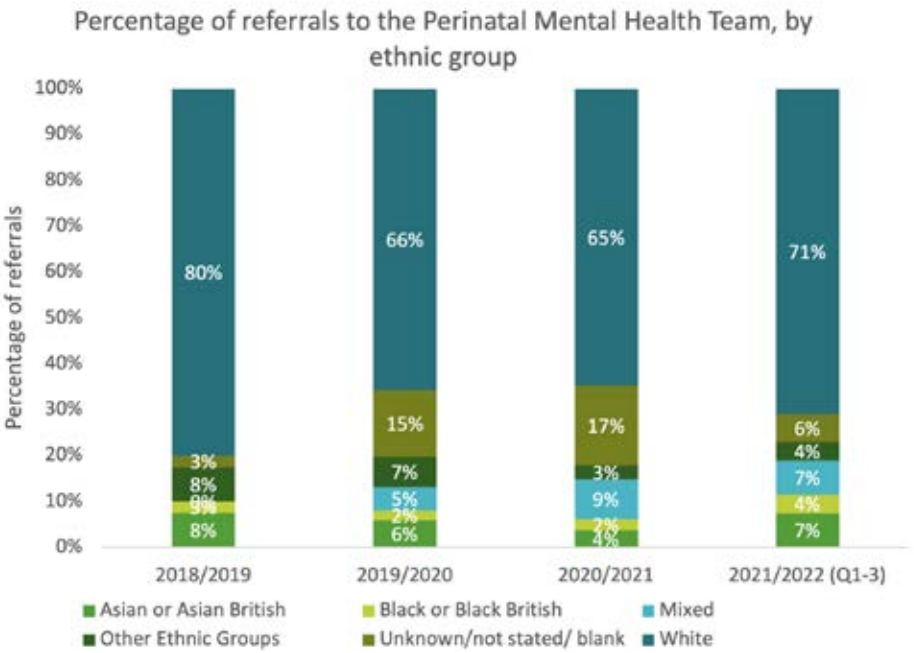


Source: Perinatal Mental Health Service. South West London St George's NHS Trust. 2018-2022.

Ethnicity of service users referred to the Perinatal Mental Health Service

- Across the four-year period, most referrals to the perinatal mental health identified as White (av. 70%).
- This was followed by service users whose ethnicity was Unknown (av. 10%), and service users from Asian or Asian British (av. 6%), Mixed (av. 5%), Other (av. 5%) and Black or Black British ethnic groups (av. 3%).

Figure 104: Percentage of service users referred to the Perinatal Mental Health Service by ethnic group between 2018/19 and 2021/22

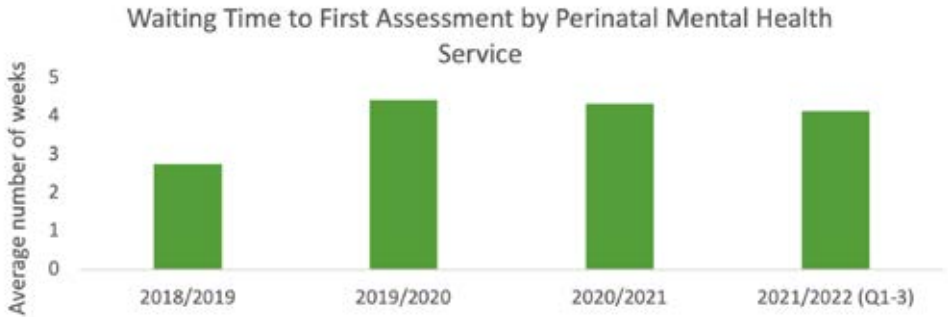


Source: Perinatal Mental Health Service. South West London St George's NHS Trust. 2018-2022.

Waiting Time to Access the Perinatal Mental Health Service

- The average wait time for first assessment by the Perinatal Mental Health Service was at its lowest in 2018/19 at 2.8 weeks, before it increased to its highest level of 4.4 weeks in 2019/20.
- The wait time has since decreased slightly to 4.3 weeks in 2020/21 and 4.1 weeks in 2021/22.

Figure 105: Average number of weeks service users waited for a first assessment with the Perinatal Mental Health Service between 2018/19 and 2021/22



Source: Perinatal Mental Health Service. South West London St George's NHS Trust. 2018-2022.

Crisis Pathway: Acute and Urgent Care Services

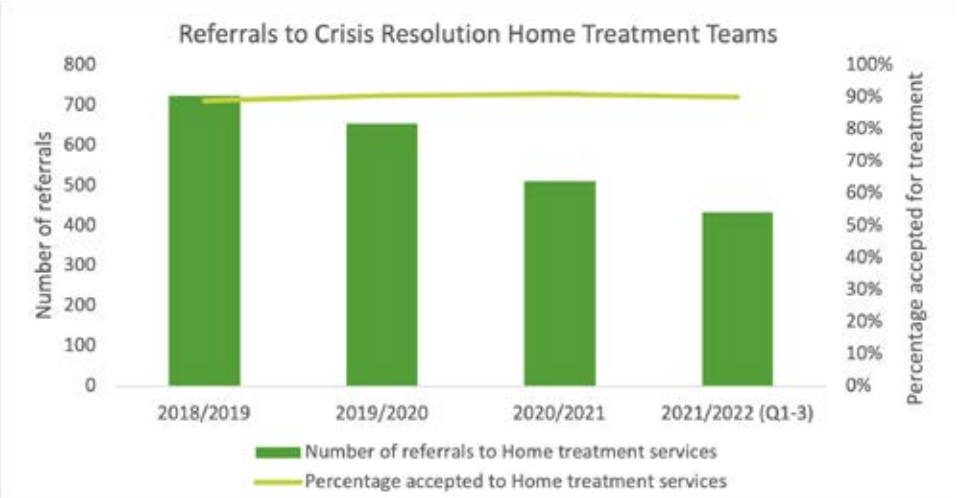
Crisis Resolution Home Treatment Teams

CRHTTs are community based mental health services who see adults experiencing a mental health crisis or requiring intensive home-based support and treatment. CRHTTs enables people to stay in their own home with increased support, as an alternative to inpatient admission. CRHTTs are a short-term service for the crisis period only.[307]

Referrals to the Crisis Resolution Home Treatment Teams

- The number of service users referred to CRHTTs declined each year from 2018 onwards.
- In 2018/19 there were 724 referrals to the service. This declined to 654 referrals in 2019/20, 511 referrals in 2020/21 and 434 referrals in 2021/22 (Q1-3).
- The number of service users accepted to CRHTTs also declined across the period, largely in correlation to the decline in referrals to the service.
- Resultantly, the percentage of service users accepted to the service from those referred remained relatively stable across the period, ranging between 89% and 91%.

Figure 106: Number of service users referred, and the percentage accepted to CRHTTs between 2018/19 and 2021/22

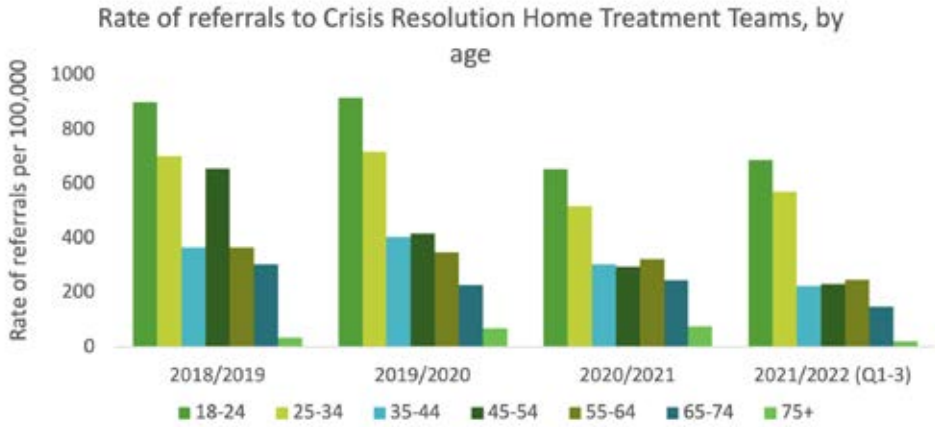


Source: Crisis Resolution Home Treatment Teams. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Crisis Resolution Home Treatment Teams

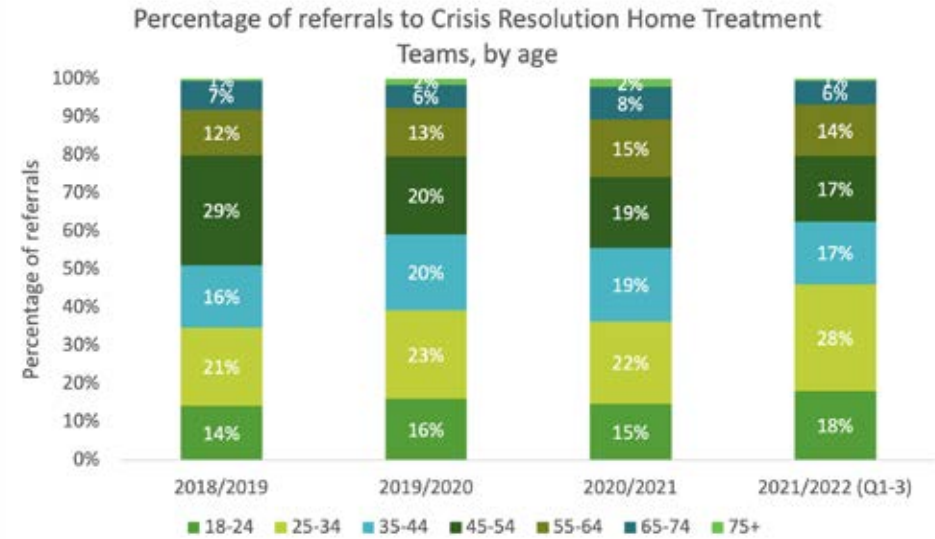
- Between 2018/19 and 2021/22, most referrals to the CRHTTs were between the ages of 18-64 (92%).
- There were low numbers of older adults referred to the service; on average across the four-year period, 7% of referrals were between the ages of 65-74, and only 1% were over 75.
- Across this period, the highest rates of referral to the service were within the younger age groups; 18-24-year-olds were referred to the service at an average rate of 790.95 per 100,000 and 25-34-year-olds at an average of 628.04 per 100,000.
- The proportion of referrals from each age group remained relatively stable across the period, with just two exceptions:
- There was a peak in referrals of 45–54-year-olds in 2018/19 at 29%, which reduced to an average of 18% across the other three years.
- There was a spike in referrals of 25–34-year-olds in 2021/22 (Q1-3) to 28% of total referrals, up from an average of 22% in previous years.

Figure 107: Rate of referral to CRHTTs by age between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Crisis Resolution Home Treatment Teams. South West London St George's NHS Trust. 2018-2022.

Figure 108: Percentage of referrals to CRHTTs by age between 2018/19 and 2021/22

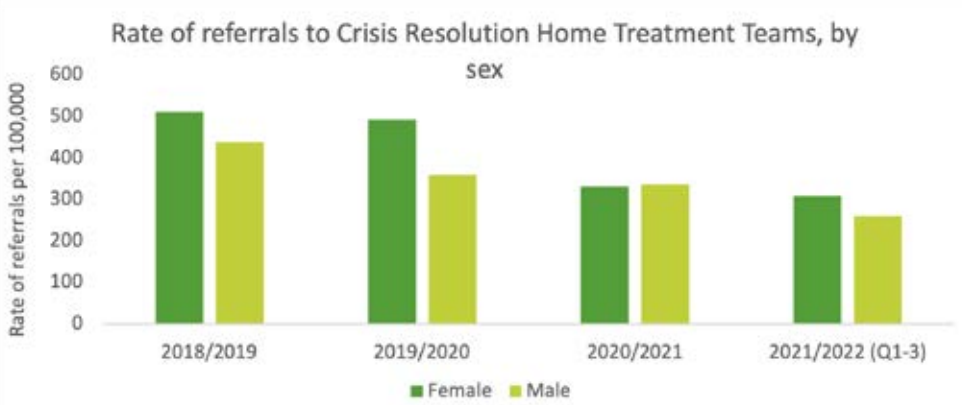


Source: Crisis Resolution Home Treatment Teams. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to Crisis Resolution Home Treatment Teams

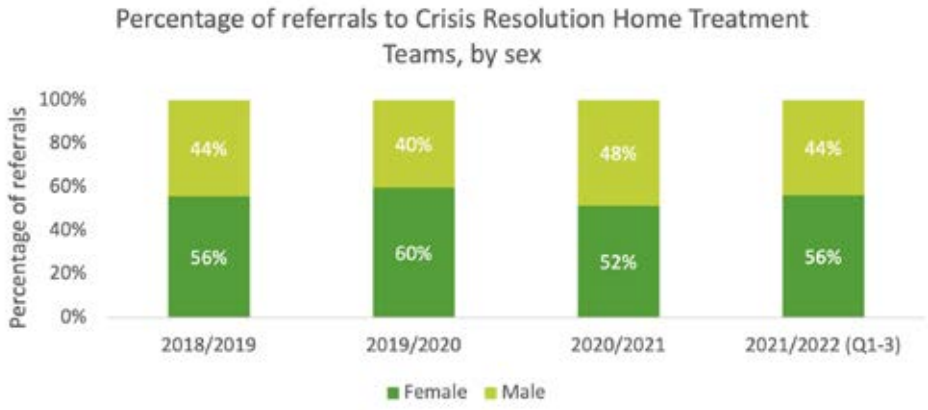
- Between 2018/19-2021/22, there were more females referred to the CRHTTs than males; 1300 females and 1019 males.
- However, the balance of referrals to the service fluctuated, with the largest imbalance seen in 2019/20 (60% female, 40% male) and the smallest in 2020/21 (52% female, 48% male).
- Whilst there were reductions in the referral rate of both males and females to the service across the years, these were not experienced simultaneously.
- There were two large drops in the rate of male referrals; between 2018/19 and 2019/20, the rate of referrals fell from 437.5 to 359.57 per 100,000, and between 2020/21 and 2021/22 (Q1-3) from 336.33 to 259.77 per 100,000.
- By contrast, females only saw one sizeable drop in referral rate, which was experienced between 2019/20 and 2020/21, falling from a rate of 492.37 per 100,000 to 330.77 per 100,000.

Figure 109: Rate of referral to CRHTTs by sex between 2018/19 and 2021/22, using the ONS mid-2020 population data.



Source: Crisis Resolution Home Treatment Teams. South West London St George's NHS Trust. 2018-2022.

Figure 110: Percentage of referrals to CRHTTs by sex between 2018/19 and 2021/22

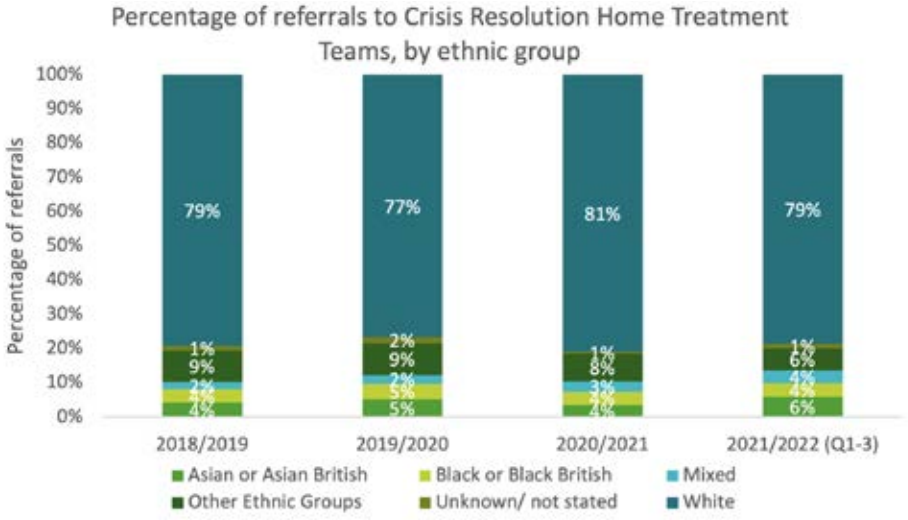


Source: Crisis Resolution Home Treatment Teams. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to Crisis Resolution Home Treatment Teams

- Over the four-year period, most referrals to the CRHTTs were from white ethnic groups (av. 79%).
- This was followed by referrals of service users from Other (8%), Asian or Asian British (5%), Black or Black British (4%), Mixed (3%) and Unknown ethnic groups (1%).
- This balance of ethnic groups was stable across the four-year period.

Figure 111: Percentage of referrals to CRHTTs by ethnic group between 2018/19 and 2021/22



Source: Crisis Resolution Home Treatment Teams. South West London St George's NHS Trust. 2018-2022.

Source of Referral to Crisis Resolution Home Treatment Teams

- Over the period, most service users were referred to CRHTTs from Emergency Care (759 referrals), Community Mental Health Teams (692 referrals) and Adult Mental Health Inpatient Services (595 referrals).

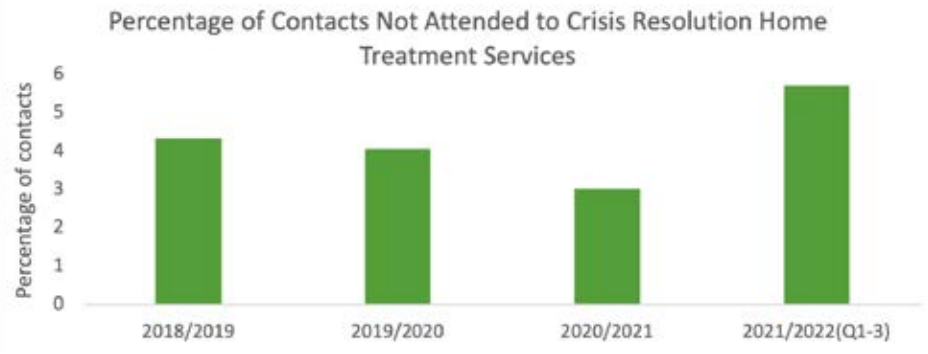
Waiting Time to Access Crisis Resolution Home Treatment Teams

- The average wait time to access CRHTTs remained at one week across all four years under analysis.

Contacts Not Attended to Crisis Resolution Home Treatment Teams

- In 2018/19 and 2019/20, the percentage of DNAs to CRHTTs averaged 4.2%.
- This decreased to a low of 3% in 2020/21, and increased to a high of 5.7% in Q1-3 of 2021/22.

Figure 112: Percentage of service users who DNA at CRHTTs between 2018/19 and 2021/22

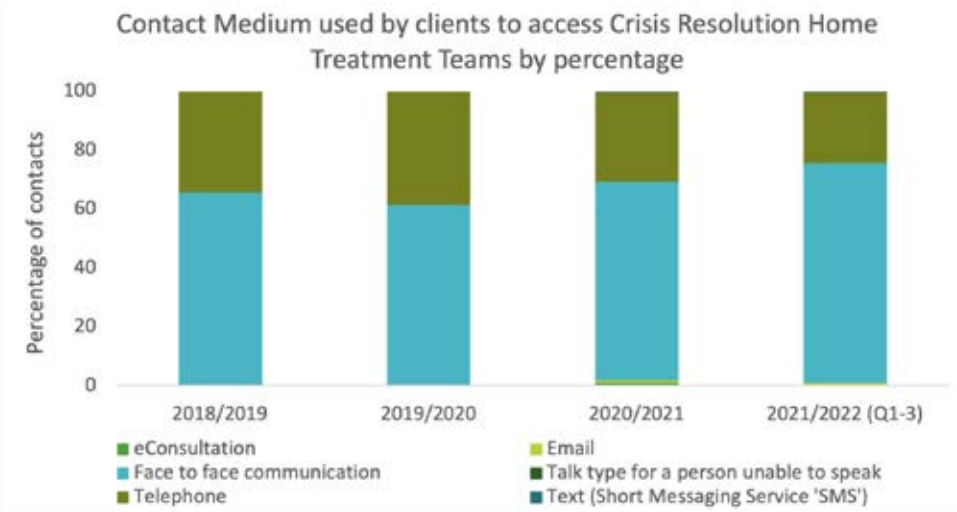


Source: Crisis Resolution Home Treatment Teams. South West London St George's NHS Trust. 2018-2022.

Contact Medium Used by Clients to Access Crisis Resolution Home Treatment Teams

- Between 2018/19-2021/22, most service users received CRHTT services through face-to-face communication (67%) or telephone appointment (31.7%).
- The percentage of contacts accessing the service by face-to-face communication increased in 2020/21 and 2021/22 (Q1-3), whilst the percentage of contacts accessing the service by telephone appointment decreased over the same period.
- This contrasts the general trend of reduced face-to-face service access during the COVID-19 pandemic and may reflect the importance of face-to-face contact for patients in crisis.

Figure 113: Contact medium used by clients to access CRHTTs by percentage between 2018/19 and 2021/22



Source: Crisis Resolution Home Treatment Teams. South West London St George's NHS Trust. 2018-2022.

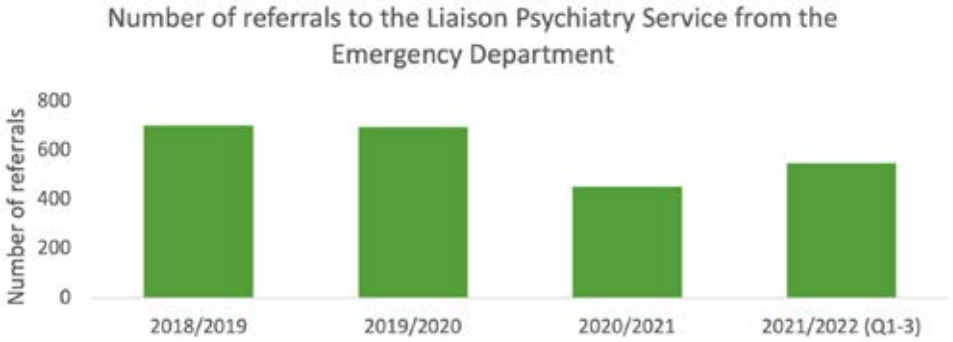
Emergency Department Referrals to the Liaison Psychiatry Service

The data presented below is for those service users referred to liaison psychiatry by the emergency department. The aim of the Liaison Psychiatry Service is to provide support and care for patients presenting with psychiatric and psychological needs within the acute trust.

Referrals to the Liaison Psychiatry Service from the Emergency Department

- In 2018/19 and 2019/20, there were 703 and 695 service users referred to the Liaison Psychiatry Service from the emergency department.
- There was a large drop in the number of referrals in 2020/21 to 454 referrals. This may have been caused by the outbreak of the COVID-19 pandemic, which, particularly at its onset, caused rates of attendance to the emergency department to fall sharply due to changes in how NHS services operated, health messaging and patient behaviour.[308] The reduction in attendance at emergency departments at major hospitals in England was recorded to be as high as 52% below normal levels in April 2020, rising to 36% below normal by mid-May 2020.[309]
- The number of referrals in Q1-3 of 2021/22 had increased to 549, indicating that attendance to the emergency department has begun to recover following the pandemic.

Figure 114: Number of service users referred to the Liaison Psychiatry Service from the emergency department between 2018/19 and 2021/22 (Q1-3)

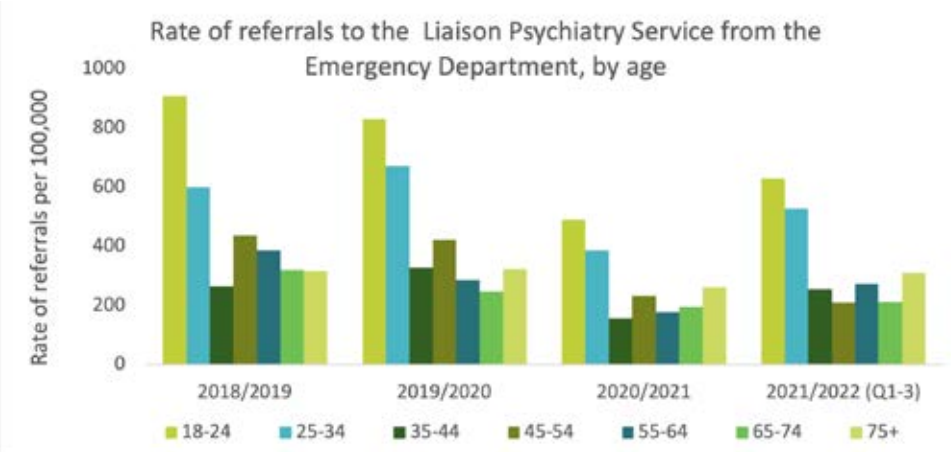


Source: Emergency Department. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Liaison Psychiatry Service from the Emergency Department

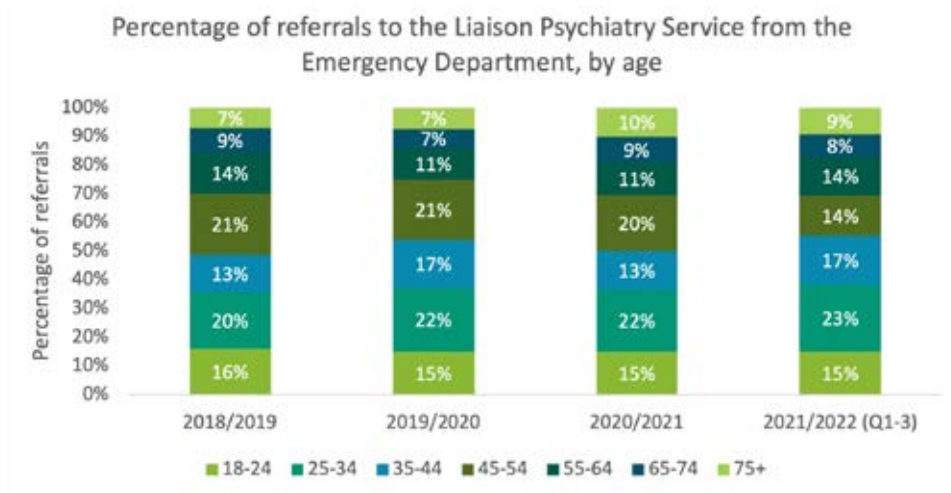
- Over the four-year period, most referrals to the Liaison Psychiatry Service were aged 18-54 (av. 71% of referrals).
- The highest rates of referral were seen in the 18-24 and 25-34 age groups, which saw average rates of 715 per 100,000 and 547 per 100,000 respectively over the period.
- This was followed by the 45-54-year-olds (av. 352 per 100,000), the 75+ age group (av. 303 per 100,000), 55-64-year-olds (av. 281 per 100,000), 35-44-year-olds (av. 250 per 100,000) and 65-74-year-olds (av. 243 per 100,000).
- The proportion of service users aged 75+ is higher than would be expected.
- All age groups saw reduced rates of referral in 2020/21 in correlation to the drop in total referrals to the service.

Figure 115: Rate of referrals per 100,000 to the Liaison Psychiatry Service from the emergency department by age between 2018/19 and 2021/22 (Q1-3), using the ONS mid-2020 population



Source: Emergency Department. South West London St George's NHS Trust. 2018-2022.

Figure 116: Percentage of referrals to the Liaison Psychiatry Service from the emergency department by age between 2018/19 and 2021/22 (Q1-3)

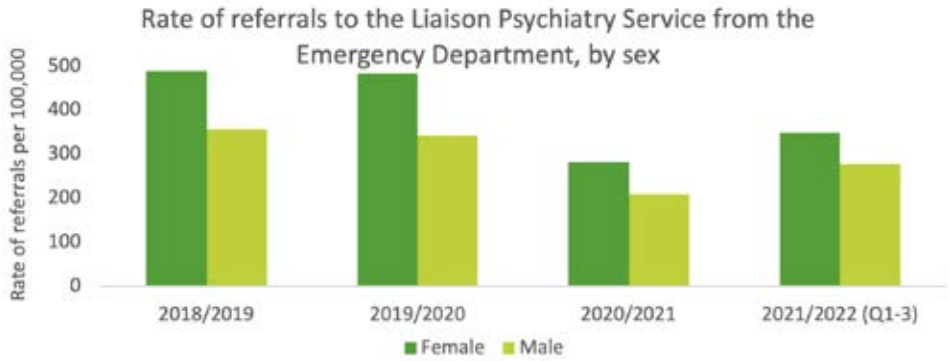


Source: Emergency Department. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Liaison Psychiatry Service from the Emergency Department

- Between 2018/19 and 2021/22, there were more females referred to the Liaison Psychiatry Service from the emergency department than males; 59.3% female and 40.7% male.
- Whilst both male and female rates of referral declined in 2020/21, this decline was slightly greater for females than males; the rate of female referral declined by 53% whereas the rate of male referral declined by 49%.
- This meant that males constituted a slightly increased proportion of total referrals in 2020/21 and 2021/22 (Q1-3).

Figure 117: Rate of referrals to the Liaison Psychiatry Service from the emergency department by sex between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Emergency Department. South West London St George's NHS Trust. 2018-2022.

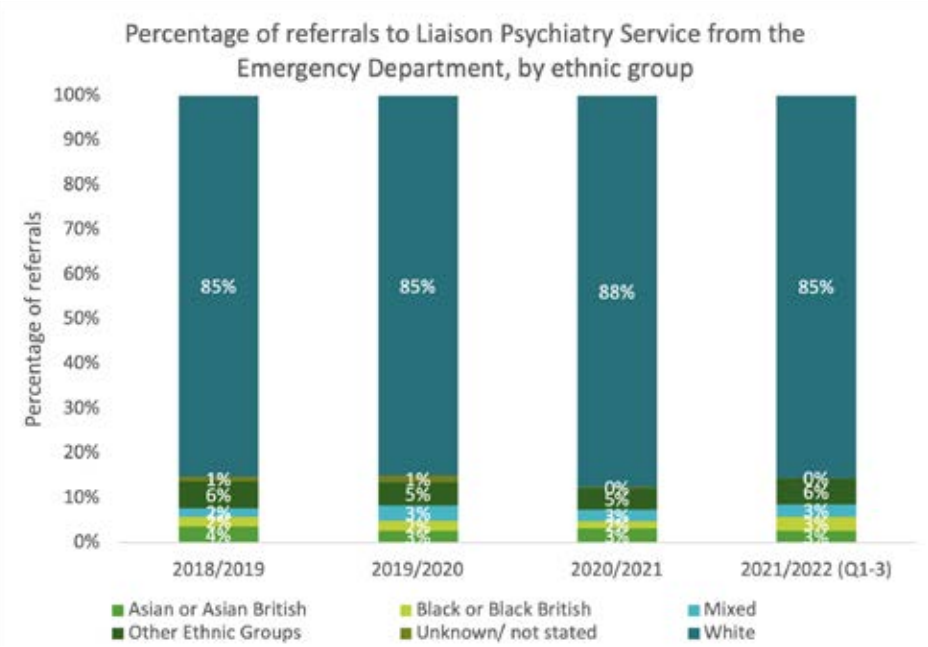
Figure 118: Percentage of referrals to the Liaison Psychiatry Service from the emergency department by sex between 2018/19 and 2021/22

Source: Emergency Department. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Liaison Psychiatry Service from the Emergency Department

- Most referrals to the Liaison Psychiatry Service from the emergency department were from White ethnic groups (av. 86%).
- This was followed by service users from Other (5%), Asian or Asian British (3%), Mixed (3%), Black or Black British (2%) and Unknown ethnic groups (1%).
- This balance of ethnic groups was stable across the four-year period.

Figure 119: Percentage of referrals to Liaison Psychiatry Service from the emergency department by ethnic group between 2018/19 and 2021/22



Source: Emergency Department. South West London St George's NHS Trust. 2018-2022.

Destination of Discharge from the Liaison Psychiatry Service

Following discharge from the Liaison Psychiatry Service, the majority of service users were:

- discharged to other destinations (472 service users)
- discharged to GP care (457 service users)
- discharged on professional advice (435 service users)
- discharged to the Home Treatment Team (297 service users)
- discharged to a secondary care mental health team (200 service users)
- discharged to the Lotus Assessment Suite (144 service users)
- detained under the Mental Health Act for admission (130 service users).

Lotus Assessment and Section 136 Suite

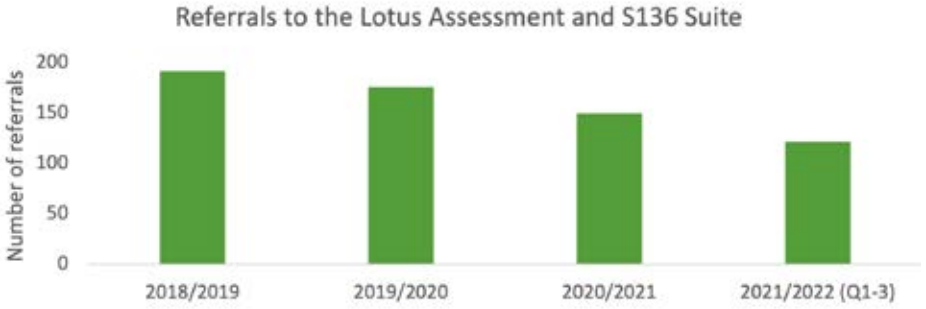
The Lotus Assessment suite is for adults experiencing a mental health crisis and in need of urgent assessment. It is designed to provide a safe and stable, calming environment away from A&E which allows mental health staff to undertake a more detailed and informed assessment of people experiencing a mental health crisis, and to determine the best follow up support approach. The Lotus Assessment Suite is located at Springfield Hospital in Tooting.[310]

The Section 136 Suites are a HBPoS for people brought to hospital by police under Section 136 of the Mental Health Act if they have concerns for their safety and wellbeing. The S136 Suites are based at Springfield Hospital in Tooting.[311]

Referrals to the Lotus Assessment Suite and S136 Suites

- Between 2018/19 and 2021/22, the number of service users referred to the Lotus Assessment and S136 Suites declined annually.
- The number of referrals fell from a high of 192 referrals in 2018/19, to 176 in 2019/20 and 150 in 2020/21.
- In Q1-3 of 2021/22 there were 122 referrals to the Suites.

Figure 120: Number of service users referred to the Lotus Assessment and S136 Suites between 2018/19 and 2021/22

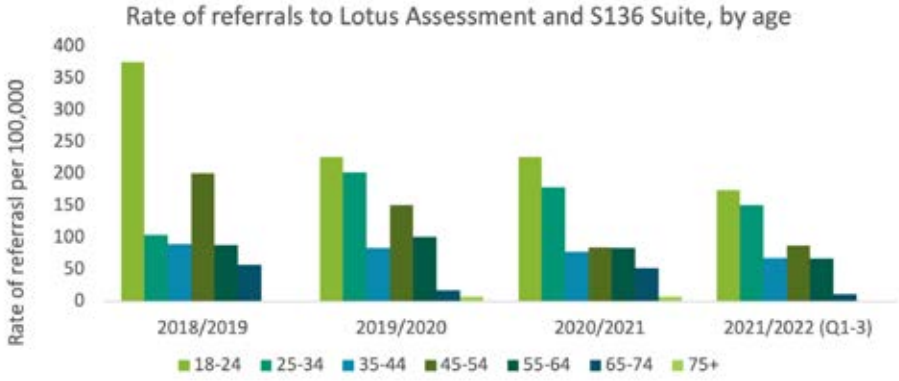


Source: Lotus Assessment Suite and Section 136 Suites. South West London St George's NHS Trust. 2018-2022

Age of Service Users Referred to the Lotus Assessment Suite and S136 Suites

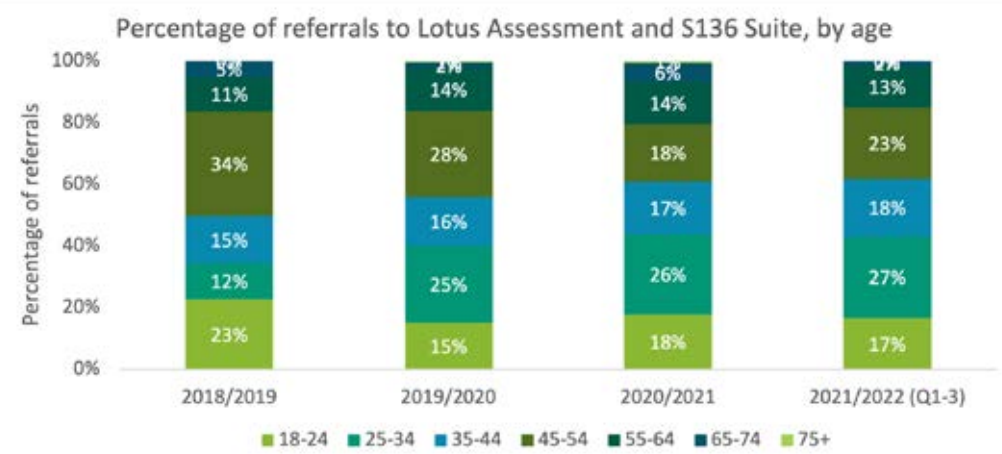
- The highest rates of referrals to the services came from the 18-24 age group (av. 251 per 100,000), followed by 25-34 (159 per 100,000) and 45-54 (131 per 100,000).
- There were low average rates of referrals among the 65-74 age group (34 per 100,000) and 75+ age group (3 per 100,000).
- Between 2018/19 and 2019/20, there were large declines in the rate of 18-24-year-olds and 45-54-year-olds referred to the service:
- Referrals of 18-24-year-olds fell from a rate of 376 per 100,000 to 227 per 100,000.
- Referrals of 45-54-year-olds fell from a rate of 205 per 100,000 to 151 per 100,000.
- By contrast, there was a large increase to the rate of 25-34-year-olds referred to the service over the same period, from 104 per 100,000 to 203 per 100,000.

Figure 121: Rate of referral to the Lotus Assessment and S136 Suites by age between 2018/19 and 2021/22, using the ONS mid-2020 population data.



Source: Lotus Assessment Suite and Section 136 Suites. South West London St George's NHS Trust. 2018-2022.

Figure 122: Percentage of referrals to the Lotus Assessment and S136 Suites by age between 2018/19 and 2021/22

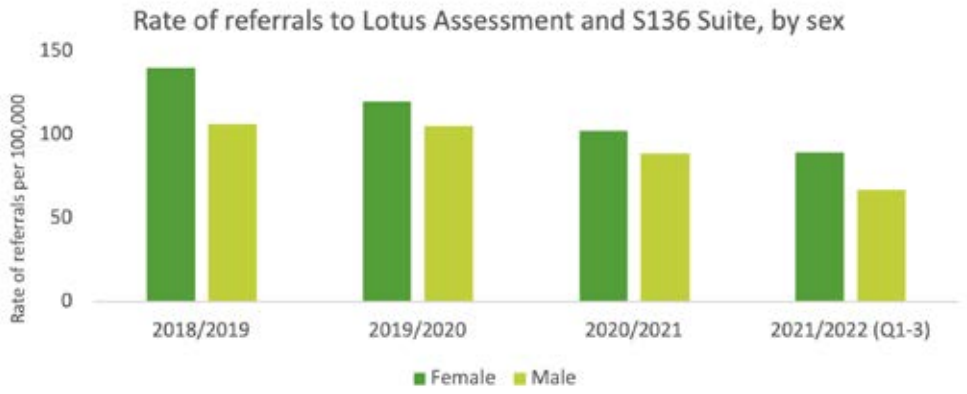


Source: Lotus Assessment Suite and Section 136 Suites. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Lotus Assessment Suite and S136 Suites

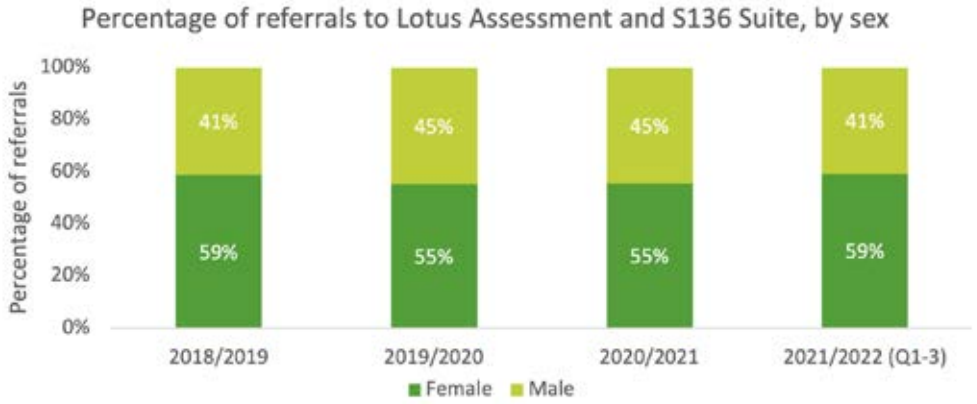
- Between 2018/19-2021/22, there were more females referred to the Lotus Assessment and S136 Suites than males; 358 female, 269 males.
- The gap in the proportion of females to males referred to the service was lowest in 2019/20 and 2020/21, however this widened again in 2021/22 (Q1-3). It should be noted that there are only three quarters of data available for 2021/22 therefore it is possible that this gap may have widened further.
- The rate of referral of both males and females decreased each year under analysis.

Figure 123: Rate of referral to the Lotus Assessment and S136 Suites by sex per 100,000 between 2018/19 and 2021/22, using the ONS mid-2020 population data.



Source: Lotus Assessment Suite and Section 136 Suites. South West London St George's NHS Trust. 2018-2022.

Figure 124: Percentage of referrals to the Lotus Assessment and S136 Suites by sex between 2018/19 and 2021/22

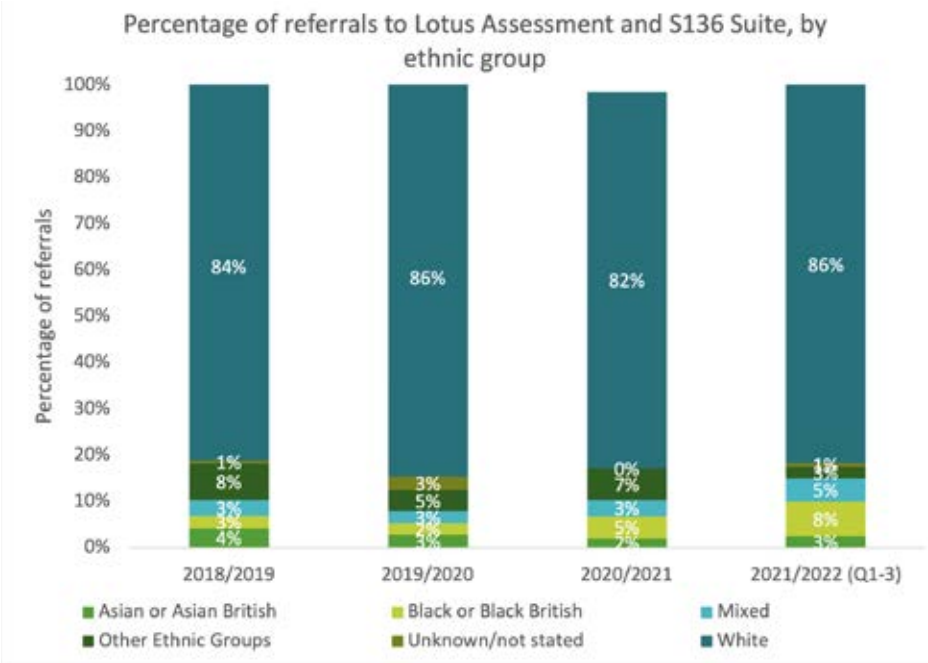


Source: Lotus Assessment Suite and Section 136 Suites. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Lotus Assessment Suite and S136 Suites

- Over the four-year period, most referrals to the Lotus Assessment and S136 Suites were from white ethnic groups (av. 84.5%).
- This was followed by Other (5.75%), Black or Black British (4.5%), Mixed (3.5%), Asian or Asian British (3%) and Unknown ethnic groups (1.25%).
- The percentage of Black or Black British service users referred to the Lotus Assessment and S136 Suites increased from 3% and 2% in 2018/19 and 2019/20, respectively, to 5% and 8% in 2020/21 and 2021/22.

Figure 125: Percentage of referrals to the Lotus Assessment and S136 Suites by ethnic group between 2018/19 and 2021/22



Source: Lotus Assessment Suite and Section 136 Suites. South West London St George's NHS Trust. 2018-2022.

Coral Mental Health Crisis Hub

The Coral Mental Health Crisis Hub provides mobile mental health crisis support to enable those in crisis to be cared for away from A&E or an acute mental health facility. The service is accessed through the Mental Health Crisis Line and works in collaboration with the Crisis Assessment Team. It is located at Springfield Hospital in Tooting.[312]

The Coral Mental Health Crisis Hub opened in June 2021, and so data is only available for this service for Q1-3 of 2021/22.

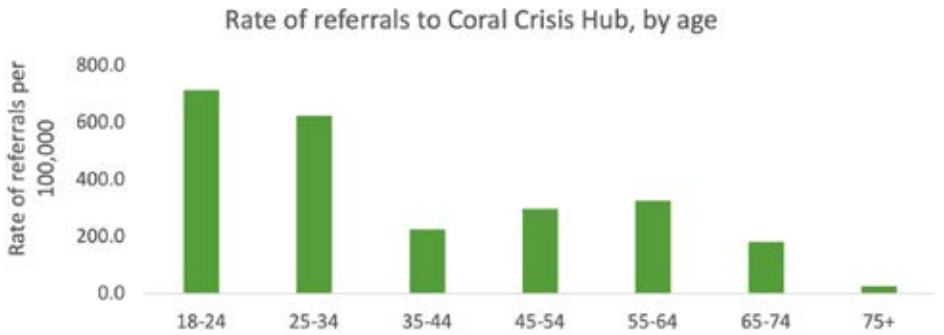
Referrals to the Coral Mental Health Crisis Hub

There were 497 referrals to the Coral Mental Health Crisis Hub in Q1-3 of 2021/22.

Age of Service Users Referred to the Coral Mental Health Crisis Hub

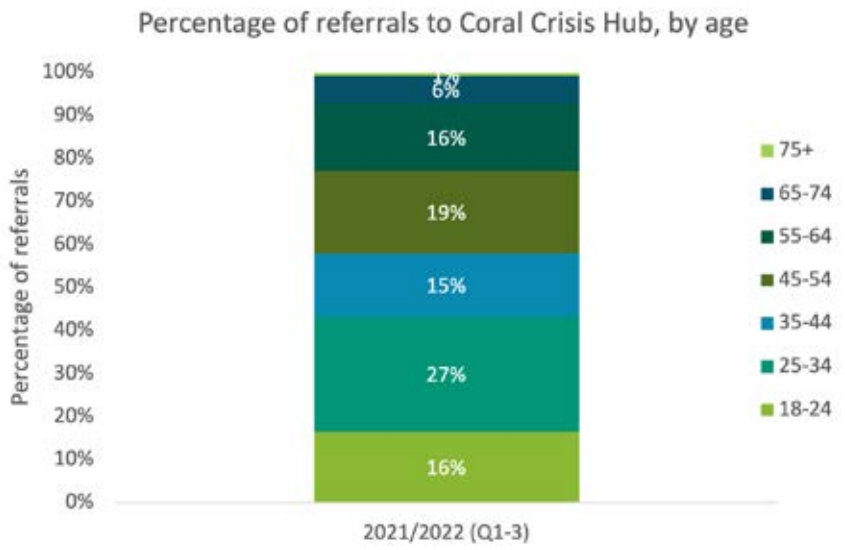
- In Q1-3 of 2021/22, the highest rates of referral to the Coral Mental Health Crisis Hub were in the 18-24 age group (716.7 per 100,000) and 25-34 age group (628 per 100,000).
- This was followed by the 55-64 age group (328.3 per 100,000), 45-54 age group (298.5 per 100,000), 35-44 age group (226.9 per 100,000) and 65-74 age group (183.2 per 100,000).
- The lowest rate of referral was in the 75+ age group (27.6 per 100,000).

Figure 126: Rate of referral to the Coral Mental Health Crisis Hub by age in Q1-3 of 2021/22, using the ONS mid-2020 population



Source: Coral Mental Health Crisis Hub. South West London St George's NHS Trust. 2018-2022.

Figure 127: Percentage of service users referred to the Coral Mental Health Crisis Hub by age in Q1-3 of 2021/22

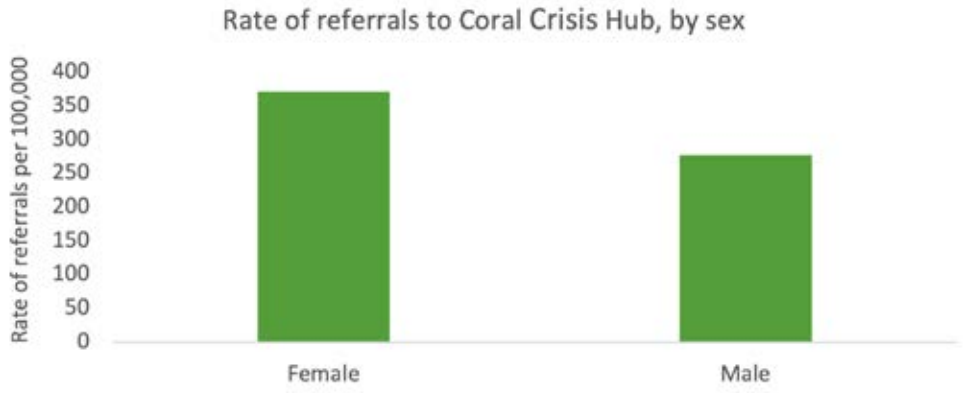


Source: Coral Mental Health Crisis Hub. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Coral Mental Health Crisis Hub

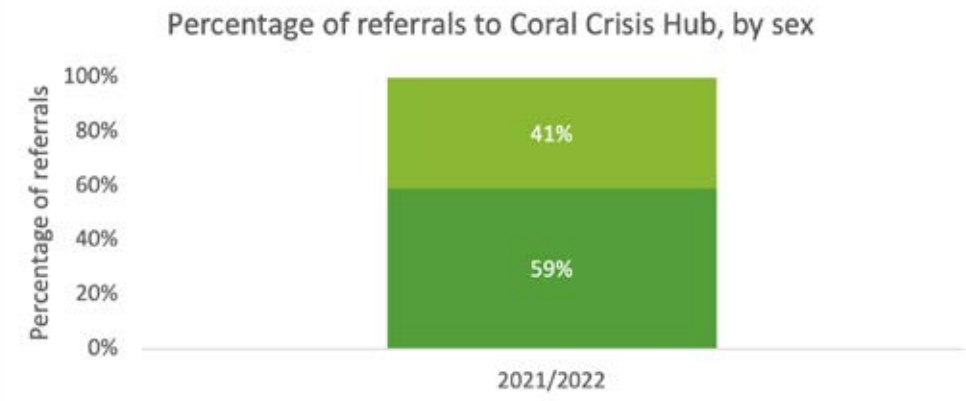
- In 2021/22 (Q1-3), there were higher numbers of females referred to the service (294 referrals) than males (203 referrals).
- This disparity was particularly high among the 18-24 age group (56 females, 26 males), 35-44 age group (51 females, 22 males) and 65-74 age group (24 females, 8 males).
- Referrals of 25-34 and 45-54-year-olds to the service were relatively balanced between males and females.

Figure 128: Rate of referral to the Coral Mental Health Crisis Hub by sex in Q1-3 of 2021/22, using the ONS mid-2020 population



Source: Coral Mental Health Crisis Hub. South West London St George's NHS Trust. 2018-2022.

Figure 129: Percentage of service users referred to the Coral Mental Health Crisis Hub by sex in Q1-3 of 2021/22

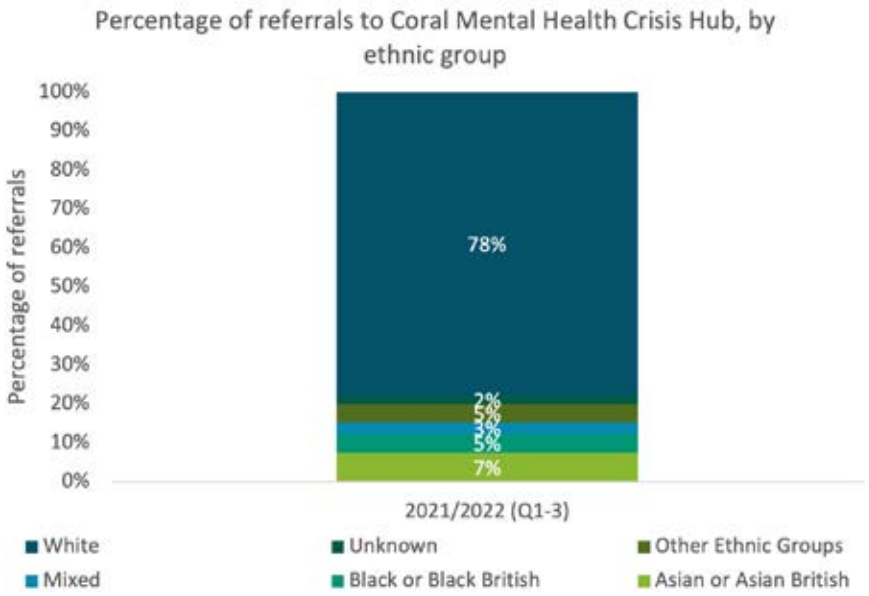


Source: Coral Mental Health Crisis Hub. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Coral Mental Health Crisis Hub

- Most referrals to the Coral Mental Health Crisis Hub in Q1-3 of 2021/22 were from White ethnic groups (78%).

Figure 130: Percentage of service users referred to the Coral Mental Health Crisis Hub by ethnic group in Q1-3 of 2021/22



Source: Coral Mental Health Crisis Hub. South West London St George's NHS Trust. 2018-2022.

Destination of Discharge from the Coral Mental Health Crisis Hub

Following discharge from the Coral Mental Health Crisis Hub, most service users were:

- Internally Transferred to Home Treatment (134 service users).
- Discharged on professional advice (86 service users).
- Detained under the Mental Health Act for admission (52 service users).
- Referred to the Home Treatment Team (45 service users).

Inpatient Services

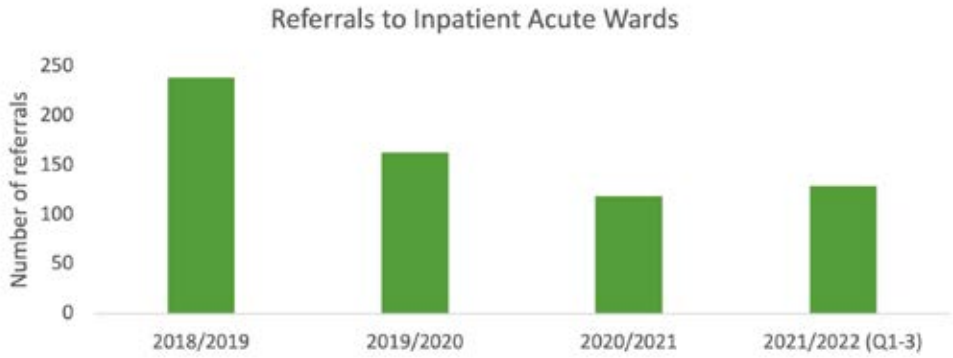
Acute Wards

The acute inpatient wards are for adults who can no longer be supported at home and need to be admitted to hospital due to severe mental health problems. SWLStG provides 9 inpatient acute wards in the borough.[313]

Referrals to the Acute Wards

- Referrals to the acute wards declined between 2018/19-2020/21, falling from a high of 239 referrals in 2018/19, to 163 referrals in 2019/20 and 119 referrals in 2020/21.
- In Q1-3 of 2021/22, there were 129 referrals to the acute wards.

Figure 131: Number of service users referred to the acute wards between 2018/19 and 2021/22

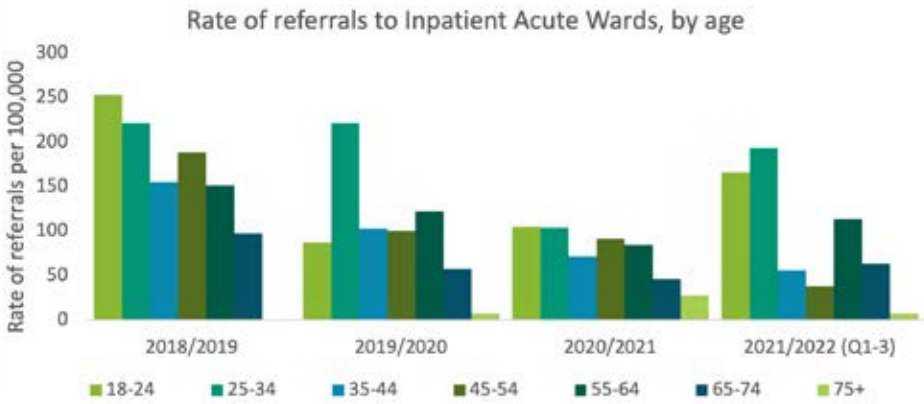


Source: Acute Wards. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Acute Wards

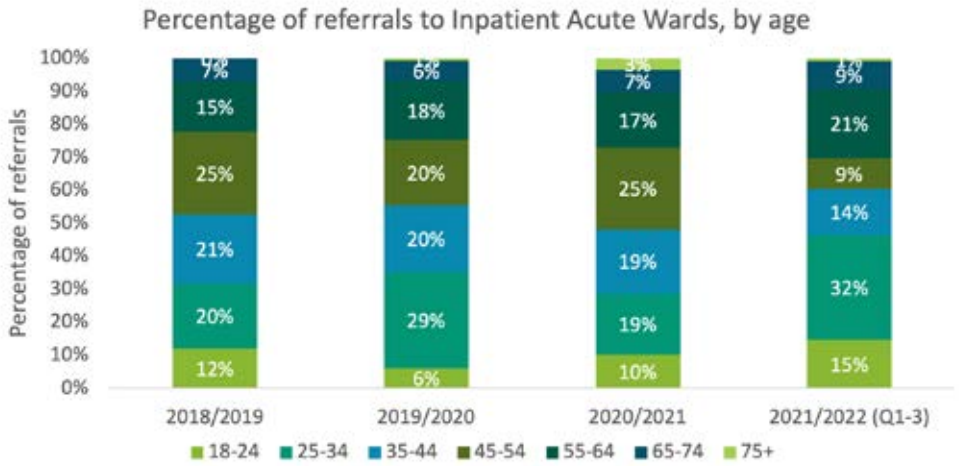
- Over the four-year period, most referrals to the acute wards were aged 25-64 years (83%). There was a relatively even spread of referrals among these age groups.
- There were very small numbers of older adults aged 75+ referred to the service, on average making up just 1% of referrals each year.
- The highest rates of referral to the service were seen in the 25-34 age group (av. 185.34 per 100,000), the 18-24 age group (av. 152.95 per 100,000) and 55-64 age group (av. 117.85 per 100,000).
- The drop in total referrals in 2019/20 led to decreased rates of referral for all age groups, except the 25-34 age group, which saw the same rate of referral as the previous year.
- Whilst most age groups saw increased rates of referrals in 2021/22 (Q1-3), the 35-44 and 45-54 age groups saw further decreases in their rates of referral.
- This resulted in a sizeable reduction in the percentage of 35-44 and 45-54-year-olds among total referrals between 2018 and 2022:
- The 35-44 age group fell from 21% of total referrals in 2018/19 to 14% in 2021/22 (Q1-3).
- The 45-54 age group fell from 25% of total referrals in 2018/19 to 9% in 2021/22 (Q1-3).

Figure 132: Rate of referrals to the acute wards by age between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Acute Wards. South West London St George's NHS Trust. 2018-2022.

Figure 133: Percentage of service users referred to the acute wards by age between 2018/19 and 2021/22

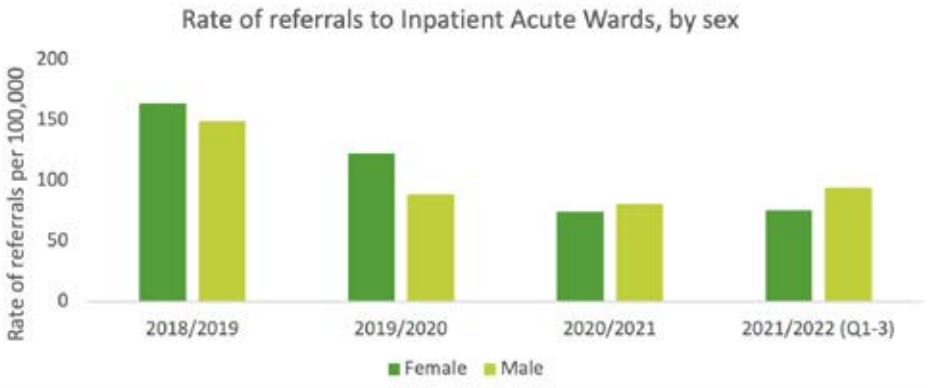


Source: Acute Wards. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Acute Wards

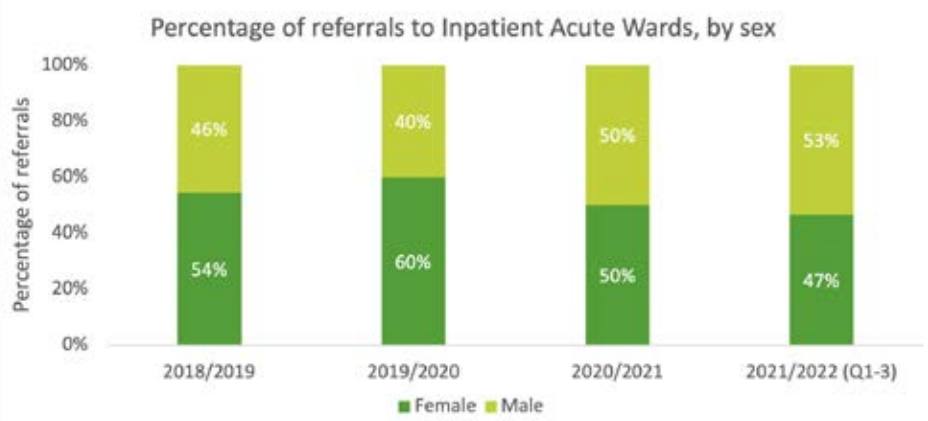
- Over the four-year period, there were more females referred to the acute wards than males (346 females, 302 males).
- However, the balance of males and females reversed over time.
- In 2018/19 and 2019/20, there were more females referred to the service than males.
- In 2020/21, the rates of both female and male referral declined, however this decrease was greatest for females (54.6%) than males (45.9%).
- This led to an equal number of male and female referrals in 2020/21.
- Whilst females remained at a reduced rate of referral in Q1-3 of 2021/22, the rate of referral of males increased slightly. Resultantly, in Q1-3 of 2020/21 there more referrals of males than females to the acute wards.

Figure 134: Rate of referrals to the acute wards by sex between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Acute Wards. South West London St George's NHS Trust. 2018-2022.

Figure 135: Percentage of service users referred to the acute wards by sex between 2018/19 and 2021/22

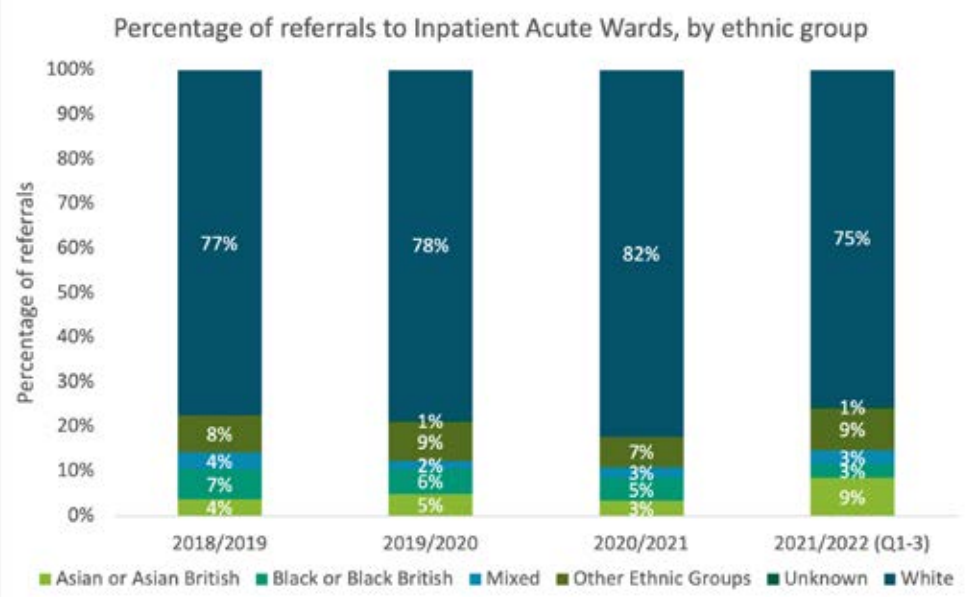


Source: Acute Wards. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Acute Wards

- Between 2018/19 and 2021/22, most referrals to the acute wards were from White ethnic groups (av. 78%).
- This was followed by Other ethnic groups (8%), Asian or Asian British (5%), Black or Black British (5%) and Mixed ethnic groups (3%).
- There was a spike in the referral of Asian or Asian British service users in 2021/22 (Q1-3), rising from an average of 4% in the years preceding to 9% of total referrals.
- In the same year there was also a decrease in the percentage of Black or Black British service users, which fell from an average of 6% between 2018-2021 to 3% in 2021/22 (Q1-3).

Figure 136: Percentage of service users referred to the acute wards by ethnic group between 2018/19 and 2021/22

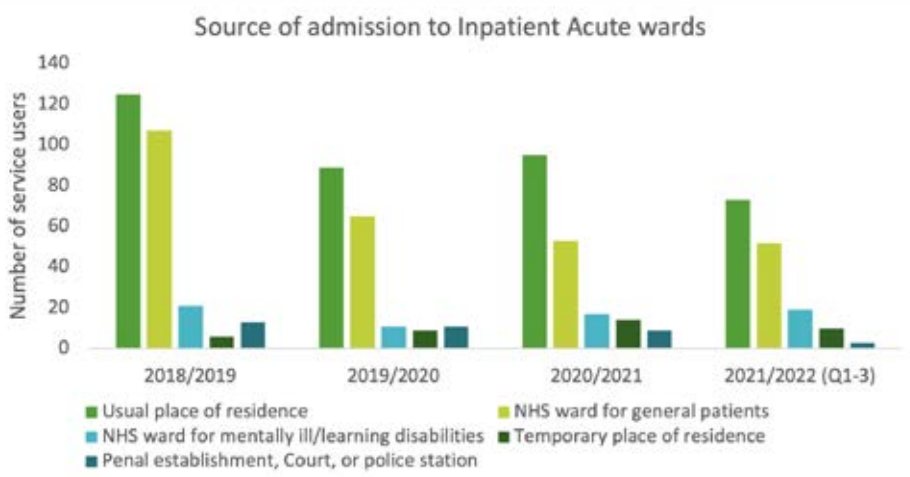


Source: Acute Wards. South West London St George's NHS Trust. 2018-2022.

Source of Admission to the Acute Wards

- Between 2018 and 2022, the majority of service users admitted to the acute wards were referred from their usual place of residence (382 service users) and NHS wards for general patients (277 service users).
- This was followed by NHS wards for mentally ill/learning disabilities (68 services), a temporary place of residence (39 service users) and penal establishment, court or police (36 service users).
- The number of referrals from most admission sources declined over the period in line with the reduced number of total referrals.
- However, referrals from NHS wards for mentally ill/LD and temporary places of residence did not follow the same trend:
- Whilst the number of service users referred from NHS wards for mentally ill/LD fell from 21 referrals in 2018/19 to 11 referrals in 2019/20, this increased to 17 and 19 referrals in 2020/21 and 2021/22 (Q1-3) respectively. This may have been caused by the rising prevalence of mental health crises among those with learning disabilities during the pandemic.[314]
- Referrals from temporary places of residence increased over the period, rising from 6 referrals in 2018/19, to 9 in 2019/20, 14 in 2020/21 and 10 in 2021/22 (Q1-3).

Figure 137: Source of service users' admission to the acute wards between 2018/19 and 2021/22



Source: Acute Wards. South West London St George's NHS Trust. 2018-2022.

Delayed Transfers of Care to the Acute Wards

- Between 2018/19-2021/22, the percentage of service users who experienced a delayed transfer of care to the acute wards increased from 3% and 1.2% in 2018/19 and 2019/20, to 5.6% and 6.5% in 2020/21 and 2021/22 (Q1-3).
- This increase may have been caused by the COVID-19 pandemic.

Length of Stay on the Acute Wards

- The Mental Health Implementation Plan 2019/20 - 2023/24 sets a standard for all adult inpatient mental health services to reduce service user length of stay to the national average of 32 days (or fewer).[315]
- Over the period, 60% (530) of service users met the standard set by the NHS Mental Health Implementation Plan and stayed on the acute wards between 1-30 days.
- However, 40% of service users did not meet the standard; 165 service users stayed 31-60 days, 107 service users stayed more than 90 days and 79 service users stayed between 61-90 days.
- Between 2018/19 and 2021/22 (Q1-3), there was an increased proportion of service users who spent over 90 days (+8%) and between 61-90 days (+6.7%) on the acute ward; and a reduced proportion who spent under 30 days (-15%) on the acute ward.

Percentage of Readmissions within 30 Days of Discharge from the Acute Wards

- A low percentage of readmission to the acute wards suggests that discharge planning has been effective and community providers have provided sufficient support to the service user to prevent the need to return to an inpatient setting.
- The percentage of service users readmitted to the ward within 30 days of discharge remained at a relatively low and steady rate between 2018/19-2021/22.
- This started at 10.9% in 2018/19, rising to its highest at 13.2% in 2019/20, before falling to 10.1% in 2020/21 and 9.2% in 2021/22 (Q1-3).

Destination of Discharge from the Acute Wards

- Across the period, most service users were discharged from the acute wards to their usual place of residence (723 service users).
- Following this, the second most common discharge destination was to a temporary place of residence (105 service users).

Psychiatric Intensive Care Unit

The PICU provides intensive care to compulsorily detained patients who are in acutely disturbed phase of a serious mental disorder such that their safe, therapeutic management and treatment in a general open acute ward is jeopardised.[316]

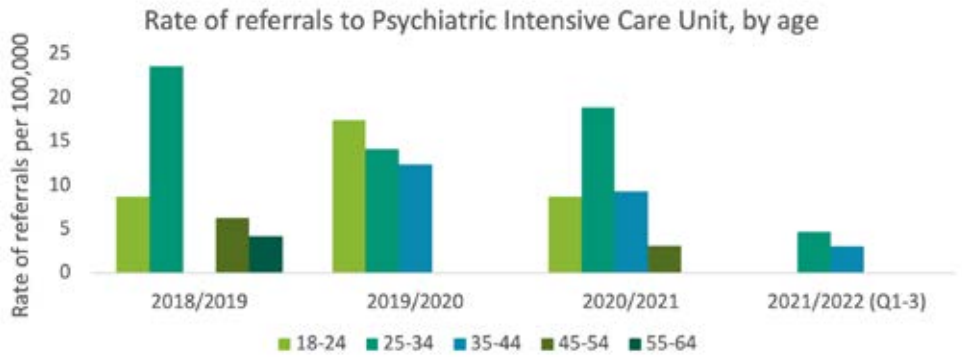
Referrals to the Psychiatric Intensive Care Unit

Between 2018/19 and 2021/22 there were very low numbers of patients referred to the PICU; across the four-year period, just 29 service users in Richmond were referred to the service.

Age of Service Users Referred to the Psychiatric Intensive Care Unit

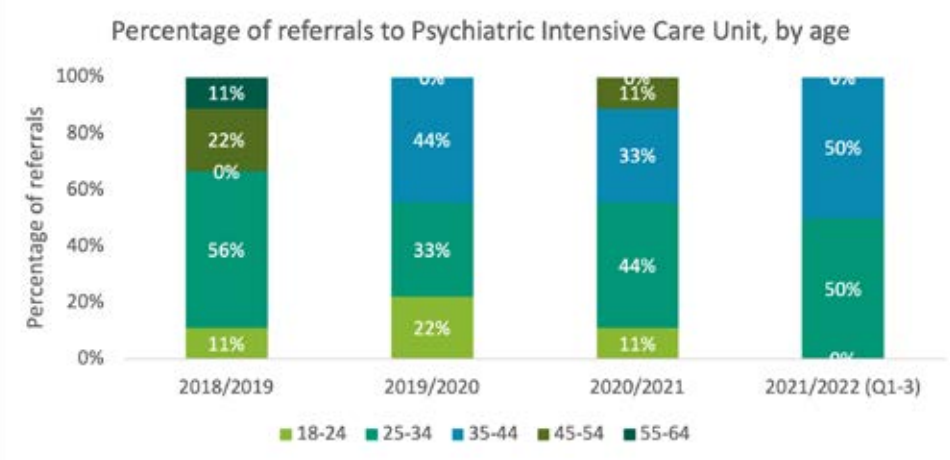
- Over the four-year period, most service users referred to the PICU were aged 25-34 years (46%) and 35-44 years (32%).

Figure 138: Rate of referrals to the PICU by age between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Psychiatric Intensive Care Unit. South West London St George's NHS Trust. 2018-2022.

Figure 139: Percentage of service users referred to the PICU by age between 2018/19 and 2021/22

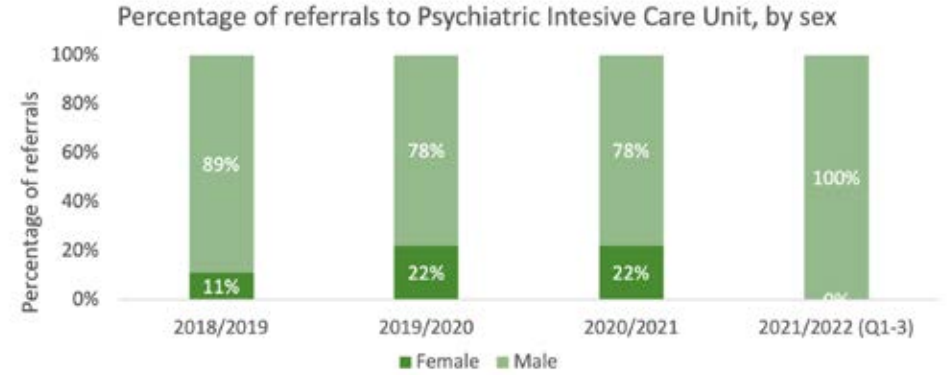


Source: Psychiatric Intensive Care Unit. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Psychiatric Intensive Care Unit

- Most service users referred to PICU between 2018/19 and 2021/22 (Q1-3) were male.
- There were no females referred to the PICU in 2021/22 (Q1-3).

Figure 140: Percentage of service users referred to the PICU by sex between 2018/19 and 2021/22

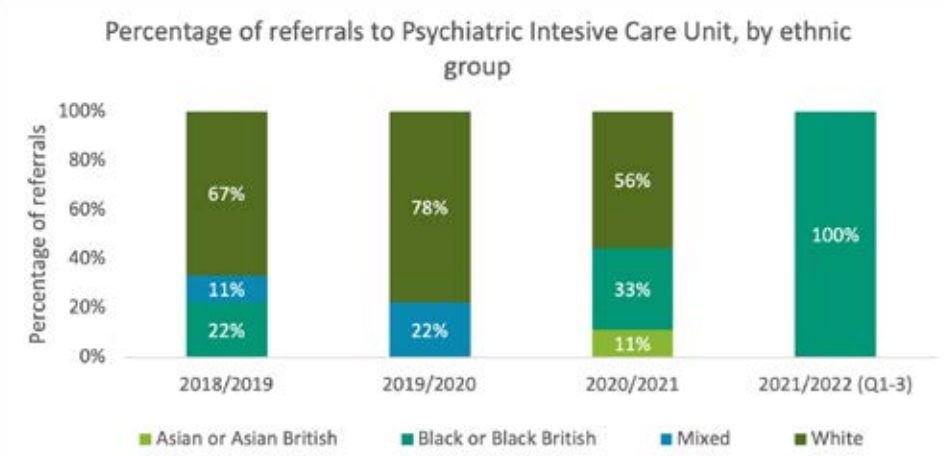


Source: Psychiatric Intensive Care Unit. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Psychiatric Intensive Care Unit

- Over the period, most service users referred to the PICU were from White ethnic groups (50%) and Black or Black British ethnic groups (39%).
- There is a disproportionately high number of Black or Black British service users referred to the service.

Figure 141: Percentage of service users referred to the PICU by ethnic group between 2018/19 and 2021/22



Source: Psychiatric Intensive Care Unit. South West London St George's NHS Trust. 2018-2022.

Source of Admission to the Psychiatric Intensive Care Unit

- Over the period under analysis, most referrals to the PICU either came from a person's usual place of residence (16 referrals) or penal establishments (13 referrals).

Adult Eating Disorders Service

The adult eating disorders service includes an outpatient unit and day-care unit.

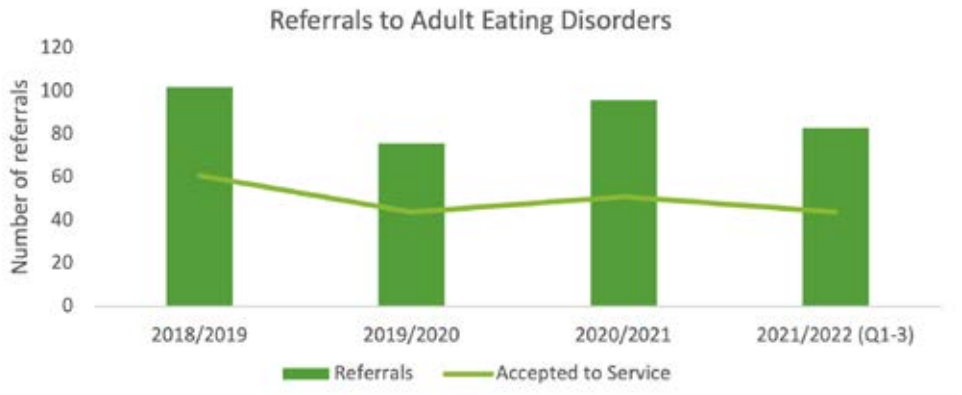
The outpatient service provides assessment, treatment and monitoring for adults with conditions such as anorexia nervosa, bulimia nervosa and binge eating disorder.

The day-care unit is a 5-day service for up to 10 male and female adults diagnosed with an eating disorder and who require a more intensive treatment programme. Treatment is offered via groups and individual sessions.[317]

Referrals to the Adult Eating Disorders Service

- Between 2018/19-2021/22, there were 357 referrals to the Adult Eating Disorder Service.
- The number of adults referred to the service fluctuated each year over the period, peaking in 2018/19 at 102 referrals, falling to 76 referrals in 2019/20, and then increasing to 96 referrals in 2020/21.
- There were 83 referrals to the service in Q1-3 of 2021/22.
- The number of service users accepted into the Adult Eating Disorder Service followed a similar trend.
- The percentage of service users accepted reduced slightly over the period.
- The percentage accepted was highest in 2018/19 at 59.8%. This reduced slightly in 2019/20 to 57.9%, before declining further to 53.1% and 53% in 2020/21 and 2021/22 respectively.

Figure 142: Number of service users referred and accepted to the Adult Eating Disorder Service between 2018/19 and 2021/22

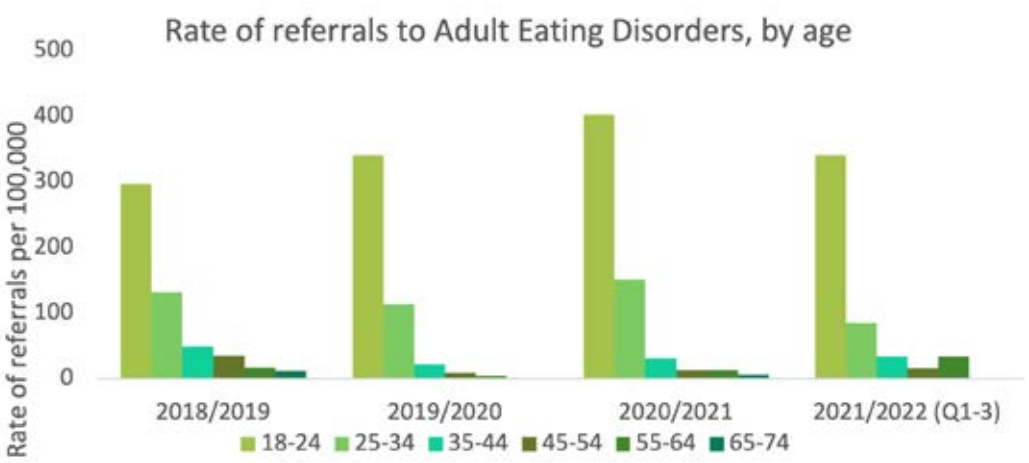


Source: Adult Eating Disorder. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Adult Eating Disorder Service

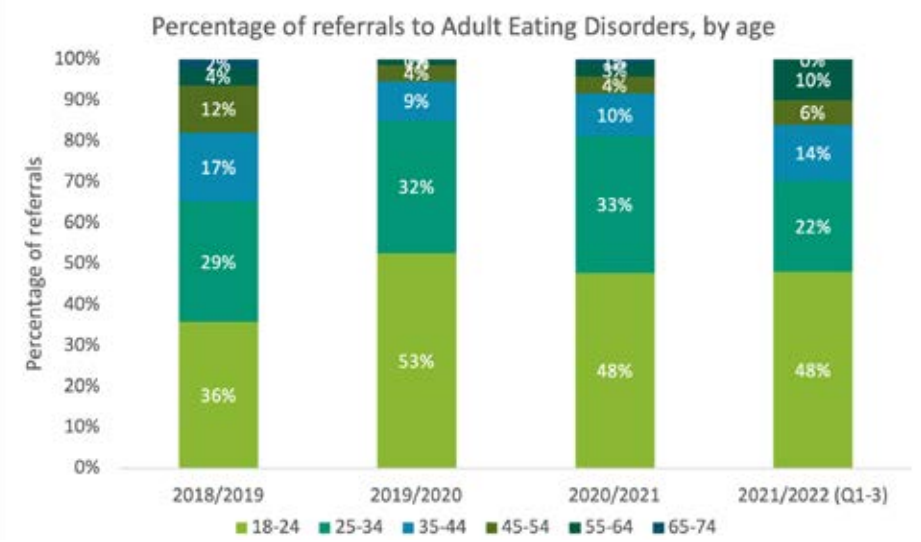
- Between 2018/19-2021/22, 88% of referrals to the Adult Eating Disorder Service were between the ages of 18 and 44.
- The average rate of referral to the Adult Eating Disorder Service decreased over the life course.
- The 18-24 age group saw the highest rates of referral at 345.22 per 100,000, followed by the 25-34 age group at 120.41 per 100,000.
- The rate of referrals fell to 34.2 per 100,000 in the 45-54 age group, 18 per 100,000 in the 55-64 age group, 16.8 per 100,000 in the 65-74 age group and 4.3 per 100,000 in the 75+ age category.
- All age groups saw reduced rates of referral in 2019/20, except the 18-24 age group, which saw an increased rate of referral.

Figure 143: Rate of referral to the Adult Eating Disorders Service by age between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Adult Eating Disorder. South West London St George's NHS Trust. 2018-2022.

Figure 144: Percentage of referrals to the Adult Eating Disorder Service by age between 2018/19 and 2021/22

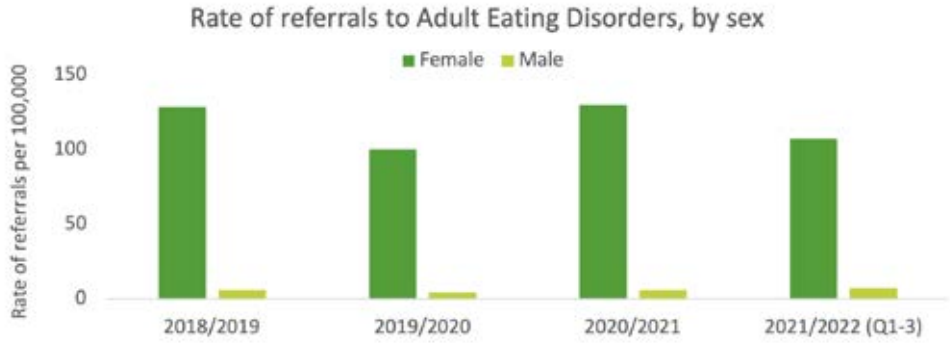


Source: Adult Eating Disorder. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to Adult Eating Disorders

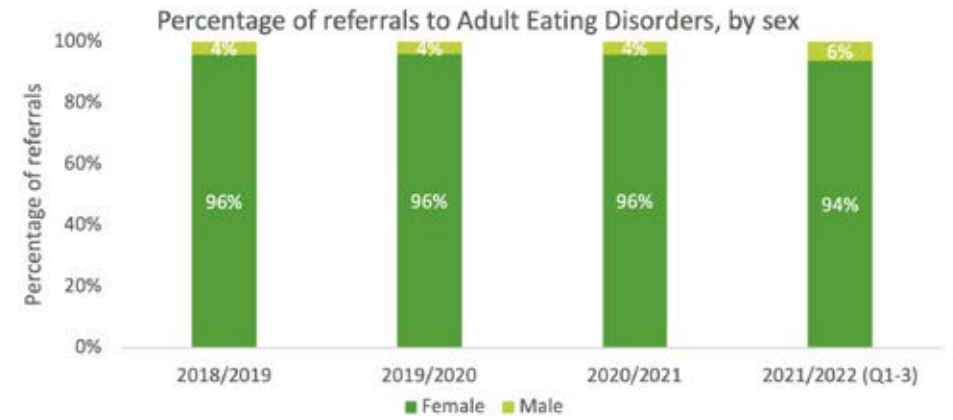
- Across the four-year period, 95% of service users referred to Adult Eating Disorder services were female.

Figure 145: Rate of referrals to the Adult Eating Disorder Service by sex between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Adult Eating Disorder. South West London St George's NHS Trust. 2018-2022.

Figure 146: Percentage of referrals to the Adult Eating Disorder Service by sex between 2018/19 and 2021/22

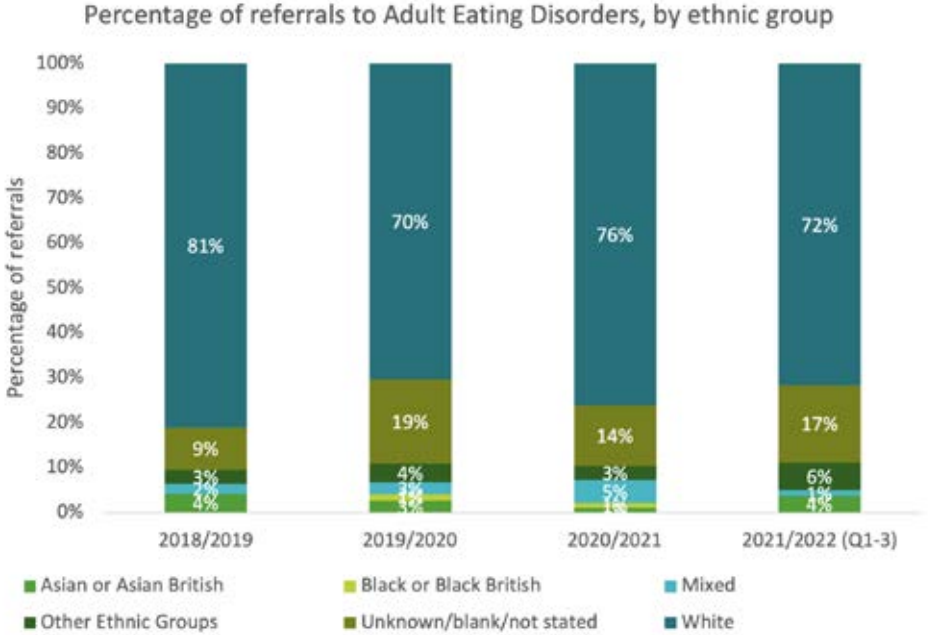


Source: Adult Eating Disorder. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Adult Eating Disorder Service

- Between 2018/19-2021/22, most service users referred to the Adult Eating Disorder Service were from White ethnic groups (av. 75%).
- There were a high number of service users whose ethnicity was unknown (av. 15%).

Figure 147: Percentage of referrals to the Adult Eating Disorder Service by ethnic group between 2018/19 and 2021/22

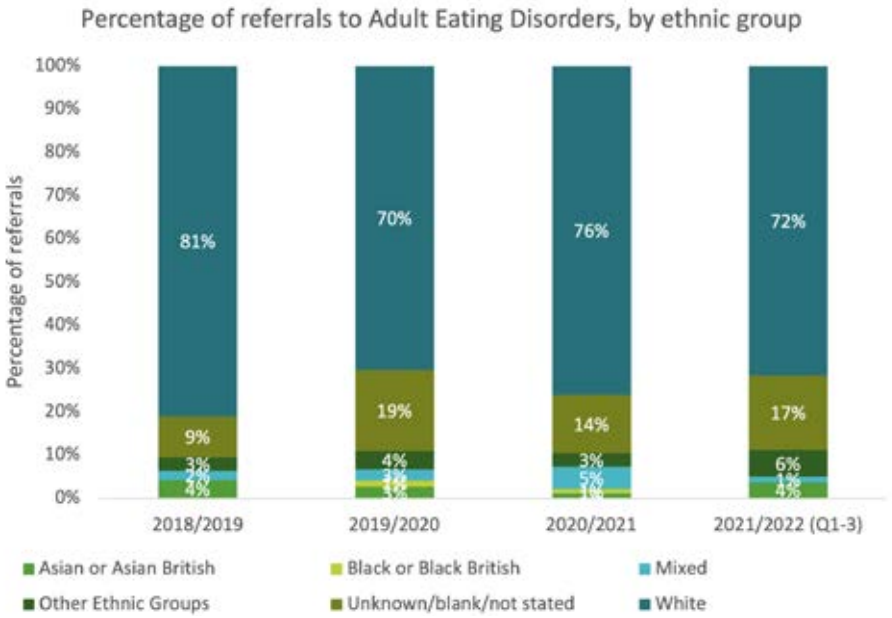


Source: Adult Eating Disorder. South West London St George's NHS Trust. 2018-2022.

Waiting Time for First Assessment at the Adult Eating Disorder Service

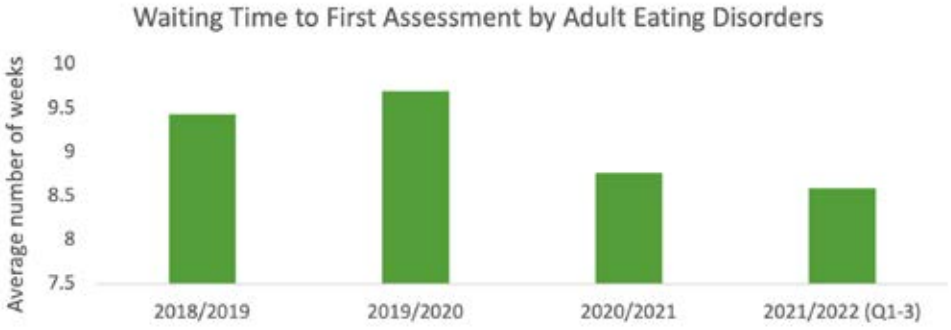
- Over the four-year period, the average number of weeks that service users waited for a first assessment at the Adult Eating Disorder Service decreased.
- In 2018/19 and 2019/20, on average service users waited 9.4 and 9.7 weeks respectively for a first assessment.
- In 2020/21 and 2021/22, this reduced to an average wait of 8.8 weeks and 8.6 weeks respectively.

Figure 148: Average wait time to a first assessment by the Adult Eating Disorder Service between 2018/19 and 2021/22



Source: Adult Eating Disorder. South West London St George's NHS Trust. 2018-2022.

Figure 149: Average wait time to a first assessment by the Adult Eating Disorder Service between 2018/19 and 2021/22



Source: Adult Eating Disorder. South West London St George's NHS Trust. 2018-2022.

Adult Social Care Services

ASC services support those in the borough who have care and support needs because of a physical or mental condition or impairment.

Service users are assessed to see whether they meet the three conditions set out in the 2014 Care Act and are therefore eligible to receive care and support from the council.

Referrals to Richmond Adult Social Care Services

- The total number of mental health service users was reasonably stable over the four-year period.
- Between 2018/19–2020/21, service users between the ages of 55-64 were most common.
- In 2021/22, the 45-54 age group became most prevalent in the service.
- The fewest service users were in the 75+ age category.
- Across the period there were more males than females in the service.

The Richmond Mental Health service user snapshot in March 31st March 2021 found that: [318]

- There were 221 adults using Richmond Mental Health services.
- Most service users accessed support in the community (78.3%).
- 21.7% of service users accessed support whilst residing in a care home.
- Nearly a quarter of service users were aged 55-64 years, and 68.5% of these received services in the community.
- There were more males service users (57.5%) than female (42.5%).
- Service users from Black and Minority ethnic groups were more likely to receive support in the community (89.2%) than service users from White ethnic groups (75%).

Table 150: Demographics of mental health service users of Richmond Adult Social Care between 2018/19 and 2021/22

Demographics of Adult Social Care Service Users		Year			
		2018/19	2019/20	2020/21	2021/22
Total Service Users		**244**	**235**	**247**	**258**
Total Service Users by Age	**18-24**	18	14	12	13
	25-34	28	32	33	44
	35-44	41	34	34	34
	45-54	52	46	55	56
	55-64	65	67	65	50
	65-74	35	38	42	50
	75+	<5	<5	6	11
	Unknown	0	0	0	0
	Total	**244**	**235**	**247**	**258**
Total Service Users by Sex	**Female**	108	100	107	108
	Male	136	134	140	150
	Unknown	0	<5	0	0
	Total	**244**	**235**	**247**	**258**
Total Service Users by Ethnicity	**Asian/Asian British**	13	12	14	14
	Black/Black British	9	10	13	15
	Mixed	6	8	8	8
	Other ethnic groups	<5	7	<5	6
	White	194	186	95	199
	Unknown	16	12	12	16
	Total	**244**	**235**	**247**	**258**

Source: Adult Social Care. 2018-2022.

Use of Richmond Adult Social Care Services

- There was a sizeable increase in the number of service users referred to the service in 2021/22.
- The average number of days waited by service users for a first assessment by ASC halved in 2020/21, falling from 66 days and 72 days in the previous years to 30 days. In 2021/22, the average wait time re-increased to 68 days.
- The number of service users placed out of borough has remained consistent over the four-year period.
- It is acknowledged by the team supplying this data that the recording of substance misuse among service users is inaccurate. Therefore, these figures should be treated with caution. These figures also do not reflect what is expected from the prevalence data.

Table 151: Use of Adult Social Care mental health services between 2018/19 and 2021/22

Use of Adult Social Care Mental Health Services	Year			
	2018/19	2019/20	2020/21	2021/22
Number of Service Users Referred to the Service	472	411	463	644
Waiting Time for Assessment (average days waited)	66	72	30	68
Number of People who have had a Care Act Assessment	204	192	247	202
Number of Service Users Receiving Direct Payments	58	51	49	49
Number of Service Users Placed Out of Borough	38	37	39	36
Number of Service Users in Substance Misuse	<5	<5	<5	<5
Number of Service Users with Home Care	81	60	81	64

Source: Adult Social Care. 2018-2022.

Approved Mental Health Professionals Service

The AMHP service responds to requests for a Mental Health Act Assessment to be carried out. A person may need a MHAA when there is an acute deterioration to their mental health, and they can be detained under the MHA and treated without their agreement. People detained under the Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.[319]

Demographics of Service Users Receiving an Approved Mental Health Professionals Assessment

Table 152: Demographics of service users assessed by the AMHP service between 2020/21 and 2021/22

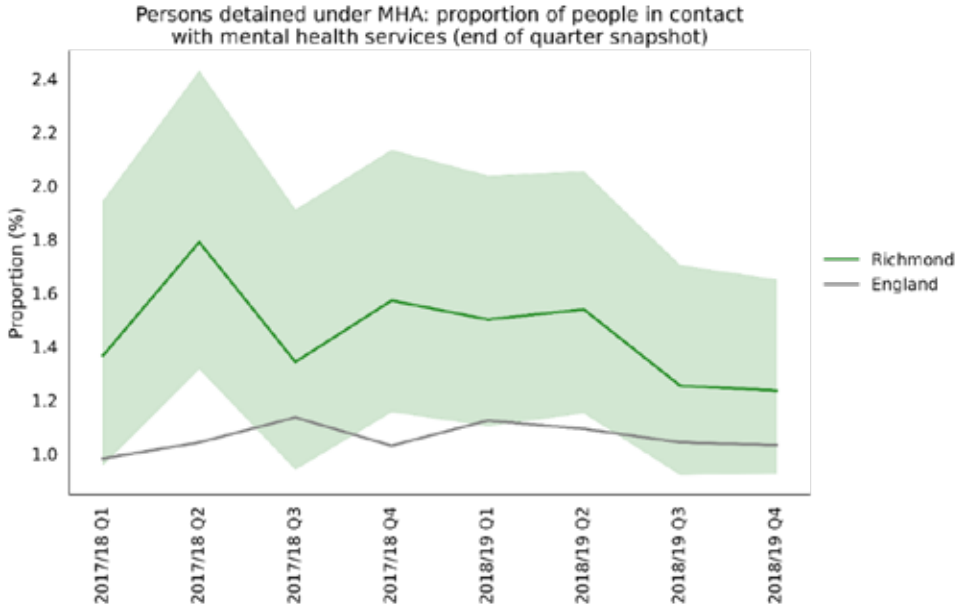
Demographics of service users receiving an AMHP Assessment		Year	
		2020/21	2021/22
Total AMHP Assessments		229	220
AMHP Assessments by Age	18-24	14	32
	25-34	51	49
	35-44	35	31
	45-54	44	27
	55-64	34	41
	65-74	19	17
	75+	32	23
	Unknown	0	0
	Total	229	220
AMHP Assessments by Sex	Female	115	105
	Male	114	115
	Unknown	0	0
	Total	229	220
AMHP Assessments by Ethnicity	Asian/Asian British	7	20
	Black/Black British	25	16
	Mixed	<5	12
	Other ethnic groups	8	9
	White	184	155
	Unknown	0	8
	Total	229	220

Source: Approved Mental Health Professionals Service. 2020-2022.

Comparison to London and England Averages

- In Q4 of 2018/19, Richmond's proportion of detained Mental Health Service Users was 1.2% (45).
- This was the 15th highest rate in London and was 19.8% higher than the England average.
- This was also 9.5% lower than in Q1 of 2017/18, in comparison with a 5.1% increase in England's rate in the equivalent time period.

Figure 153: Proportion of service users detained under the MHA who were in contact with mental health services in Richmond and England between 2017 and 2019.



Source: Richmond JSNA.

Older Adult Mental Health Services

Richmond Older People's Mental Health Community Services are based at Barnes Hospital.

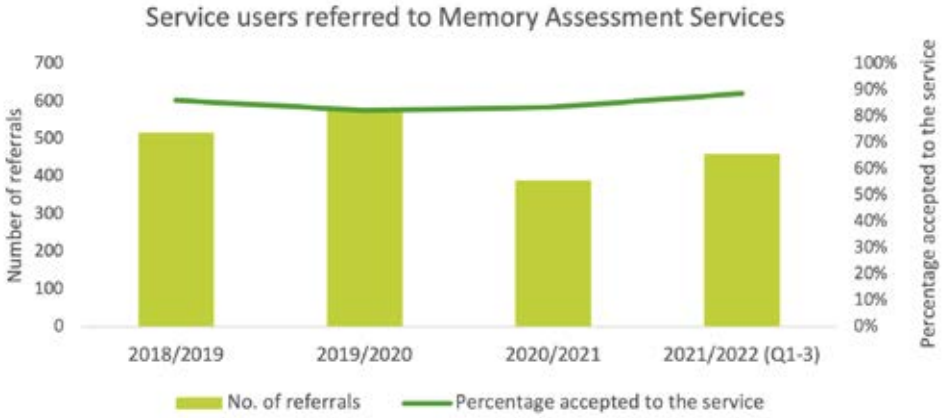
Memory Assessment Services

Richmond Memory Assessment Service is a diagnostic pathway that provides timely assessment, diagnosis and treatment for people who are experiencing cognitive difficulties.

Referrals to Memory Assessment Services

- In 2018/19 and 2019/20, there were 517 and 583 referrals to Memory Assessment services, respectively.
- In 2020/21, the number of service users referred to Memory Assessment services reduced sizeably, falling to 390 referrals. This may have been caused by the COVID-19 pandemic, as service users were reluctant to seek a referral due to concerns of burdening the health service or fears of COVID-19 infection.[320]
- In Q1-3 of 2021/22, there were 460 referrals to Memory Assessment services, which indicates that referrals began to recover following the pandemic.
- The percentage of service users accepted to the service across the period was relatively high (av. 85%).
- Although there was a small decrease in the percentage of service users accepted to the service in 2019/20, wherein it fell from 86% in the previous year to 82%, the percentage has since increased, growing to a peak of 89% in 2021/22 (Q1-3).

Figure 154: Number of service users referred to Memory Assessment Services and the percentage accepted between 2018/19 and 2021/22

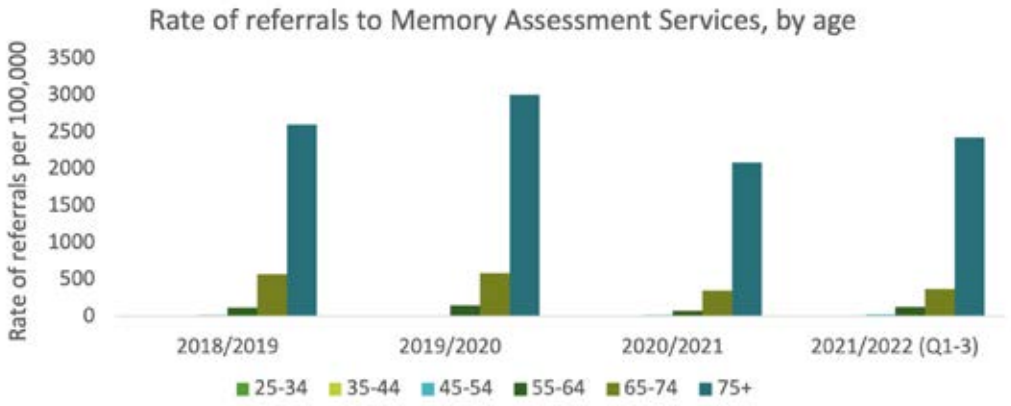


Source: Memory Assessment Services. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Memory Assessment Service

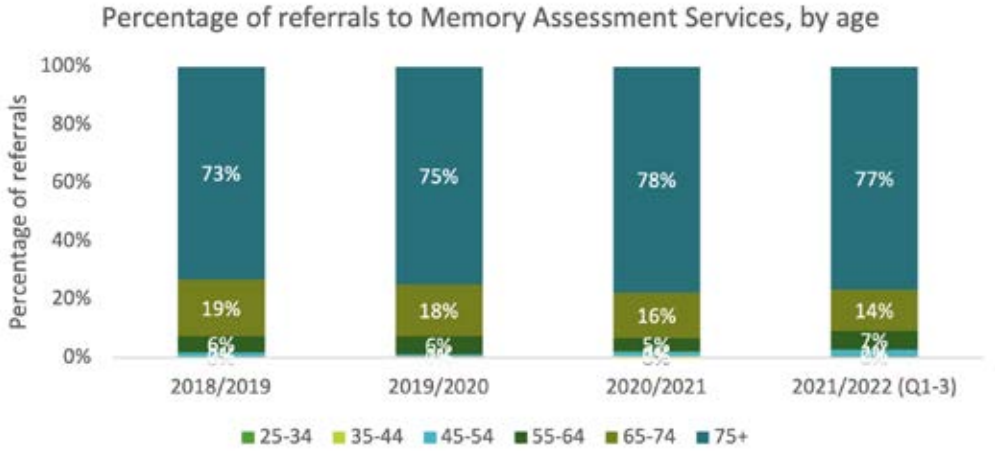
- Most service users referred to the Memory Assessment Service are above the age of 75 (75.75%) or between the ages of 65-74 (16.75%).

Figure 155: Rate of referral to the Memory Assessment Service by age between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Memory Assessment Services. South West London St George's NHS Trust. 2018-2022.

Figure 156: Percentage of referrals to the Memory Assessment Service by age between 2018/19 and 2021/22

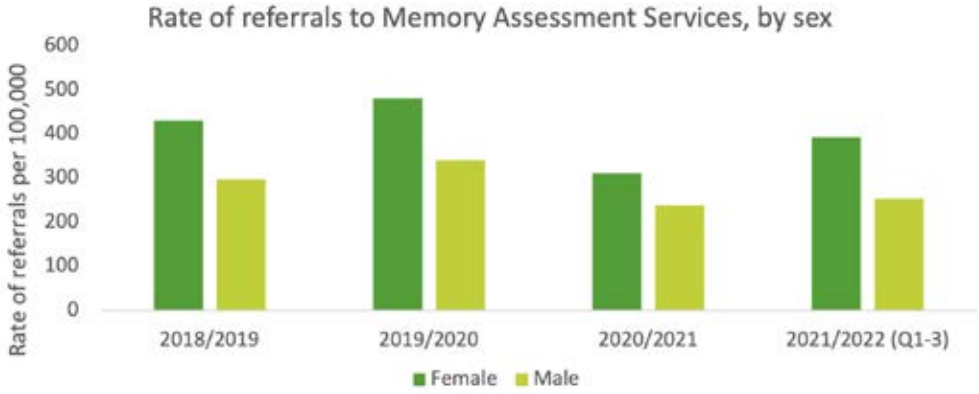


Source: Memory Assessment Services. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Memory Assessment Service

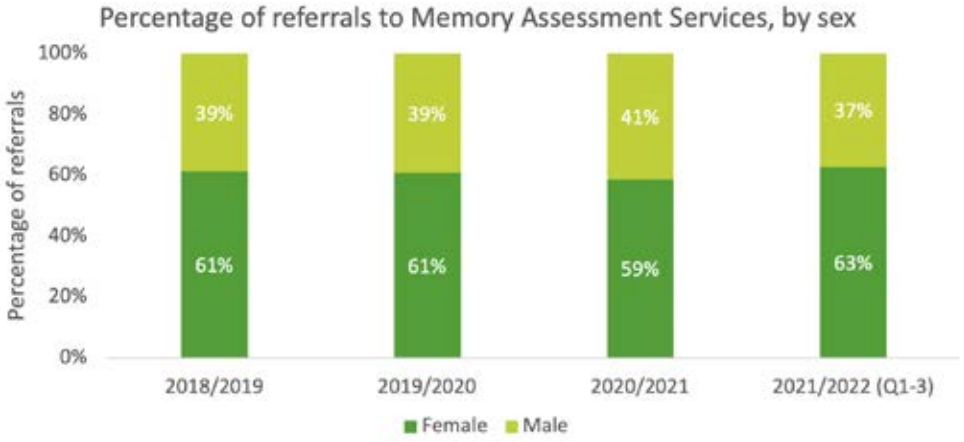
- Over the period, there were more females referred to the Memory Assessment Service than males; 61% female and 39% male.
- In 2020/21, the rate of referrals of both males and females declined.
- However, there was a larger decline in the rate of female referral than male; the rate of female referral fell by 35.3% and the rate of male referral fell by 29.7%.
- This led to a slight increase in the percentage of males among total referrals to the service in 2020/21 to 59% female and 41% male.

Figure 157: Rate of referral to the Memory Assessment Service by sex between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Memory Assessment Services. South West London St George's NHS Trust. 2018-2022.

Figure 158: Percentage of referrals to the Memory Assessment Service by sex between 2018 and 2022

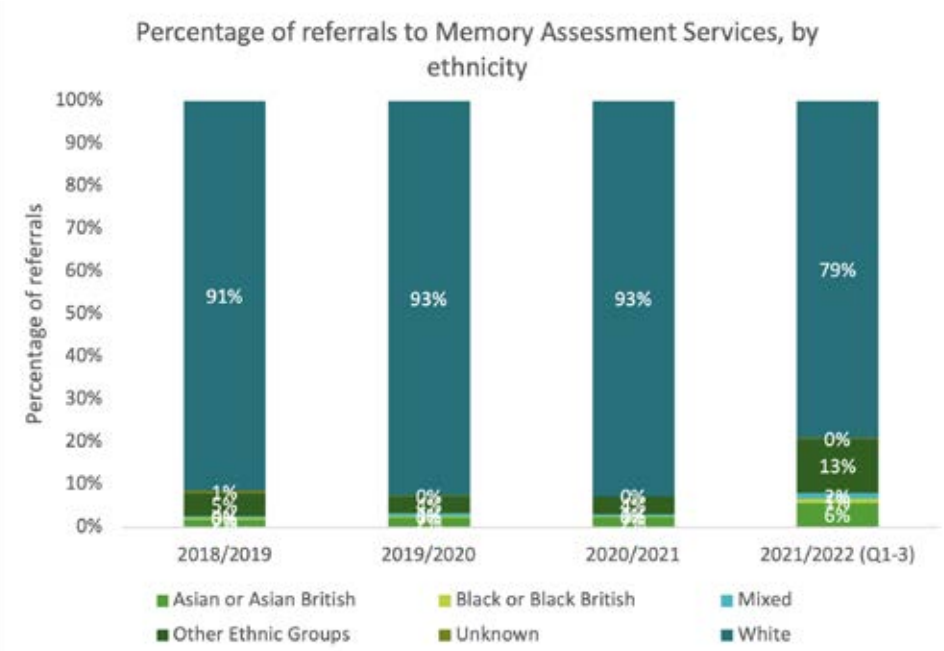


Source: Memory Assessment Services. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Memory Assessment Service

- Between 2018/19-2021/22, most referrals to the Memory Assessment Service were from White ethnic groups (av. 89%).
- In Q1-3 of 2021/22, there was a sizeable increase in the number of service users from Other ethnic groups; this rose from an average of 4.3% of total referrals between 2018-2021 to 13% of total referrals.
- In the same year there was also a small spike in the number of service users from Asian or Asian British service users referred to the service; this grew from 2% of total referrals in all previous years to 6% of total referrals.
- There were low numbers of service users from Black or Black British ethnic groups referred across all years.

Figure 159: Percentage of referrals to the Memory Assessment Service by ethnic group between 2018/19 and 2021/22

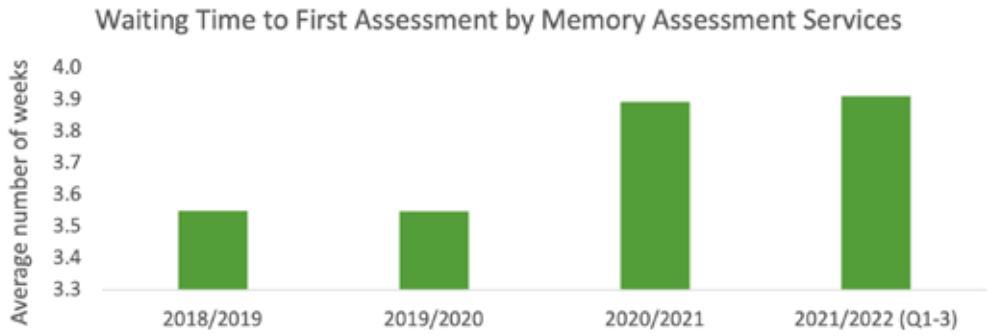


Source: Memory Assessment Services. South West London St George's NHS Trust. 2018-2022.

Waiting Time to First Assessment at the Memory Assessment Service

- The average number of weeks waited by service users for a first assessment saw a small increase over the period.
- In 2018/19 and 2019/20 service users waited an average of 3.5 weeks for a first assessment, and this increased in 2020/21 and 2021/22 (Q1-3) to an average of 3.9 weeks.
- This may have been caused by the COVID-19 pandemic, which caused disruption to health services.[321]

Figure 160: Average number of weeks service users waited for a first assessment at the Memory Assessment Service between 2018/19 and 2021/22



Source: Memory Assessment Services. South West London St George's NHS Trust. 2018-2022.

Contacts Not Attended at the Memory Assessment Service

- The percentage of DNA decreased over the period from a high of 8.4% in 2018/19, to 6.13% in 2019/20 and reached a low of 2% in 2020/21.
- The percentage of DNA increased slightly in Q1-3 of 2021/22 to 3.9%.

Figure 161: Percentage of DNA to Memory Assessment Services between 2018/19 and 2021/22

Source: Memory Assessment Services. South West London St George's NHS Trust. 2018-2022.

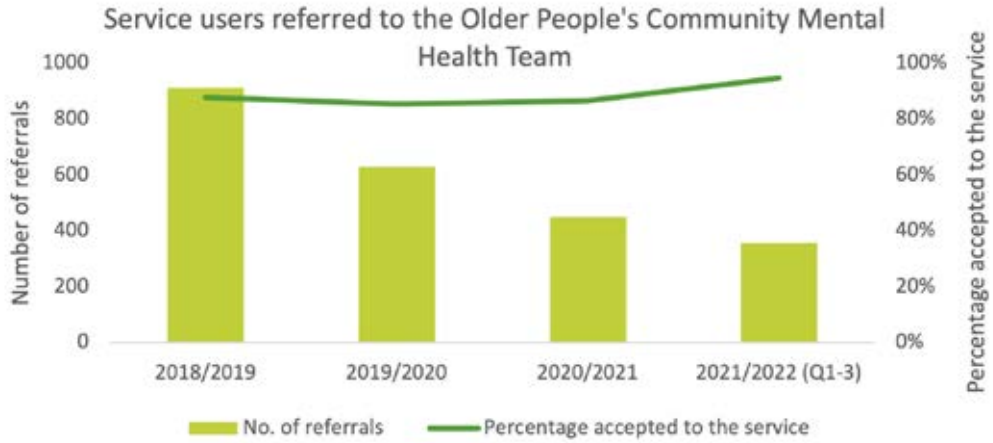
Older People's Community Mental Health Team

Richmond Older People's CMHT provides care and treatment for patients who live in Richmond and are over the age of 75 with functional mental health diagnoses, or any age for patients with neurodegenerative disorders such as dementia.

Referrals to the Older People's Community Mental Health Team

- The number of service users referred to the Older People's CMHT has decreased over time.
- The number of referrals to the service was highest in 2018/19 at 912.
- Since then, the number of referrals to the service declined each year, falling to 629 referrals in 2019/20 and 451 referrals in 2020/21.
- In Q1-3 of 2021/22, there had been 357 referrals to the service.
- The percentage of service users accepted to the service averaged at 86.6% between 2018 and 2021 and increased to a high of 95% in 2021/22 (Q1-3).

Figure 162: Number of service users referred and the percentage accepted to the Older People's CMHT between 2018/19 and 2021/22

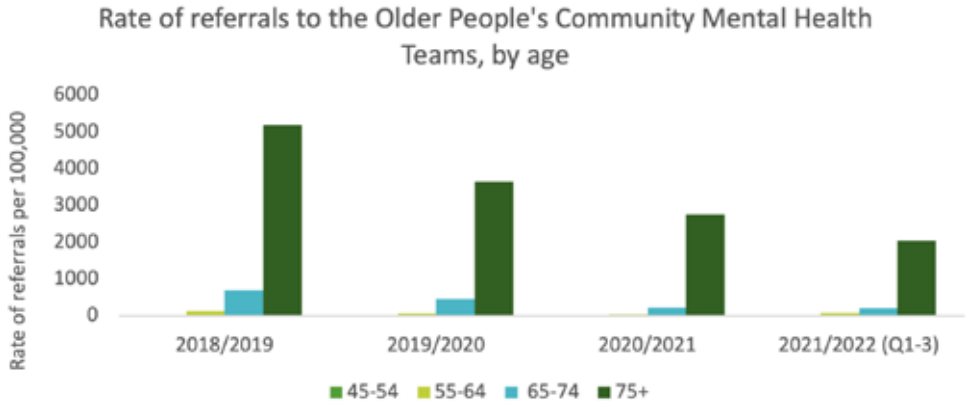


Source: Older People's Community Mental Health Team. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Older People's Community Mental Health Team

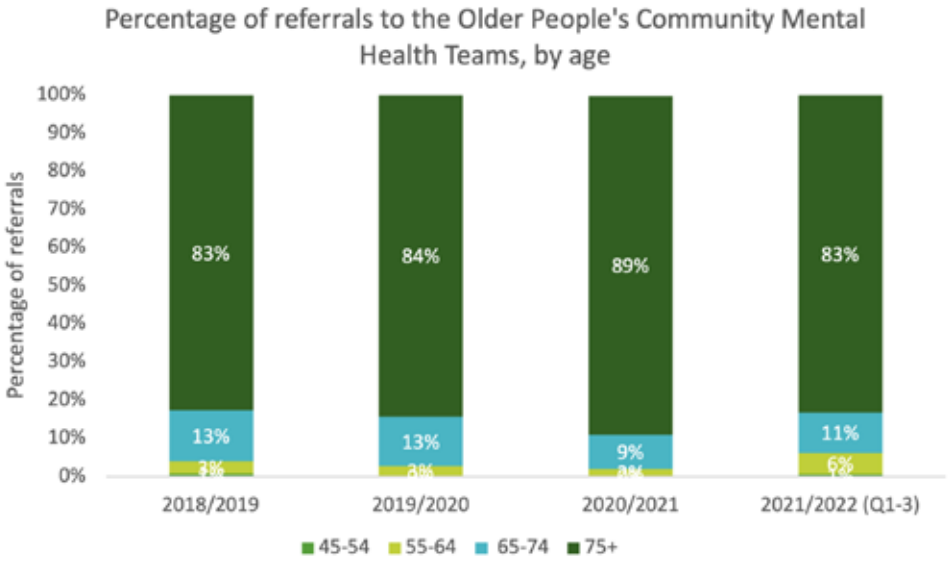
- Between 2018/19-2021/22, most service users referred to the Older People's CMHT were above the age of 75 (85%).
- Whilst all age groups saw declines in their rate of referral each year in line with the reduced number of total referrals, there was a slight increase to the rate of referral of 55–64-year-olds in 2021/22 (Q1-3).

Figure 163: Rate of referral to the Older People's CMHT by age between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Older People's Community Mental Health Team. South West London St George's NHS Trust. 2018-2022.

Figure 164: Percentage of referrals to the Older People's CMHT by age between 2018/19 and 2021/22

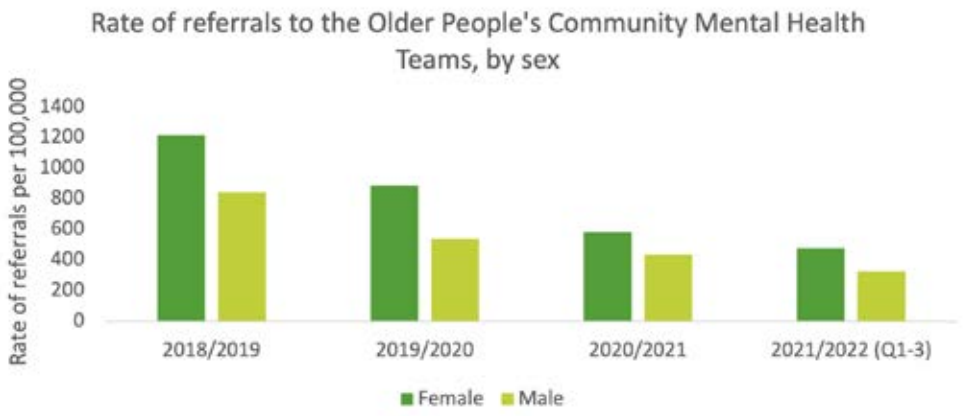


Source: Older People's Community Mental Health Team. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Older People's Community Mental Health Team

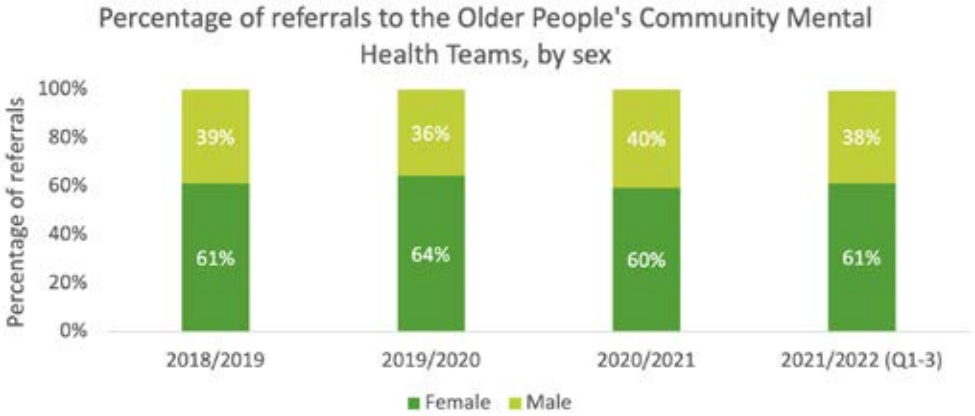
- Over the period, there were more females referred to the Older People's CMHT than males (62% female, 38% male).
- Both males and females saw decreased rates of referral each year in line with the decreasing number of total referrals.

Figure 165: Rate of referrals to the Older People's CMHT by sex between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Older People's Community Mental Health Team. South West London St George's NHS Trust. 2018-2022.

Figure 166: Percentage of referrals to the Older People's CMHT by sex between 2018/19 and 2021/22

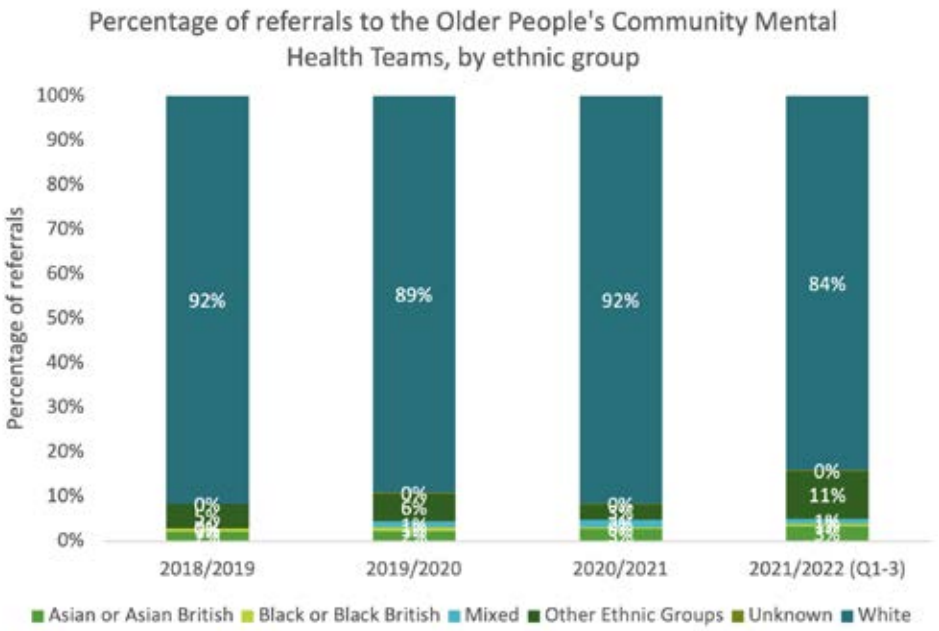


Source: Older People's Community Mental Health Team. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Older People's Community Mental Health Team

- Between 2018/19-2021/22, most service users referred to the Older People's CMHT were from White ethnic groups (89%).
- Whilst the number of service users referred to the service from all ethnic groups decreased each year in line with the reduced number of total referrals, the number of service users from Other ethnic groups referred to the service increased from 15 in 2020/21 to 38 in 2021/22 (Q1-3).

Figure 167: Percentage of referrals to the Olde People's CMHT by ethnic group between 2018/19 and 2021/22

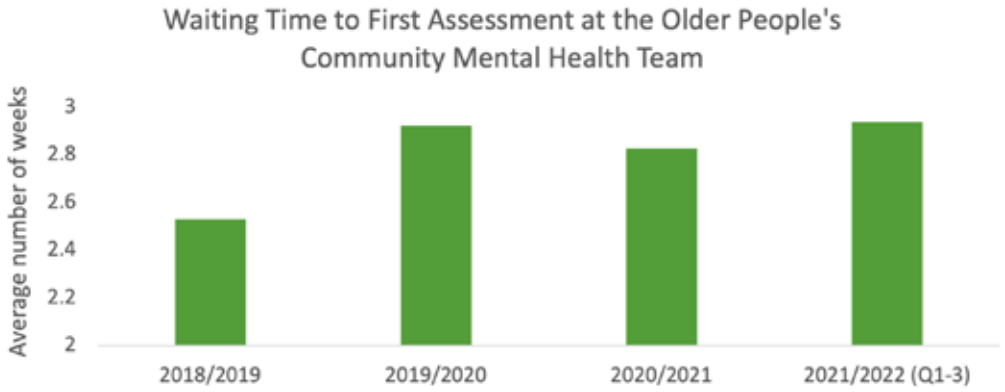


Source: Older People's Community Mental Health Team. South West London St George's NHS Trust. 2018-2022

Waiting Time to First Assessment at the Older People's Community Mental Health Team

- Over the four-year period, service users waited an average of 2.8 weeks for a first assessment by the Older People's CMHT.
- In 2019/20, the average wait time for a first assessment saw a small increase from 2.5 weeks in 2018/19 to 2.9 weeks.
- This increased wait time was maintained in 2020/21 and 2021/22 (Q1-3).

Figure 168: Average number of weeks that service users waited for a first assessment at the Older People's CMHT between 2018/19 and 2021/22

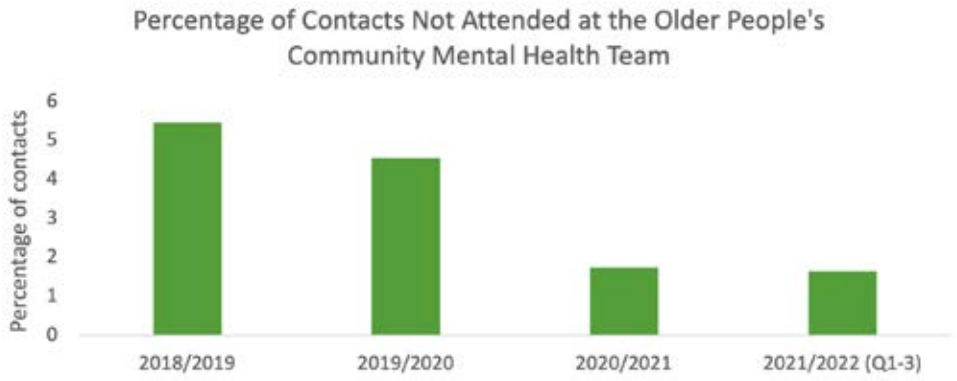


Source: Older People Community Mental Health Team. South West London St George's NHS Trust. 2018-2022.

Contacts Not Attended to the Older People's Community Mental Health Team

- There was a low percentage of DNA to the Memory Assessment Service (av. 3.4%) over the period under analysis.
- The percentage of DNA decreased over the period, starting at a high of 5.46% and 4.55% in 2018/19 and 2019/20, and falling to 1.74% and 1.65% in 2020/21 and 2021/22 (Q1-3).

Figure 169: Percentage of DNA to the Older People's CMHT between 2018/19 and 2021/22



Source: Older People Community Mental Health Team. South West London St George's NHS Trust. 2018-2022.

Older People's Wards

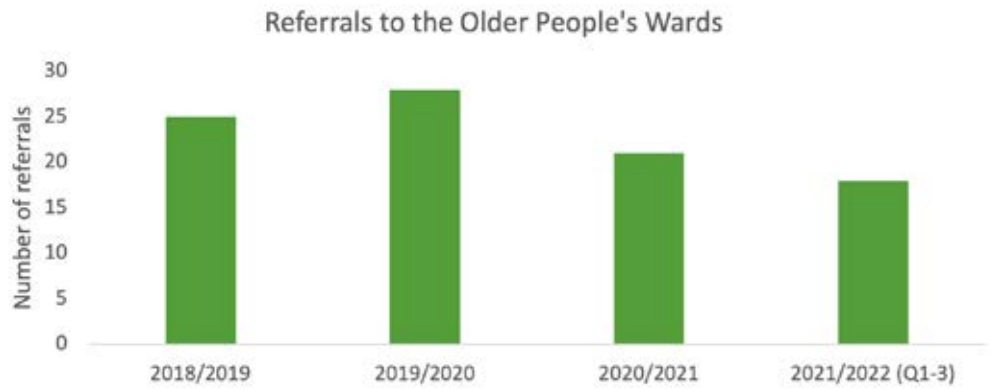
The older people's wards offer care and treatment for older adults over the age of 75 with a functional mental illness, or adults of any age with a diagnosis of dementia.

South West London and St George's NHS Trust provides 2 older people's wards - Crocus Ward at Springfield Hospital and Jasmines Ward at Tolworth Hospital.

Referrals to the Older People's Wards

- Between 2018/19-2021/22, there were low numbers of service users referred to the older people's wards.
- The number of service users referred to the Wards peaked in 2019/20 at 28 service users.
- The number of service users referred to the Wards declined in 2020/21 to 21 service users
- In Q1-3 of 2021/22, there were 18 service users referred to the Wards.

Figure 170: Number of service users referred to the older people's wards between 2018/19 and 2021/22

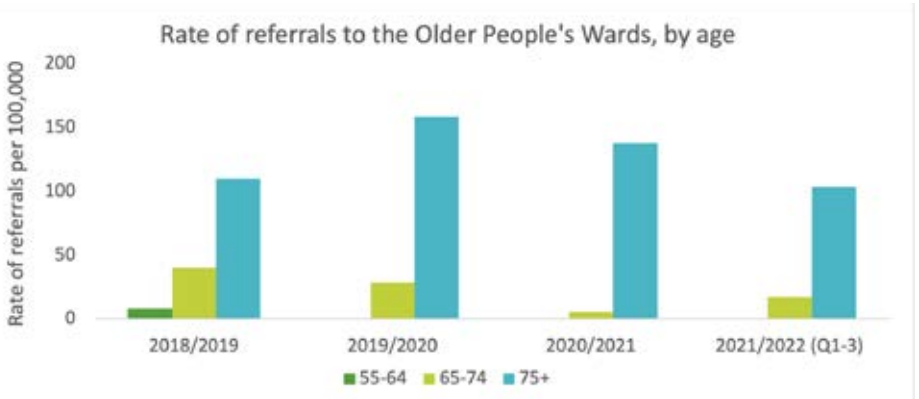


Source: Older People's Wards. South West London St George's NHS Trust. 2018-2022.

Age of Service Users Referred to the Older People's Wards

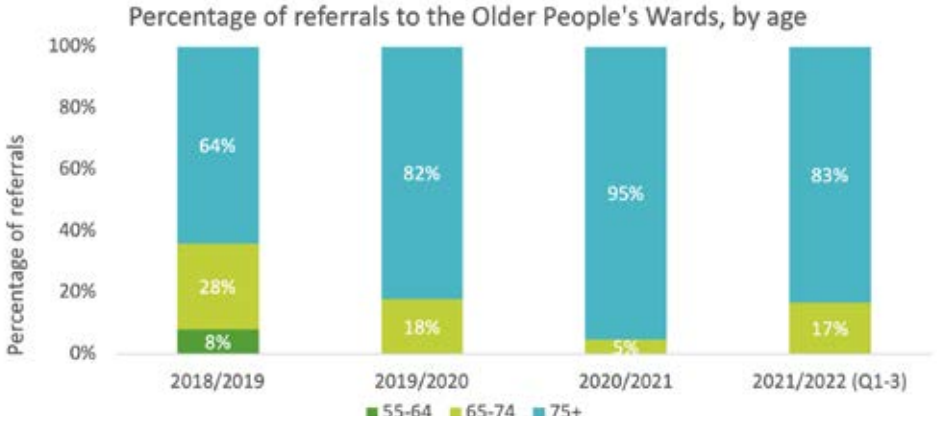
- Over the 4-year period, most service users referred to the older people's wards were above the age of 75 (av. 81%).
- The rate of referral of service users aged 55-64 has declined since 2018/2019, and this fell to a particular low in 2020/21.
- There have been no service users aged 55-64 referred to the service since 2018/19.

Figure 171: Rate of referral to the older people's wards by age between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Older People's Wards. South West London St George's NHS Trust. 2018-2022.

Figure 172: Percentage of referrals to the older people's wards by age between 2018/19 and 2021/22

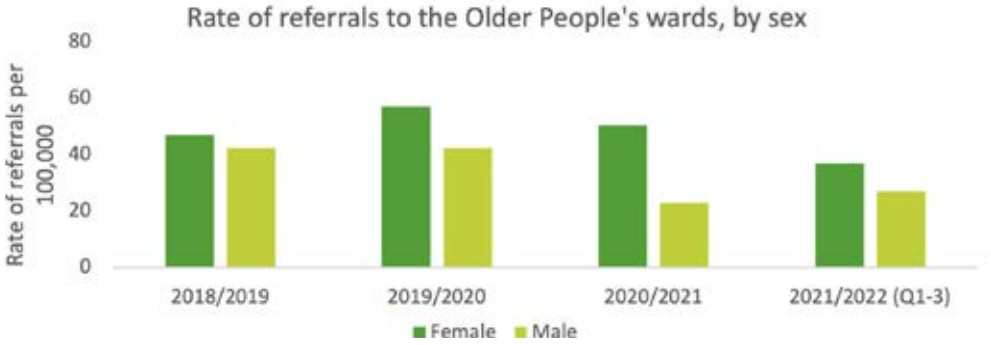


Source: Older People's Wards. South West London St George's NHS Trust. 2018-2022.

Sex of Service Users Referred to the Older People's Wards

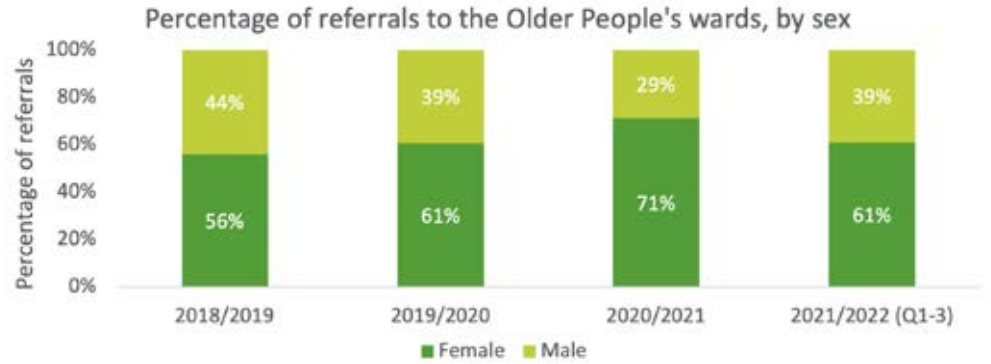
- Over the 4-year period, there were more females referred to the older people's wards than males; 62% female, 38% male.
- The balance between males and females was most even in 2018/19; 56% female, 44% male.
- Both males and females saw an increase to their rate of referral in 2018/19.
- Whilst both males and females saw decreased rates of referral in 2020/21, the rate of male referral saw a greater reduction (-59%) than the rate of female referral (-13%).
- This led to an increased proportion of females among total referrals to the service in 2020/21; 71% female, 29% male.
- Whilst the rate of male referral saw a small increase from the previous year in Q1-3 of 2021/22 (+16%), the rate of female referral declined (-31%).

Figure 173: Rate of referrals to the older people's wards by sex between 2018/19 and 2021/22, using the ONS mid-2020 population



Source: Older People's Wards. South West London St George's NHS Trust. 2018-2022.

Figure 174: Percentage of referrals to the older people's wards by sex between 2018/19 and 2021/22

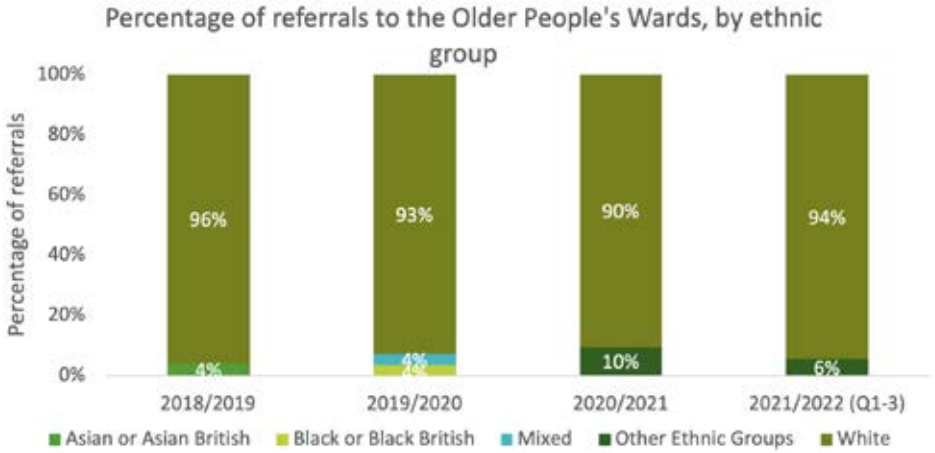


Source: Older People's Wards. South West London St George's NHS Trust. 2018-2022.

Ethnicity of Service Users Referred to the Older People's Wards

- Between 2018/19-2021/22, most service users referred to the older people's wards were from White ethnic groups (av. 93%).
- This was followed by service users from Other ethnic groups (av. 4%), Mixed (av. 1%), Black or Black British (av. 1%) and Asian or Asian British ethnic groups (av. 1%).

Figure 175: Percentage of referrals to the Older People's Wards by ethnic group between 2018/19 and 2021/22



Source: Older People's Wards. South West London St George's NHS Trust. 2018-2022.

Source of Admission to the Older People's Wards

- Most service users were admitted to the older people's wards from a ward for general patients (46%) or their usual place of residents (41%).

Delayed Transfers of Care to the Older People's Wards

- The percentage of service users experiencing a delayed transfer of care was highest in 2018/19 at 4.33%.
- This fell to 3.81% in 2019/20.
- No service users experienced a delayed transfer of care in 2020/21 or 2021/22.

Length on Inpatient Stay on the Older People's Wards

- The Mental Health Implementation Plan 2019/20 - 2023/24 sets a standard for all adult inpatient mental health services to reduce service user length of stay to the national average of 32 days (or fewer). [322]
- Over the four-year period, only 29% of service users met this target.
- By contrast, 71% of service users stayed on the ward for over 31 days; 35% stayed between 31-60 days, 27% stayed upwards of 91 days and 14% stayed between 61-90 days.

Percentage of Service Users Readmitted to the Older People's Wards Following Discharge

- A low percentage of readmission to the older people's wards suggests that discharge planning has been effective and community providers have provided sufficient support to the service user to prevent the need to return to an inpatient setting.
- Over the period, there was a low percentage of service users readmitted to the older people's wards.
- The percentage of service users readmitted was highest in 2021/22 (Q1-3) at 5.55%, followed by in 2018/19 at 4%.
- There were no service users readmitted to the ward in 2019/20 or 2020/21.

Destination of Discharge from the Older People's Wards

- Most service users were discharged to their usual place of residence (43%), an NHS run care home (27%) or ward for general patients (11%).

Mental Health Service Utilisation: Key Findings

- The number of service users referred to IAPT and voluntary sector services increased over the four-year period.
- There was also an increase in the number of referrals to CMHTs, Early Intervention Teams and the Perinatal Mental Health Service.
- By contrast, there has been a consistent decline in the number of service users referred to Crisis and Inpatient services, except for Adult Eating Disorder services which saw a relatively stable number of referrals across the period.
- There was a large drop in the number of service users referred to the Liaison Psychiatry Service from the Emergency Department in 2020/21, which was likely caused by reduced attendance to ED during the COVID-19 pandemic.
- Older adult mental health services saw reduced rates of referral in 2020/21, likely due to the COVID-19 pandemic. Though the rate of referrals to the Memory Assessment Service showed indications of recovery in Q1-3 of 2021/22, the referral rate to OP CHMT and OP Wards reduced further.
- Most services received a higher number of referrals from females than males, at an approximate rate of 60:40. This balance is most skewed in referrals to Adult Eating Disorder services, of which 95% are female.
- The exception to this is referrals to PICU and ASC mental health services, which are male dominated.
- Most services show a general trend of a declining rate of referral with age, with the highest representation seen among the 18-24 and 25-34 age groups, and the lowest among those aged 75+.
- Inpatient services receive a comparatively high proportion of referrals from service users aged 45-54 and 55-64.
- White British ethnic groups are most represented in all services.
- There is a high representation of Black and Black British male service users referred to PICU.
- Except the Adult Eating Disorder service, all SWL CCG commissioned services saw increased waiting times over the period.
- Services saw decreased rates of DNA in 2020/21, likely caused by the COVID-19 pandemic.
- Though the rate of DNA remained reduced for older adult services, this has re-increased for all other services.
- The onset of the COVID-19 pandemic in 2020/21 saw reduced numbers of face-to-face appointments with SPA, CMHTs and Early Intervention Teams, and saw these services introduce new contact mediums such as eConsultations.
- By contrast, CRHTTs saw increased numbers of contacts through face-to-face appointments, which shows the importance of in-person support for crisis patients.

Stakeholder Consultation

Key Issues Facing Adults in Richmond

Through the consultations, the following key issues facing working-age adults in Richmond were identified:

Increased prevalence of mental health need

Stakeholders reported that mental health conditions among adults in Richmond are increasing in prevalence, complexity, acuity and longevity. Although a significant issue beforehand, the COVID-19 pandemic has had dramatic adverse impacts on mental health needs, caused both directly through stressors of the pandemic and indirectly through the escalated challenges of accessing mental health services.

Stakeholders particularly reported the increased complexity of service users' mental health needs, noting the growth of people experiencing multiple mental health needs simultaneously: "one patient can have 57 diagnoses." Complex clients were identified as presenting more commonly with "huge histories of complex trauma", with one stakeholder noting that trauma was "present almost in every referral right now." Respondents also identified that these complex cases commonly presented with co-occurring mental health and substance misuse issues.

Despite this growth of complexity, stakeholders felt that there is a dearth of services available to attend to the needs of complex clients. This was particularly identified for clients with diagnoses of PTSD and Personality Disorders. Services continue to attend to singular mental health needs, meaning that mental health support staff frequently face the challenge of finding the right service to signpost complex clients to noting, "if they don't fit into a certain category, where do you put them?" Consequently, mental health support staff are "often forced to refer [clients] to different services for each individual need."

As mental health services are not specialised to work with complex clients, stakeholders reported that these clients struggle to have their needs met within current services. For example, one stakeholder identified the lack of intensive psychological therapy offered by CMHTs:

"a lot of our more complex clients have huge histories of complex trauma, loads of issues that they need to work through with high quality intensive psychological therapy. But there doesn't seem to be enough scope for that in things like CMHT. They do offer psychologist services, but the amount of times that I have worked with somebody with huge complex traumas and delusions and I have asked if they have received therapy for it, and even if they have been in hospital multiple times, I'm always surprised how many have not formal psychological therapies to support them. Not for everybody, but if they are being offered medication this should be something which happens and I feel like it is not"

Barriers to accessing mental health services

Stakeholders repeatedly identified that "there can be boundaries and barriers to getting support when you need it."

Extensive waiting lists:

Stakeholders reported that service users are experiencing long waiting lists to access mental health services due to limited capacity within and increasing demands on services. This was suggested to span across the breadth of mental health services.

In addition, it was frequently reported that the inability to provide intervention at the point of need caused service users' needs to escalate and to spend longer times within services when eventually accessed: "Services have a very big impact – when they are absent, they have a very big impact on people's mental health and their ability to cope on the day to day." This was criticised by one stakeholder as "a disservice to our community that we serve." The waiting list to access mental health services was frequently raised as an issue during the stakeholder consultation at Tolworth Hospital; one service user described how the extensive wait times could be "fatal" for some people, and another suggested that they may not have been admitted to the ward had they been able to access services sooner.

Stakeholders also suggested how these waiting times and barriers to access "put people off" trying to seek support for their mental health. Stakeholders recognised that individuals with a mental disorder are likely to be experiencing lower levels of motivation, and therefore may not have the resilience to keep battling the challenges to access mental health care. For example, if a service user is placed on hold when calling to self-refer into a service: "if you are struggling, you are going to stop calling back and stop bothering and things are going to get worse and worse."

Stakeholders also reported the impacts that long waiting lists are having on lower-level and voluntary services, which are left to hold service users whilst they await a referral. For example, it was raised how social prescribing services are increasingly taking on clients with mental health needs, which stakeholders regarded with concern due to the escalating levels of risk which these services are having to contain.

Capacity and resource limitations:

In addition to the extensive waiting lists, stakeholders reported other aspects of the mental health system which are struggling to deal with the capacity demands placed upon them. For example, it was reported that there is a lack of sufficient Health Based Place of Safety beds for clients detained under S136 of the MHA.

It was also suggested how capacity demands mean that mental health services are often only able to provide highly limited offerings to service users. For example, it was reported that if a client is referred to KARAT, they will only try to call the service user once, and "if the client doesn't engage then they just discharge them."

Meeting the criteria for acceptance to mental health services:

Stakeholders identified that "there's a lot of barriers and thresholds" to mental health services in the borough, which is posing significant barriers to access. This is particularly significant for service users who sit between tier thresholds and are multiply rejected because "you're not sick enough or you're too sick."

One service user described their experience of trying to access Cognitive Behavioural Therapy:

"If you're not stable enough, you don't qualify. They tell you basically that if you're unstable, you can't have it. Well, if I was stable, it wouldn't need it. How does offering a treatment that you have to be well enough to have make sense?"

It was suggested by one stakeholder that a key group which fall between the thresholds of tiered services are clients with "mild to moderate mental health issues," whose inability to access preventative services means that "these are the people who regularly end up in A&E." However, stakeholders also reported that this is a scenario experienced by even the most 'at-risk' service users: "there are people who are acutely unwell who are expressing suicidal ideation, who have plans, who don't meet a criteria."

Resultantly, it was felt that these service users "spend [their] life being passed from pillar to post" trying to find a service which will accept them, and that this "prevent[s] people accessing services in a timely manner," consequently leading their mental health needs to escalate.

Awareness of mental health services offered in Richmond:

Stakeholders questioned how aware service users, GPs and carers are of the mental health services which are available in Richmond. They also questioned people's comprehension of the pathways between mental health services, which were seen to be "fragmented" and "complex to understand." This included for services which are not mental health specific, but which can support people with mental health needs, such as peer support, voluntary and social prescribing groups.

Stigma of mental health:

Although declining, stakeholders considered the stigma of mental health to remain an ongoing issue in Richmond. Stakeholders highlighted the challenges that this posed for getting people to attend mental health services and suggested that this prevents mental health from being considered on parity with physical health services, which impacts on service commissioning.

Inconsistency of services in Richmond:

Stakeholders recognised that the quality of mental health services, particularly from GPs, varied significantly across Richmond. One stakeholder reported that there are areas in the borough which are "extremely poor for mental health support". This presents a geographical barrier to accessing high-quality mental health services in the borough.

Time limits to services:

Stakeholders recognised that although increasing numbers of service users are requiring long-term, if not life-long, mental health support, mental health services continue to be provided for a limited duration. Because a set service duration does not reflect individual mental health needs, stakeholders reported how service users are frequently referred back into services only a short period after being discharged. For example, one stakeholder raised that Richmond Floating Support provide their services for a maximum of two years, after which "questions are being asked." Because these time scales do not reflect individual mental health needs, "for some specific clients, you have the case being closed but you know that before the end of the month or next month that person is going to come back on the referral again because they are going to fall off the track."

Stakeholders reported that they are witnessing growing numbers of service users relapsing and returning into services following discharge because they "do not have ongoing support." It was suggested that when service users are stepped down to low support and/or primary care they become isolated and lost in the system, and support is only reignited "when they relapse, a proper relapse which is really difficult for us to witness when they are crying out for help and they have just been set aside." Stakeholders emphasised that it needs to be recognised that some service users will require long-term support, which contests the logic of unilaterally offering time-restricted services to all service users.

Inflexible Provision of Mental Health Services:

Stakeholders felt that services are provided in a "rigid" manner and need to be "more flexible and tailored to the individual".

For example, stakeholders raised that the Richmond Wellbeing Service offers service users CBT, however, service users often would prefer to receive one-to-one support. They reported that many service users do not want CBT because this "requires some motivation, homework and things", which in practice present a "massive wall [for the service user to climb] when they are feeling not very motivated to access the support and move on."

Stakeholders enforced the need to recognise that mental health "is not a one size fits all issue, so you can't make an offer and then expect everybody to make use of that offer, you need lots of different services to reach different needs." Stakeholders also emphasised that services need to be flexible to service users' need for varying levels of support across their mental health journey; "one day they might need significant help and the next day they might just need somebody to... have a warm chat with them."

Co-occurring needs:

Stakeholders suggested that services were particularly inflexible when dealing with service users with co-occurring needs, who frequently experience diagnostic overshadowing and/or denial of access to MH services. Stakeholders identified this to be affecting service users who experienced mental health issues alongside dementia diagnoses, physical health conditions, learning disabilities and substance misuse issues. One stakeholder suggested that this was due to services' "reluctance to commission things which fall outside of their parameters."

One service user described their experience of seeking support with co-occurring physical and mental health conditions:

"If you go to the mental health group, they'll say sort out your physical condition first. Then if you go to the physical group, they'll say, sort your mental health out first. So, you just get sent around the houses."

Service users resultantly feel that they are being "palmed off between services," and emphasised that they "would really like to see a no closed-door approach so that everyone gets seen."

Recruitment

Stakeholders reported a recruitment issue across the mental health workforce. For example, one stakeholder reported that they had been advertising for a clinical lead for 2-3 months and that they "just can't find them." It was felt that the recruitment issue needs to be prioritised, because even if all other needs and gaps are resolved, "who is going to provide the services?"

Vulnerable Groups

Stakeholders identified the following groups as particularly vulnerable to mental ill health and suggested that they required additional, targeted input to support their mental health.

Service users with neurodiversity and/or Learning Disability:

Stakeholders expressed concern for the growing number of service users with neurodiversity and/or LD entering the system with mental health needs.

This was felt to be a particular concern because mental health "services at the moment do not understand or know how to respond" to people with neurodiverse or LD needs. Stakeholders felt that there is currently a lack of specialised professionals to meet the co-occurring needs of service users with neurodiversity and/or LD within services, especially for those who have communication difficulties. Resultantly, these service users "find themselves being torn between mental health and autism" as "there is nowhere for these people to go" that is specific to their needs. Stakeholders variously enforced the requirement for services to adjust to meet the needs of these clients, or for a specialised service to be established to accommodate those with this dual diagnosis.

Stakeholders also identified how this demographic group often lack the language to talk about mental health; "you can see physically that someone is not in a good place, but they are not necessarily equipped with the language to talk about what's going on for them." Stakeholders enforced that more needs to be done to help support this group to develop the language to talk about their mental health and emotions.

Co-occurring substance misuse and mental health:

Stakeholders identified high levels of mental health disorder among those with substance misuse issues and suggested that their mental health needs are often highly complex and overlapping.

Stakeholders also frequently reported that this group faced additional barriers to accessing mental health services. Firstly, it was recognised to be a challenge to find

services which are skilled enough or willing to manage the complex needs of this group. Stakeholders reported how care providers find these clients particularly difficult to support with their mental health, "because you don't know what problem you are dealing with and where it is coming from."

Secondly, stakeholders noted that clients with co-occurring substance misuse and mental health issues are a hard-to-reach group, as they are often reluctant and/or unable to engage with mental health services. However, rather than receiving additional input from services as a result of this, stakeholders felt that "if they do not want to engage there is no input really from many services."

Further groups felt to be at heightened risk included:

- **Those experiencing poverty:** Financial and housing insecurity were recognised to place heightened stress on mental health. Despite the relative affluence of Richmond, stakeholders recognised there to be pockets of deprivation which are growing as a result of the cost-of-living crisis, and that these groups require additional support to prevent a growth of mental ill-health.
- **Carers:** Stakeholders suggested there to be high numbers of unpaid carers in Richmond due to the older age of the population. It was recognised that this group experiences heightened stressors on their mental health, as well as challenges to access and attend mental health services due to their care responsibilities.
- **Ethnic minorities:** Stakeholders raised concern for the high rates of DNA and incomplete treatment among ethnic minority groups, especially for higher tier services. It was enforced that more needs to be done to bring these groups into mental health services.
- **Homeless people:** Stakeholders identified a high presentation of trauma and complex needs among this group.

Key Issues Facing Older Adults' Mental Health in Richmond

Interconnections between physical and mental health:

Stakeholders emphasised the need for greater recognition of the interconnections between physical and mental health and enforced the need for an integrated approach to these issues. Recognising this link was felt to be particularly important for the older adult demographic group who experience greater physical health conditions and whose mental health issues can often go "unnoticed and unsupported" as they "tend to exclude themselves from asking for help when it is required." This need was emphasised as heightened following the COVID-19 pandemic, with reduced mobility over lockdown provoking a "vicious spiral" of physical deterioration causing mental decline, which in turn caused further physical deterioration.

Pressures on community and voluntary sector groups:

Stakeholders reported that because mental health issues among older adults tend to go "unnoticed and unsupported", they are commonly left to be supported by smaller community and voluntary sector groups. This is placing undue pressure on community and voluntary sector groups, who are "not equipped to deal with this," whilst also leaving older adults with their needs not being adequately met.

Social isolation and loneliness:

Stakeholders identified a "high incidence of isolation and depression" among older adults in Richmond which, although recognised as a significant issue beforehand, was exacerbated by the COVID-19 pandemic. Stakeholders particularly highlighted the impact of reduced community groups and activities, which have still not returned to their pre-pandemic operation. It was suggested that the ramifications of older adults' increased loneliness and isolation will become an increasing problem that is not going to go away anytime soon.

Access to services:

As services move increasingly online, stakeholders enforced the need to recognise the barrier that this may pose to some older adults, especially for those with physical or mental conditions which make it harder to use digital technologies. It was enforced that provisions need to be made for those who cannot use digital technologies to ensure they are not resultantly restricted from accessing mental health services.

Dementia:

Stakeholders reported dementia to be a heightened issue in Richmond due to the large population of older residents. Stakeholders identified the dementia diagnostic rate to have escalated in the aftermath of COVID-19, and that people are presenting later and with more advanced needs than previously. Stakeholders consequently emphasised the need for more post-diagnostic mental health support for the service user and their families during this stressful and anxiety-inducing period.

Beneficial Services for Adults and Older Adults' Mental Health in Richmond

Stakeholders identified the following existing services in Richmond as beneficial to people's mental health:

- **Richmond Borough MIND:** a local community organisation which offers a range of services to support people's mental health. Services offered include a helpline, psychotherapy and counselling, a peer group network and support for carers. Stakeholders particularly praised MIND for the flexibility of their service offering.

- **RUILS:** a user-led charity which supports disabled children and adults and people with long-term health and mental health conditions to live a full, connected and independent life. Services include community and befriending activities, direct payment support, social prescribing and counselling.
- **FISH:** an organisation which aims to combat loneliness and social isolation in older and vulnerable people living in Barnes to enable them to live independent and dignified lives. Services include a helpline, transportation assistance, befriending, community activities and classes.
- **Richmond AID:** a charity run by and for people with disabilities, including physical and sensory impairments, mental health issues and learning difficulties, to provide information and advice on disability.
- **Southwest London Recovery Café:** offers a safe, inclusive and welcoming space for adults who are struggling with their mental health. The café is a drop-in service, where individuals can be supported to develop a safety plan and talk through resilience and/or coping mechanisms.
- **The Alzheimer's Society Dementia Support Service:** provides post-diagnostic information, guidance and support for patients with dementia and their carers and/or families.
- **Dose of Nature:** provides mental health support through encouraging people to engage with nature.
- **24/7 Mental Health Crisis Line:** offers emotional support and advice to people who are affected by urgent mental health issues, 24 hours of the day.

Strategic Priorities for Improving Adults and Older Adults' Mental Health in Richmond

Stakeholders identified the following treatment approaches as beneficial to adults' mental health, and enforced the need to make these strategic priorities over the coming years:

- **Prevention and early intervention:** Stakeholders repeatedly emphasised the importance of prevention and early intervention due to recognition that "the quicker that something is picked up, there is a better chance of recovery and success."
  - Regarding prevention, stakeholders enforced the importance of promoting and creating the conditions which enable good mental health and wellbeing, particularly in the community and workplaces. Stakeholders also recognised the need to provide practical support to tackle the social determinants of mental ill health, such as income, food and housing insecurity, particularly in the context of the cost-of-living crisis.
  - Regarding early intervention, stakeholders enforced the importance of services such as primary care, GPs and IAPT to detect and respond to mental health disorders when in their early stages. Stakeholders enforced the need for more input into these services to cope with escalating demands.
- **Voluntary sector organisations and groups:** Stakeholders multiply praised the wealth of voluntary sector organisations and groups in Richmond which directly and indirectly support the mental health of their service users. It was commonly felt that more funding and resources should be directed into these groups.
- **Social connections:** Respondents also frequently enforced the importance of social connection for those with mental health issues. This included peer support groups, face-to-face activities and befriending services, as well as general social contact with friends and the community.
- **Integrated approach to mental health:** stakeholders enforced the importance of an integrated approach to mental health, whereby a service users' health needs are considered holistically rather than broken down and compartmentalised into multiple distinct diagnoses.
- **Collaboration between services:** Stakeholders enforced the importance of strengthening the capacity for partnership working between the various services in the borough, because "how we work together is important for providing a seamless service for our service users." This was felt to be vital to streamline the patient journey, improve communication and establish a network of support around a service user. Service collaboration was recognised to be particularly important for service users with complex, co-occurring and long-term needs.
- **Expanding mental health support:** It was commonly felt that all services, whether targeted at mental health or not, should seek to promote, normalise and talk about mental health with service users.
- **Relationship between services and service users:** Stakeholders emphasised the importance of establishing good relationships between service users and mental health support workers to create the conditions for trust and good rapport to be established.
- **Consistent support network:** For neurodiverse service users, it was recognised to be particularly important that they have a consistent staff team around them to recognise changes in their mental health and to prevent any additional anxiety which may be caused by frequently meeting new people.

To specifically support older adults' mental health, stakeholders felt that the following also need to be strategically prioritised over coming years:

- **Integrated approach to physical and mental health:** given the interconnections between physical and mental health, an integrated and holistic approach to health should be at the forefront of the local Health and Care Plan for older adults. Stakeholders recommended that when presenting to services, Older Adults should have their health inspected holistically, including their physical and mental health, and social care. Stakeholders also felt that older adults should be assisted to navigate through services and their proposed care plan.
- **Voluntary sector services and groups:** more resources and training should be provided to voluntary sector services and groups to increase their capacity to support older adults' mental health.

Stakeholder Consultation: Key Findings

During consultations, stakeholders identified the following key issues facing adults:

- It was commonly felt that mental health conditions among adults in Richmond were increasing in prevalence, complexity, acuity and longevity.
- Although a significant issue beforehand, the COVID-19 pandemic was felt to have had dramatic adverse impacts on mental health needs, both directly through stressors of the pandemic and indirectly through escalated challenges of accessing mental health services.
- There is a dearth of services to support the needs of complex clients, particularly those with PTSD, Personality Disorders and/or co-occurring needs.
- There are long waiting lists to access services, which causes service users' needs to escalate and to spend longer times within services when eventually accessed.
- The thresholds for acceptance to services pose a significant barrier to access, particularly for service users whose needs sit between tiers and are multiply rejected by services.
- There is a lack of awareness of the services available in the borough.
- Although service users increasingly require long-term mental health support, services continue to be provided for a limited duration, which leads service users to relapse.
- Services need to be provided in a more flexible and individualised manner, particularly for those with co-occurring needs.
- There is a recruitment issue across the mental health workforce.
- The following groups were identified as particularly vulnerable to mental ill-health and requiring additional, targeted support; service users with neurodiversity and/or LD; service users with co-occurring substance misuse and mental health issues; those experiencing poverty; carers; service users from ethnic minority backgrounds; and homeless people.

During consultations, stakeholders identified the following key issues facing older adults:

- There is a high incidence of isolation and depression among older adults in Richmond, which was exacerbated by the COVID-19 pandemic.
- Mental health needs among older adults tend to go unnoticed and unrecognised.
- The unrecognised mental health needs of older adults are placing undue pressure on community and voluntary sector groups, who are left to support their needs.
- There is a need for greater recognition of the interconnections between physical and mental health and an integrated approach towards this.
- The movement toward providing services online may pose a barrier to some older adults.
- Dementia is a heightened issue in Richmond due to the large population of older residents.

Conclusion

This needs assessment set out to systematically understand the mental health problems facing the population of Richmond across the life course, how services are meeting that need and identify where gaps exist and areas that require improvement. Since the last comprehensive mental health needs assessment over a decade ago, the profile of mental health has increased significantly, none more so than over the COVID-19 pandemic when the experience of lockdown, illness, isolation, and the loss of life impacted on the mental health and wellbeing of the entire population.

This report provides evidence that mental health need and demand for services is increasing in Richmond. It proposes a number of recommendations to address the current challenges and ensure that the residents of Richmond are provided with safe and effective mental health services that meet their needs.

Appendix

Stakeholder Engagement: Focus Group Discussion Guides

Multi-Agency Focus Groups

Focus Group Questions

Question 1

To start the discussion please tell us your views about 'Mental Health and Well-being in Richmond.' This can be anything that comes into your mind. You can use stories or examples to help us understand your views.

Question 2

What are the most important mental health issues for you now, for the service you work for and the people you work with?

Question 3

Do you have any examples of services that can stop people from getting unwell in the first place? Do you have examples of services that help people who become unwell to get better and to stay better?

Question 4

Are there any groups of people whose mental health you are particularly worried about? Tell us more about your worries?

Question 5

What things can be done to make people's mental health better in the future?

Do you have anything to share?

Service User Focus Groups

Focus Group Questions

Question 1

Please tell us your views about 'Mental Health and Well-being in Richmond You can use stories and examples to help us understand.

Question 2

How much is mental illness an issue today in your community (family/friendship group/ school/workplace?)

Question 3

Do you have examples of support and services that have helped you or your family and friends - What things can help people recover from mental illness?

Question 4

What things stop people from getting the help they need?

Question 5

What needs to change to improve poeple's mental health?

Question 6

Are there any groups of people that need extra help with their mental health?

Are there any final comments?

Estimated Mental Health Need Among Children and Young People in Richmond

Mental Health Disorders'

Table 176: Estimated number of CYP in Richmond aged 5-19-years-old with a mental disorder by type, age and sex

Type of disorder	5 to 10 year olds			11 to 16 year olds			17 to 19 year olds		
	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Emotional disorders	388	295	685	547	802	1,351	223	626	840
Anxiety disorders	371	280	652	480	713	1,195	177	567	736
Separation anxiety disorder	83	90	173	58	28	86	Data not available		
Generalised anxiety disorder	104	17	122	80	161	241	54	128	180
Obsessive compulsive disorder	10	11	21	56	42	98	20	18	39
Specific phobia	55	78	132	60	73	133	12	24	36
Social phobia	13	15	28	59	97	156	28	74	101
Agoraphobia	4	Data not available	4	18	55	73	18	79	95
Panic disorder	4	Data not available	4	49	121	170	41	156	194
Post-traumatic stress disorder	16	17	34	26	62	88	10	66	75
Body dysmorphic disorder (BDD)	8	4	13	12	136	149	23	157	177
Other anxiety disorder	125	74	200	94	160	254	34	95	127
Depressive disorders	31	19	50	126	283	410	91	183	271
Major depressive episode	21	11	32	79	205	285	69	131	198
Other depressive episode	10	8	18	47	78	125	22	52	73
Bipolar affective disorder	Data not available			4	Data not available	4	Data not available	7	7

Table 177: Estimated number of CYP in Richmond aged 5-19-years-old with a behavioural disorder by type, age and sex'

Type of disorder	5 to 10 year olds			11 to 16 year olds			17 to 19 year olds		
	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Behavioural disorders	564	263	832	574	368	941	29	15	45
Oppositional defiant disorder	395	208	606	301	220	520	20	Data not available	20
Conduct disorder confined to family	15	11	26	Data not available	13	14	Data not available		
Unsocialised conduct disorder	31	18	50	54	38	92	Data not available		
Socialised conduct disorder	47	4	52	147	74	220	10	2	12
Other conduct disorder	75	22	98	72	23	95	Data not available	13	12

Table 178: Estimated number of CYP in Richmond aged 5-19-years-old with a hyperactivity disorder by type, age and sex'

Type of disorder	5 to 10 year olds			11 to 16 year olds			17 to 19 year olds		
	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Hyperactivity disorders	220	63	286	248	54	301	44	Data not available	45
Hyperkinesis	204	59	265	201	49	249	24		24
Other hyperactivity disorder	16	4	21	47	5	52	20		20

Other Less Common Disorders

Table 179: Estimated number of CYP in Richmond aged 5-19-years-old with an other less common mental health disorder by type, age and sex

Type of disorder	5 to 10 year olds			11 to 16 year olds			17 to 19 year olds		
	Boys	Girls	All	Boys	Girls	All	Boy	Girls	All
Other less common disorders	284	78	366	185	146	331	39	62	100
Pervasive Developmental Disorder (PDD)/ Autism Spectrum Disorder (ASD)	211	32	245	137	48	184	27	0	28
Eating disorders	5	4	9	18	71	89	0	45	44
Tics/other less common disorders	136	52	190	64	31	95	12	23	35

Children and Young People: Service Activity

Single Point of Access

Table 180: Referrals to CYP Single Point of Access by age between 2018/19 and 2021/22

Age	Year			
	2018/2019	2019/2020	2020/2021	2021/2022
0-4 ALL	62	47	47	27
5-10 ALL	861	853	584	508
11-16 ALL	1,159	1,246	1,165	1,127
17-19 ALL	163	166	189	173
ALL	**2,245**	**2,252**	**1,985**	**1,835**

Table 181: Referrals to CYP Single Point of Access by ethnic group between 2018/19 and 2021/22'

	Asian or Asian British	Black or Black British	Mixed	Not Stated	White	Other Ethnic Groups	Unknown	Blank
2018/19	80	38	194	39	1298	51	542	<5
2019/20	90	36	210	17	1507	106	331	19
2020/21	72	34	140	22	1270	127	290	35
2021/22	88	27	87	19	1179	156	241	40

Estimated Mental Health Need Among Adults in Richmond

Common Mental Disorders

Table 182: Estimated number of adults in Richmond with a common mental disorder by age, sex and type of disorder, based on national prevalence estimates

Common Mental Disorder (CMD)		Age							
		16-24	25-34	35-44	45-54	55-64	65-74	75+	All
All adults	Generalised anxiety disorder	1001	1292	2220	2323	1521	699	363	9,251
	Depressive episode	365	741	1,319	1,432	1,022	367	189	5,174
	Phobias	524	699	965	859	547	105	73	3,763
	Obsessive compulsive disorder	286	296	515	509	356	52	44	2,038
	Panic disorder	191	106	97	159	119	122	87	941
	CMD-Not otherwise specified	1,334	1927	2,638	2,769	1,925	908	711	12,230
	Any CMD	**3,002**	**4,024**	**6,208**	**6,078**	**4,277**	**2,008**	**1,278**	**26,655**
Men	Generalised anxiety disorder	306	609	1,049	944	725	164	55	3,694
	Depressive episode	73	416	417	661	491	197	18	2,186
	Phobias	105	284	386	362	140	58	18	1,357
	Obsessive compulsive disorder	97	112	262	220	82	25	18	829
	Panic disorder	32	30	31	16	82	33	18	226
	CMD-Not otherwise specified	451	802	941	881	795	288	231	4,372
	Any CMD	**806**	**1,767**	**2,515**	**2,172**	**1,823**	**666**	**341**	**9,950**
Women	Generalised anxiety disorder	705	694	1171	1367	809	536	304	5,536
	Depressive episode	298	309	920	772	531	176	169	3,012
	Phobias	423	419	586	482	398	46	51	2,443
	Obsessive compulsive disorder	188	176	268	289	254	37	17	1,221
	Panic disorder	172	66	50	129	48	83	67	651
	CMD-Not otherwise specified	885	1124	1724	1898	1135	638	481	7,816
	Any CMD	**2,208**	**2,282**	**3,732**	**3,892**	**2,439**	**1,358**	**928**	**16,853**

Table 183: Estimated number of adults in Richmond with a Common Mental Disorder in the past week, by type of disorder and ethnic group, based on national prevalence

CMD		Ethnic group				
		White British	White Other	Black/ Black British	Asian/ Asian British	Mixed, multiple and other
Men	Generalised anxiety disorder	2774	197	58	264	74
	Depressive episode	1600	134	19	158	97
	Phobias	853	63	37	137	130
	Obsessive compulsive disorder	427	236	41	92	Data not available
	Panic disorder	213	Data not available	Data not available	Data not available	Data not available
	CMD-Not otherwise specified	3041	583	76	310	183
	Any CMD	**7041**	**1072**	**144**	**626**	**410**
Women	Generalised anxiety disorder	3811	552	83	388	117
	Depressive episode	2014	318	87	158	58
	Phobias	1688	127	45	237	64
	Obsessive compulsive disorder	817	170	17	73	46
	Panic disorder	327	21	31	146	71
	CMD-Not otherwise specified	5117	743	206	504	503
	Any CMD	**11106**	**1602**	**368**	**1292**	**798**
All adults	Generalised anxiety disorder	6575	740	144	647	187
	Depressive episode	3665	444	110	323	157
	Phobias	2587	185	82	368	193
	Obsessive compulsive disorder	1293	425	55	167	48
	Panic disorder	539	18	33	123	66
	CMD-Not otherwise specified	8192	1331	291	792	674
	Any CMD	**18215**	**2663**	**530**	**1840**	**1192**

Psychotic Disorder

Table 184: Estimated number of adults in Richmond with a Psychotic Disorder by age and sex, based on national prevalence

		Age							
		16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Psychotic disorder in the past year	Men	16	30	154	79	82	8	Data not available	377
	Women	39	88	151	80	97	28	17	489
	All adults	64	127	322	159	166	35	15	784
Probable psychotic disorder	Men	16	91	185	110	105	25	18	528
	Women	55	121	184	161	72	28	8	651
	All adults	79	212	354	255	190	52	29	1,098

Table 185: Estimated number of adults in Richmond with a Psychotic Disorder by ethnic group and sex, based on national prevalence'

Psychotic disorder	Ethnic group			
	White	Black	Asian	Mixed/other
Men	132	32	60	Data not available
Women	296	Data not available	22	Data not available
All adults	432	29	91	Data not available

Bipolar Disorder

Table 186: Estimated number of adults in Richmond showing characteristics of bipolar disorder in their lifetime by age, sex and number of symptoms, based on national prevalence'

A positive screen for bipolar disorder requires at least 7 lifetime manic/hypomanic symptoms, as well as several co-occurring symptoms and moderate or serious associated functional impairment.

Number of bipolar disorder characteristics on the Mood Disorder Questionnaire		Age							
		16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Men	0-6	6,131	8,976	14,074	14,717	10,823	7,879	6,005	6,7916
	7+	1,925	1,178	1,358	1,023	865	345	79	7,462
	7+ and several at same time	902	843	833	708	444	173	12	4,221
	7+ and several same time and this caused problems	250	315	448	331	187	33	Data not available	1,583
Women	0-6	6,162	9,921	15,681	15,085	11,614	9,083	8,324	75,148
	7+	1,668	1,102	1,054	997	459	157	110	6,269
	7+ and several at same time	806	871	736	466	302	65	34	3,664
	7+ and several same time and this caused problems	290	342	318	193	157	37	Data not available	1,466
All adults	0-6	12,296	18,890	29,722	29,817	22,454	16,958	14,329	14,3154
	7+	3,590	2,287	2,445	2,005	1,307	506	189	13,641
	7+ and several at same time	1,716	1,715	1,576	1,177	760	244	44	7,840
	7+ and several same time and this caused problems	540	656	772	509	356	70	Data not available	3,136

Suicidal Thoughts, Suicide Attempts and Self-harm

Table 187: Estimated number of people in Richmond experiencing suicidal thoughts, self-harm, suicidal attempts in terms of sex and age, based on national prevalence

		Age							
		16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Men	Suicidal thoughts	1,555	2,142	3,256	3,258	2,630	979	432	14,096
	Suicidal attempts	435	812	1,003	850	631	288	61	4,070
	Self-harm	781	1,107	1,019	519	386	164	Data not available	4,297
Women	Suicidal thoughts	2,709	2,657	3,816	4,278	2,765	1,081	742	18,237
	Suicidal attempts	994	1,003	1590	1319	1038	342	177	6,513
	Self-harm	2,012	1,455	1,540	804	604	166	51	7,246
All adults	Suicidal thoughts	4,257	4,786	7,045	7,542	5,394	2,061	1,176	32,300
	Suicidal attempts	1,430	1,800	2,573	2,164	1,663	629	247	10,505
	Self-harm	2,780	2,562	2,541	1,305	974	332	44	11,446

Table 188: Estimated number of adults in Richmond experiencing suicidal thoughts, suicide attempts and self-harm by ethnic group and sex

Suicidal thoughts, suicide attempts and self-harm		Ethnic group				
		White British	White other	Black/Black British	Asian/ Asian British	Mixed, multiple and other
Men	Suicide thoughts	10,242	1,490	283	651	316
	Suicide attempts	2,774	473	150	300	74
	Self-harm	2,827	631	92	351	94
Women	Suicide thoughts	12,413	2,048	258	983	903
	Suicide attempts	4,464	658	61	419	325
	Self-harm	5,172	520	67	467	255
All adults	Suicide thoughts	22,635	3,532	537	1,606	1,198
	Suicide attempts	7,222	1,128	203	714	391
	Self-harm	8,084	1,165	157	814	343

Autism

Table 189: Estimated number of adults in Richmond with autism by age and sex

Autism	Age				
	16-34	35-54	55-74	75+	All
Men	401	62	239	Data not available	829
Women	132	Data not available	Data not available	Data not available	163
All adults	556	64	247	Data not available	1,098

ADHD

Table 190: Estimated number of adults in Richmond with ADHD by age and sex

The 2014 survey is based on the six-item Adult ADHD Self-Report Scale (ASRS). A score of 4 or more means a positive screen for ADHD.

ASRS score		Age							
		16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Men	4 or more	1,225	1,543	1,435	1,558	1,017	280	201	7,538
	All 6	153	61	77	94	129	Data not available	Data not available	528
Women	4 or more	1,104	1,003	1,958	1,833	1,111	462	295	7,735
	All 6	149	121	67	64	48	9	Data not available	489
All adults	4 or more	2,319	2,584	3,378	3,405	2,138	733	494	15,209
	All 6	302	169	161	159	190	0		1,098

Dependent drinking

Table 191: Estimated number of adults in Richmond experiencing dependent drinking, by age, sex and severity

AUDIT score		Age							
		16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Men	Non-drinkers	2,143	1,645	3,410	2,109	1,893	1,225	1,478	14,096
	Low risk (AUDIT score 1-7)	3,335	5,219	7,731	9,727	6,218	5,510	4,113	41,383
	Hazardous drinking (AUDIT score 8-15)	2,159	2,620	3,333	3,274	3,132	1,357	456	16,508
	Harmful drinking/mild dependence (AUDIT score 16-19)	258	366	478	362	316	82	Data not available	1,884
	Probable dependence (AUDIT score 20+)	161	305	478	283	129	41	37	1,432
	8 or more	**2,578**	**3,290**	**4,275**	**3,904**	**3,577**	**1,489**	**493**	**19,824**
	16 or more	**419**	**670**	**941**	**645**	**444**	**132**	**37**	**3,317**
Women	Non-drinkers	1,589	3,053	4,334	3,377	2,680	2,846	3,812	21,738
	Low risk (AUDIT score 1-7)	4,228	6,338	10,024	10,550	7,823	5,812	4,428	48,769
	Hazardous drinking (AUDIT score 8-15)	1,754	1,378	1,975	1,882	1,328	517	194	9,444
	Harmful drinking/mild dependence (AUDIT score 16-19)	164	187	251	161	157	55	Data not available	1,058
	Probable dependence (AUDIT score 20+)	86	55	151	113	72	9	Data not available	489
	8 or more	**2,004**	**1,631**	**2,376**	**2,155**	**1,569**	**582**	**194**	**10,910**
	16 or more	**251**	**243**	**402**	**257**	**229**	**65**	**Data not available**	**1,466**
All adults	Non-drinkers	3,733	4,659	7,720	5,473	4,586	4,034	5,285	35,749
	Low risk (AUDIT score 1-7)	7,562	11,541	17,724	20,271	14,067	11,334	8,551	90,157
	Hazardous drinking (AUDIT score 8-15)	3,908	4,045	53,40	5,155	4,443	1,904	653	26,028
	Harmful drinking/mild dependence (AUDIT score 16-19)	429	551	740	509	475	140	Data not available	2,979
	Probable dependence (AUDIT score 20+)	238	360	643	382	190	52	44	1,882
	8 or more	**4,591**	**4,977**	**6,723**	**6,078**	**5,109**	**2,096**	**682**	**30,889**
	16 or more	**667**	**932**	**1,383**	**891**	**665**	**192**	**44**	**4,861**

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