Restoration and Recovery planning for Children and Young People's Mental Health Services Interactive Webex

1000-1200
22nd July 2020

South East Region

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Housekeeping

- This webinar is a live event, therefore you will be on mute unless you are a designated speaker
- The webinar will be recorded and sent to participants after the event.
- Please use the chat function to ask any questions and for discussion. We will cover as many questions as possible during the Q and A sections
- If you can't access the chat box, please email Rebecca.furlong@nhs.net and we can pick up your questions
- Any questions we aren't able to answer in the session we will follow up separately

Introduction – Purpose of Webinar

- This webinar will focus on considerations in the ongoing development of restoration and recovery plans for children and young people's mental health services in response to Covid-19
- This webinar is being arranged to help all systems across the South East and can be used by all providers and commissioners of children's mental health services
- The first aim of the webinar is to focus on evidence/data that might inform restoration and recovery planning, how evidence is understood and interpreted, and how this might translate into predictive modelling of changes to demand for CYP MH services in response to Covid-19
- Building on this, the second aim of the webinar is to share practice examples of predictive modelling, and restoration and recovery plans, from services

South East Mental Health, Learning Disabilities and Autism Cell
Recovery and Restoration planning for Children and Young People's Mental health services
Wednesday 22nd July 2020
1000-1200
Agenda

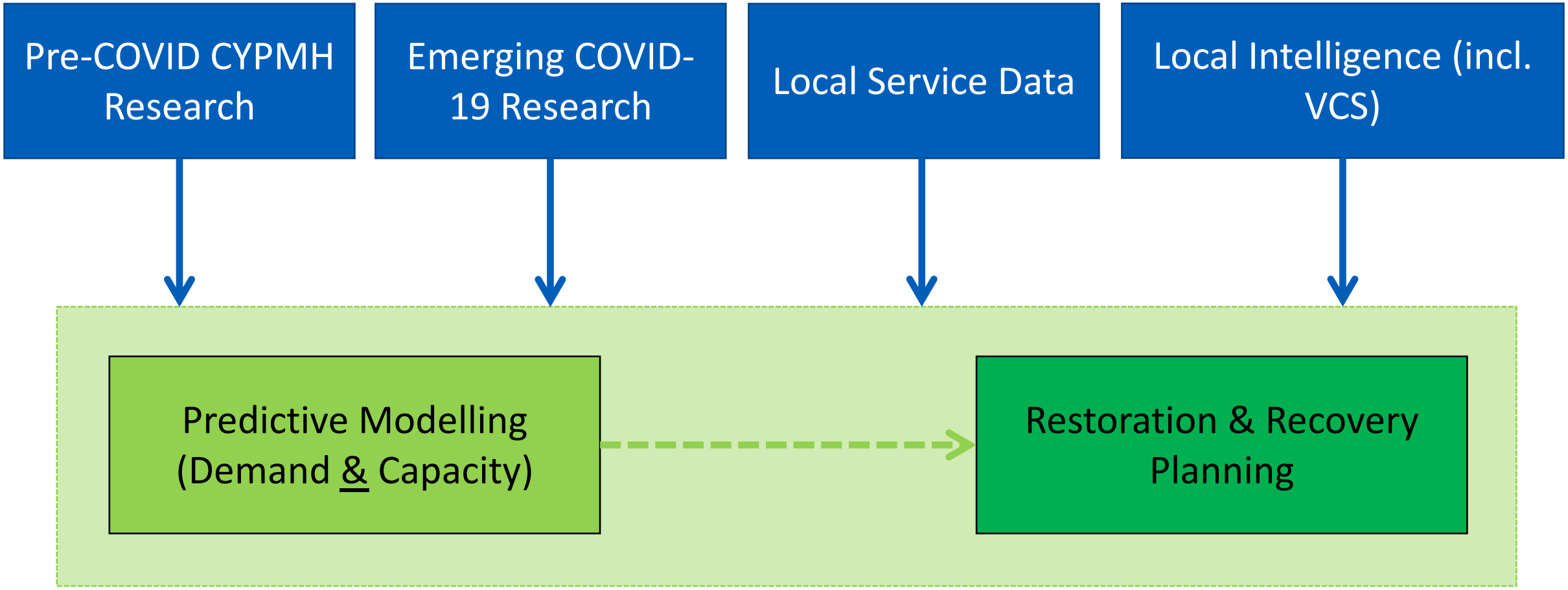
Item No.	Agenda Item	Timings
1.	Welcome & introductions – Becky Furlong Senior Quality Improvement Manager Purpose of the webinar – Dr Gavin Lockhart SE Clinical Lead CYP MH	1000-1010
1.	NHS E National CYP MH team 2020 Refresh Local Transformation plans and the impact of Covid-19	1010-1020
1.	**Section 1: Predictive Modelling** Evidence/data that might inform predictive modelling, and restoration and recovery planning Navigating and interpreting evidence Headlines from "live" literature review Update on predictive modelling work Predictive modelling & literature review Q&As	1020-1100
3	**Part 2** **Restoration and Recovery plans:** Systems sharing examples of recovery and restoration plans • Hampshire Children and Adolescent Mental Health Services modelling and framework to support recovery and restoration planning - 20 mins **Lao Cooper** **Head of Service** Hampshire Child and Adolescent Mental Health Service **Mandy Burton** **Clinical Lead and Nurse Consultant** for Hampshire Child and Adolescent Mental Health Services (CAMHS). • Oxfordshire's approach to support recovery and restoration planning - 20 mins **Andrea Shand** **Head of Service- CAMHS & ED Transformation** Oxon & BSW Mental Health Directorate Oxford Health NHS Foundation Trust **Lajla Johansson, Senior Commissioning Manager**, Oxfordshire CCG	1100-1140
4	Conclude Webinar • Restoration & Recovery Plans Q&A • Sharing plans from other systems • Identified Workforce Needs • Support for staff wellbeing as part of Restoration and Recovery • Next Steps/Further Support Requests	1140- 1200

Predictive Modelling for CYP MH in the Context of Covid-19

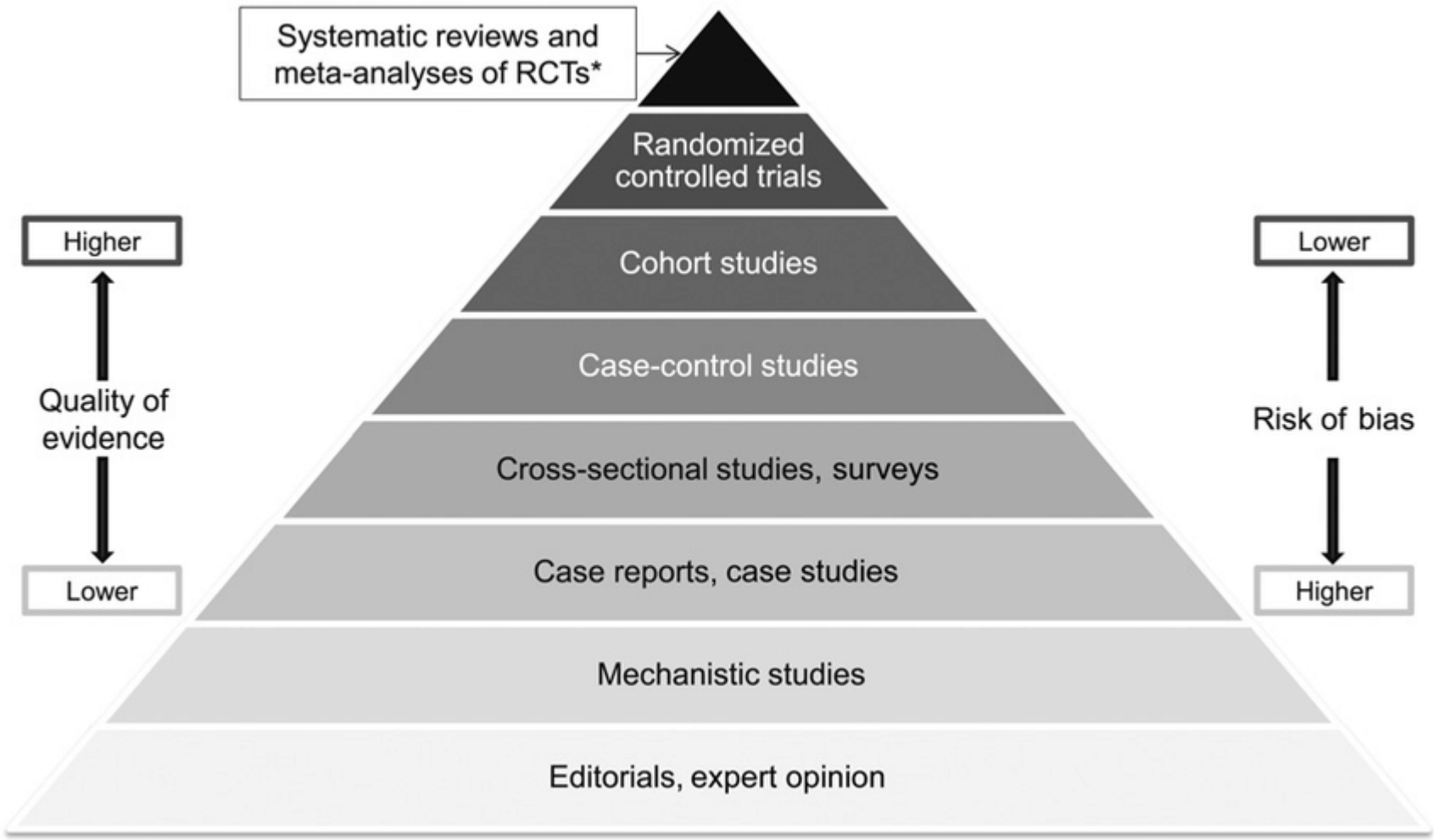
Dr Gavin Lockhart
Consultant Clinical Psychologist: Clinical Lead for CYP Mental Health
(NHSE South East MHLDA Cell & Health Education England – Kent, Surrey & Sussex)

NHS England and NHS Improvement

Evidence/Data Supporting Predictive Modelling and Restoration & Recovery Plans



Hierarchies of Evidence



Navigating and Interpreting Pre-Existing CYP MH Research

- Although Covid-19 is unprecedented there is pre-existing research into factors that we might consider a “best approximation”, and their impact on CYP MH (e.g. prior pandemics, quarantine/social isolation)
- Considerations in interpreting these and applying to the current situation:
  - How directly comparable the conditions were (e.g. pandemic vs. terrorist incident)
  - Are prevalence rates similar across these studies?
  - Methodology and how MH has been assessed/measured
  - Sample characteristics (number, age, representative, nationality)
  - Whether other influences on MH were controlled for
  - Whether they tracked young people over time

Navigating and Interpreting Emerging Findings from Covid-19 CYP MH Studies (1)

Key considerations and cautionary notes:

- How representative is the sample?
- How is MH assessed/measured?
- Do they have a baseline, pre-Covid, measure of MH for YP in their sample?
- At what time-point during the pandemic was MH measured?
- Are reported MH “scores” or symptoms at a level that would likely require support/ intervention (now or if persisted)?
- Mean scores (average scores for a sample or group) are limited:
  - They do not capture the spread or range of scores (e.g. CYP at the extremes)
  - When used to report “change over time” they provide a group average but NOT how individual young people’s mental health alters over time
- Where change scores or “statistically significant differences” are reported, this is not necessarily clinically meaningful – e.g. scores may have reduced but still fall in the same clinical range (e.g. “mild”)

Navigating and Interpreting Emerging Findings from Covid-19 CYP MH Studies (2)

We need to be realistic that studies have often been implemented rapidly, so methodology may not be as robust

- There are a number of large-scale UK and international studies that show promise – we are closely monitoring these
- We can still interpret emerging findings with caution and look at:
  - Common themes across emerging studies (e.g. rates of specific difficulties, groups more at risk)
  - Common themes overlapping with relevant pre-Covid research (viewing “through the lens” of prior findings)

Headlines from “Live” Literature & Data Review (1)

General Population

- Prior studies of pandemics and quarantine/social isolation suggest potentially up to 1/3 of CYP require MH services (or up to 5x more likely to require services)
  - Increasing number of surveys identify social isolation and loneliness as key concern for CYP during current pandemic
- Prior studies of pandemics, quarantine/social isolation, disasters, bereavement, ICU and emerging COVID-19 studies suggest:
  - Largest increase will potentially be in **depression** and this may be a longer-lasting problem. Teenage females and CYP of black of mixed ethnicity might be more at risk
  - Some increase in **anxiety.** Potential spike on return to school. Less clear evidence on whether it will be a sustained issue. Males possibly more at risk
  - Rates of **PTSD** likely to rise. Hard to estimate degree as multiple risk factors. Again likely to be longer lasting

Headlines from “Live” Literature & Data Review (2)

General Population (cont’d)

- Emerging COVID-19 studies
  - No current studies producing findings on **SMI in CYP**. Service level data indicates significant increases in new referrals for eating disorders, and high complexity, acuity and physical risk in these referrals. Referral data on psychosis is mixed, with many reported increases but some decreases
  - Survey data suggests increases in **behavioural difficulties**, particularly for CYP with SEN. However, few published findings use validated measures
  - **Family functioning** is a key factor
  - Compelling evidence from prior and emerging studies that **supportive adults serve a protective function and when adults (parents/carers or teachers) are struggling or perceived to be, CYP struggle more**

Headlines from “Live” Literature & Data Review (3)

Vulnerable Groups

- Pre-COVID prevalence studies (e.g. NHS Digital, 2018) highlight groups with higher rates of MH disorder and there is no evidence to suggest that these groups are any less at risk now – numbers of CYP in some of these groups likely to have increased (e.g. low income families)
- **Bereaved CYP** around 4x more likely to experience depression and at risk of PTSD but support around acute grief reactions can mitigate some of this risk. Hard to obtain accurate figures on prevalence of prolonged complex grief and these are likely to be underestimates anyway in the current context
- Some emerging evidence on CYP with **pre-existing MH difficulties**
- Very little evidence regarding certain groups (e.g. CYP in the care system)
- Teenage females, CYP of black or mixed ethnicity, CYP of keyworkers, bereaved CYP and those in previously known groups at higher risk of MH disorders potentially most at risk

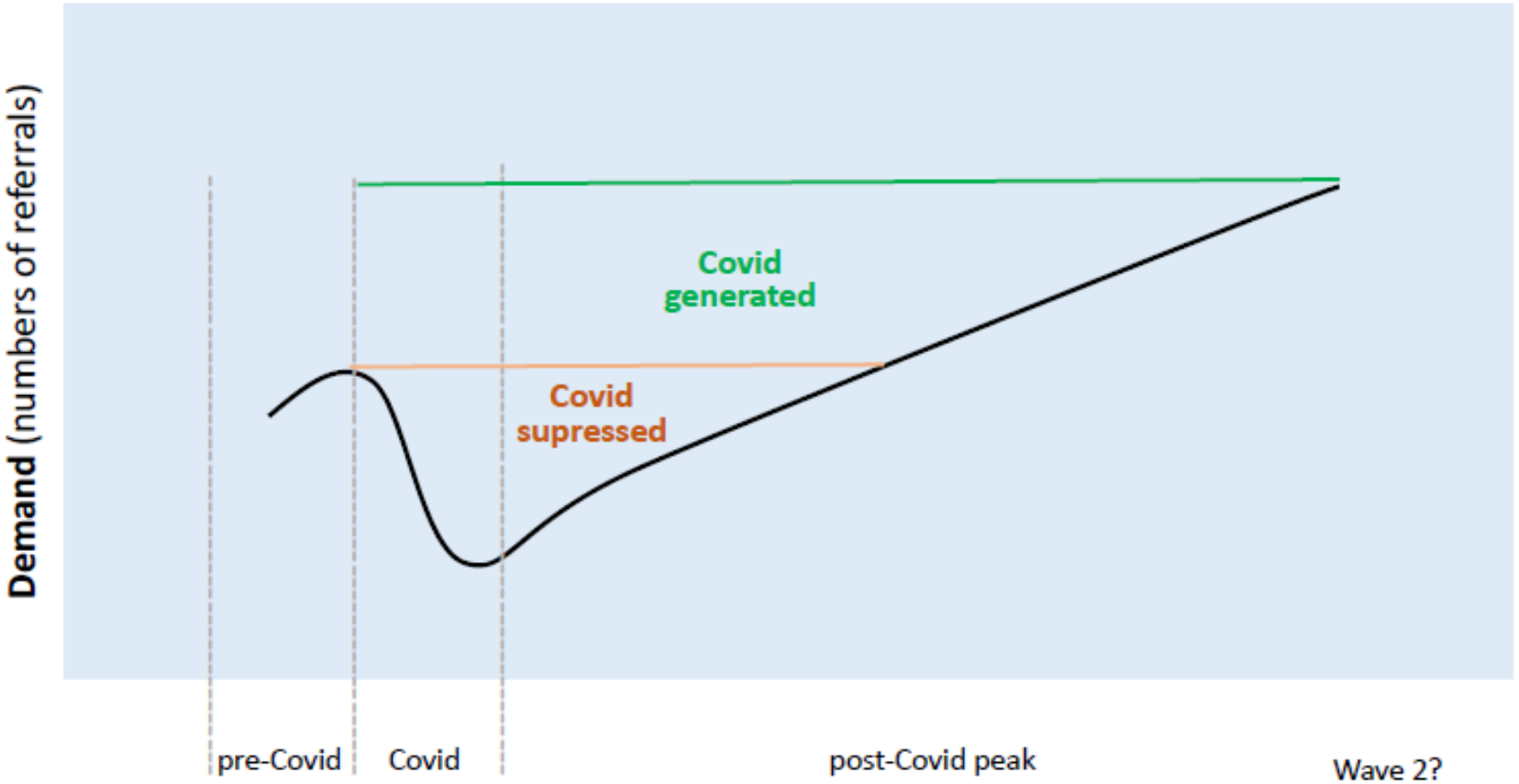
Suggestions from “Live” Literature & Data Review (1)

1. Restoration & recovery plans need to be integrated across statutory and VCS
2. Ideally CYP and adult MHEW support linked or integrated
3. Could we build on concept of “wellbeing hubs” (adult) - schools critical
   - Community-based screening
   - Signposting to support/advice
   - Supporting lower-level difficulties (e.g. bereavement reactions)
   - Clear pathways and thresholds to specialist care
4. CYP sense of connectedness is crucial
5. Wellbeing support for adults (parents/carers & teachers) critical
6. Building capacity outside of specialist CAMHS for effective, evidence-based, treatment of high incidence MH disorders potentially likely to show largest increase

Suggestions from “Live” Literature & Data Review (2)

7. Specialist CAMHS
   - Possibly surge (COVID suppressed & generated demand) around September but some difficulties longer to emerge or be recognised
     - Some suggestion difficulties peak in first year but longitudinal studies have extended as much as 9-25 years
   - Re-engaging CYP not able to engage with remote offer
   - Routinely screening for bereavement, trauma incidents and trauma symptoms, and maintaining awareness of heightened grief responses
   - Routinely screening parental mental health
   - Understanding potential increase in both high and low incidence difficulties and establishing sufficient skillset in the workforce to offer effective, evidence-based treatments for these
   - Supporting discharge whilst working remotely
   - Monitoring increase in contacts and factoring into demand-capacity modelling
   - Staff wellbeing
   - Both predictive modelling and R&R planning need to be fluid and iterative

Predictive Modelling of Demand



Covid-supressed
People who we would have expected to be referred to our services, had Covid-19 not occurred.

It is assumed these people will seek support from services over time.

Covid-generated
People not yet known to us, whose experiences of Covid, both direct and indirect, has caused them to develop a degree of mental illness.

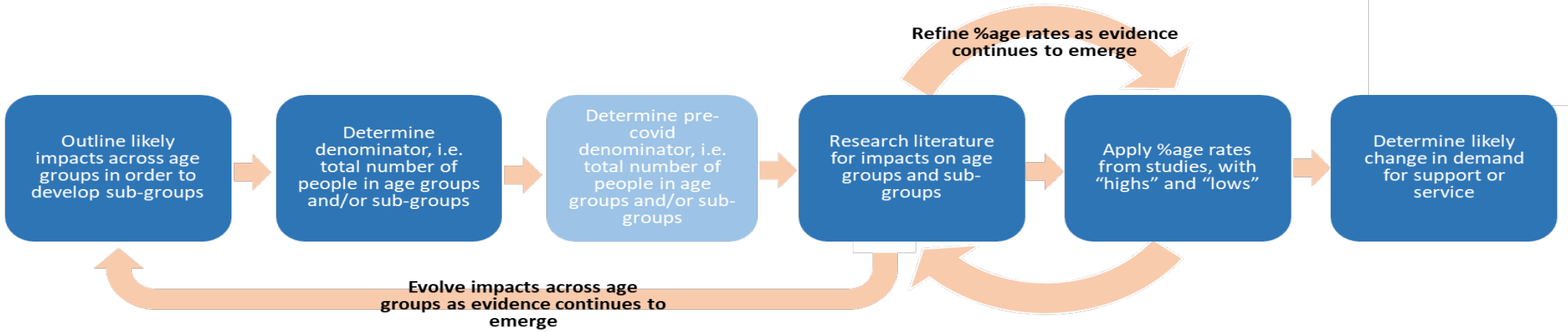
Covid-altered intervention
Service users in this group have remained in contact with services, but have received a changed intervention, i.e. telephone and/or video call. For some, this will result in a change in their mental health.

Considerations in Predictive Modelling

1. Predictive modelling is a “best estimate” so inexact and imperfect – do you model best and worst case scenarios, a mid-point, or all of the above?
2. Do you model for the whole service, care pathways, or both?
3. **Covid-Suppressed Demand** – use local referral data – referrals are picking up at different rates in different parts of the system
4. **Covid-Generated** – predictions are likely to be a fluid process and need updating based on emerging evidence (research & local data)
5. **Covid-Altered Activity** – needs to be factored into demand-capacity modelling – discharge rates, new treatments started, and changes in number of sessions taken to discharge may be more useful than contacts (as could be brief check-in) – need to continue monitoring as we do not know if any changes in these will continue for new cases
6. Important to consider Covid-altered capacity (e.g. staff sickness, shielding, redeployment)

Predictive Modelling of Covid-Generated Demand

Covid-generated: assessing demand (2)



Example

Age Group: 20-64

Sub group (event): Lockdown and isolation measures

Impact: Anxiety

Denominator: 1,025,617 (i.e. total number of people aged 20-64)

Pre-covid denominator: (i.e. total number of people already experiencing anxiety pre-Covid)

Researched evidence base for impacts on sub-group: One study identified†

%age rates: Study 1: increasing to 20% anxiety in overall population

Change in demand for support or service:

72,955
(205,123 – 132,179)

(Denominator x rate) less pre-Covid denominator

†Researched evidence base for impacts on sub-group
Study 1: Example

Example of Predictive Modelling Tool for Covid-Generated Demand (1)

COVID-19 MH Forecast Model (All-age)

- Developed by a collaborative of clinician's, researchers, health economists and commissioners – Centre for Mental Health, Oxford Academic Health Science Network (AHSN), South East MHLDA Cell, service commissioners, leads and providers from Surrey, Lancashire, Newcastle, Cheshire & Wirral
- Approach:
    1. Identify key groups whose mental health is likely to suffer during/after the pandemic – local CCGs/service providers input denominators (i.e. number of people in their local population who fall in these groups)
    2. Where available, uses the most robust evidence/research to estimate the increase in MH difficulties for that group (criteria for selection of studies)
        - Note: some "at risk" groups are not included as there is currently no robust evidence/research to base predictions on
    3. Combines information from 1 and 2 to offer a total for MH difficulties in each group
    4. Offers a total figure for increase in need for a given community

Example of Predictive Modelling Tool for Covid-Generated Demand (2)

COVID-19 MH Forecast Model (All-age)

- Use:
  - Provides estimates for % of people with a specific difficulty that are likely to require a service but this figure can be altered by CCGs/service providers based on their local service model, remit, access targets etc.
  - Estimates potential overlap between groups (people who fall in more than one group) and applies a “discount factor” that can be adjusted locally
  - Outputs of the spreadsheet + local data on suppressed demand = anticipated demand – CCGs/services to consider when and where this demand will enter the system
- Assumptions in modelling are transparent
- Plan for further iterations as evidence evolves/emerges – needs to be dynamic
- Principles on previous slide similar for any predictive modelling/tool
- Example: predictive modelling regarding impact of social isolation/quarantine…