North East Lincolnshire
MENTAL HEALTH AND WELL BEING NEEDS ASSESSMENT
2018

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EXECUTIVE SUMMARY

Mental health is “a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.2 It is a public health issue and reducing the prevalence of mental health problems is still a major public health challenge.6 The promotion of mental wellbeing and prevention of mental health problems are very crucial as mental health influences all other health outcomes.

A mental health and wellbeing needs assessment of people with mental health problems in North East Lincolnshire across the various stages of the life course was undertaken through consultations with a wide range of professional groups or stakeholders. Stakeholders were consulted by the administration of questionnaires, online surveys and interviews. These consultations were carried out by members of both the Public Health Team and the Commissioning and Strategic Support Unit (CSSU). Also undertaken were: a literature review; a service review of statutory mental health and wellbeing services provided in NEL; a community engagement exercise; and an evidence review of support mechanisms that assist with positive mental health and wellbeing issues across the various stages of the life course. The key points from the study are listed below.

Key Data Findings

Mental Health Prevalence

- An estimated 2,320 children aged 5 to 16 years have a mental health condition locally.
- An estimated 21,757 people aged 15 to 74 in North East Lincolnshire have suffered a common mental health disorder episode in the last week.
- A lower proportion of local people believe they have good life satisfaction, a worthwhile life, are happy and who have low anxiety compared to national and regional proportions.
- Depression prevalence is 8.2% with females more likely to be diagnosed than males. Locally, new depression diagnoses are at a lower rate than national and regional rates and it is estimated that nearly half of depression is undiagnosed locally. Depression appears to be underdiagnosed in many parts of North East Lincolnshire.
- It is estimated that as many as 565 women suffer adjustment disorders and 285 women suffer mild-moderate depression in their perinatal period locally.
- It is estimated that there are 2097 older people living with dementia locally, of which 1512 have been diagnosed. The diagnosis rate in North East Lincolnshire of 70% is higher than the national target of 66.7%. Of the total dementia prevalence locally, it is possible to estimate the proportion of people who are yet to be diagnosed with dementia (30.4%), the proportion that have been diagnosed and are eligible for dementia treatment (63.9%) and the proportion of the estimated dementia population who are receiving treatment (58.4%).
- There are an estimated 1409 people living with severe mental illness (i.e. schizophrenia, bipolar affective disorder and other psychoses) with the highest numbers of people with severe mental illness living in the most deprived areas of North East Lincolnshire.
- There were 69 hospital admissions as a result of self-harm for young people ages 10 to 19 in 2016/17. Nationally the rates of self-harm in young people have generally increased whereas locally the rates have stayed relatively constant despite some fluctuations in numbers over the last 5 years.
- The local suicide rate is currently lower than both the nationally and regional rates.

Our Place Survey

- A third of people (33.4%) felt that their mental health had had a bad impact on their life in the previous 12 months with older people less likely to say mental health had affected them than younger people.
- Males aged 20 to 34 were half as likely to report mental health had impacted on their life compared to females of the same age.

- Those who live in the two most deprived quintiles in North East Lincolnshire were almost twice as likely to report that mental health had a negative impact on their life in the previous 12 months compared to those who live in the least deprived quintile.

- The majority of young people feel happy about their life (84.3%), however those living in the most deprived quintiles were far less likely to feel happy compared to the least deprived quintile.
- Other differences were found between the most deprived and the least deprived; the most deprived young people were more likely to often feel sad and tearful, bad tempered or angry, anxious and depressed and wish they had a different kind of life.
- For emotional wellbeing measures relating to friendships, relationships with parents, worrying a lot, being proud and trying new things the differences between the most and least deprived were smaller.
- Young people are more likely to talk to someone about a problem if it relates to school, bullying or friends. More deprived children are less likely to talk to anyone about their problems.
- School work/ exams are the biggest worry for young people. Children in the most deprived quintile were less likely to worry though, compared to the others. The other main worries for young people included the future/ getting a job and the way they look.
- Children in the least deprived quintiles had a better score on the SWEMWBS.
- Generally, across the different measures of emotional wellbeing, emotional wellbeing declines as age increases, additionally there are differences between males and females with females reporting worse emotional wellbeing across the different measures.

Hospital Admissions

- Those living in the most deprived parts of North East Lincolnshire are significantly more likely to be admitted to hospital for mental health illness (226.55/100,000 compared to NEL 128.45/100,000) and for self-harm (352.63/100,000 compared to NEL 200.92/100,000).
- 43% of all admissions for a mental health disorder were due to psychoactive substance use, the majority of which related to alcohol withdrawal and acute intoxication from alcohol.
- For mental health admissions, males accounted for 62% of admissions and have a significantly higher rate than females.
- For self-harm admissions, females account for 60% of admissions and have a significantly higher rate than males.

NAViGO

- There were 6,483 open patient referrals with NAViGO in 2017/18 and a total of 16,147 new referrals in the last year. New referrals are increasing year on year.
- 52% of referrals are females and 48% were male. 35% were aged 25-44 years, 25% were aged 65+.
- The highest rates of referrals to NAViGO are from those who live in the most deprived areas of NEL.
- 20% of all in referrals into NAViGO came from GP's, followed by 10% of self-referrals and 10% from the Police.
- 21% of all patients were referred onto Improving Access to Psychological Therapies (IAPT), 15% were referred to the Single Point of Access (SPA) and 10% referred to Adult Crisis.
- IAPT rates are below national average despite recent improvements.

Police

- Mental Health related calls to Humberside Police have increased over the last 5 years.
- East Marsh and West Marsh had the highest number of mental health related calls to police.
- In a third of all sections 136 referrals drugs or alcohol were recorded.
- No one was taken to a police station as a result of a section 136 referral, however a police car was the most common mode of transport to the place of safety rather than ambulance.
- The majority of section 136 referrals were after 5pm.

Mental Health Prescribing

- 200,000 antidepressant items prescribed per year in North East Lincolnshire at a rate of 101 antidepressant items prescribed per month per 1,000 patients and a total cost of £3.1 million for 2013-2018.
- 35,000 antipsychotic items prescribed per year in North East Lincolnshire at a rate of 18 antipsychotic items prescribed per month per 1,000 patients and a total cost £2.2 million for 2013-2018.
- Antidepressant and antipsychotic prescribing were highest in the more deprived areas of North East Lincolnshire (e.g. East Marsh and Sidney Sussex).

Mental Health Mortality

- There were a total of 810 mental health related deaths locally between 2013 and 2017 with the majority of deaths in the under 65's being associated with suicide or mental disorders due to psychoactive substances.
- In the over 65's, dementia was the leading cause of mortality.
- In 2017 dementia became the leading cause of mortality for all persons of all ages for the first time, overtaking ischaemic heart disease.

Suicide

- The male suicide rate in North East Lincolnshire is over five times higher than the female suicide rate compared to nationally where the male rate is only three times higher than the female rate.
- The highest proportion of suicides in North East Lincolnshire were in the 35-44 age band whereas nationally it is in the 40-49 age band.
- A highest proportion of suicides were recorded by those who had lived in areas of higher deprivation with those from the two most deprived quintiles more likely to die from suicide.
- The most common method of suicide in North East Lincolnshire was hanging and this proportion was considerably higher than at a national level suggesting that other methods of suicide are not as accessible locally.
- 31.3% had suffered a traumatic event in their life.
- 39% of those who died from suicide in North East Lincolnshire had a diagnosed mental health condition, 87.8% of which were diagnosed with depression.
- Locally, over a third (32.8%) had previously attempted suicide and 53.1% had expressed suicidal thoughts (some had expressed suicidal thoughts and attempted suicide). 67.2% had either expressed suicidal thoughts and/or attempted suicide previously.
- The proportion of people with a financial difficulty prior to their death appears to be increasing in North East Lincolnshire and is now similar to that of suicides recorded nationally who have suffered financial difficulty.

Suicide Ambulance Call Outs

- There were 843 suicide ambulance related call outs in 2016/17 within North East Lincolnshire. Over half of all suicide related ambulance call outs were for people aged 20 to 39 years.
- A higher number of suicide related ambulance call outs were in the spring and summer months.

Service Review

- There is currently no dedicated perinatal mental health service in the area
- The Young Minds Matter services for children and young pole with mental health problems was commissioned in April 2018 to address the gaps identified in mental health service provision for children and young people in the area.

- Increased demands being placed on NAViGO and other providers needs to be recognised and included in the action plan going forward.
- There is currently no early intervention provision for people aged 35 years and over.
- Also, there is a gap in service for people who misuse drug and alcohol and are unwell and do not have a dual diagnosis but turn up at Harrison House for support.
- There is an absence of social prescribing for low level mental health support and intervention in the community.
- There is a lack of formal peer support groups where people with common mental health issues could meet to support each other and share advice and coping strategies.
- More resources are needed to expand the psychology service in the area to enable psychology input in areas lacking psychology provision.
- Greater resource is required to increase robustness of the Rethink provisions as service resilience is low due to the quantity and intensity of the work outstripping the staffing resource available.
- Funding is required by NEL Mind to reconfigure the service and develop a new service.
- Specialist mental health services are facing an increase in demand. That is, there is increased demands placed on NAViGO and other providers and this is not matched by available funding.

- Universal Credit is having an impact on people receiving this in NEL and has created massive issues within services including mental health services in the area. People are in distress because of financial difficulties and this impact on their wellbeing.
- Currently, pathways are unclear where a person has mental health issues on top of pre-existing vulnerabilities (for example Learning Disability or Autism).
- There is a gap in equity of access in the provision of Primary Care Mental health (PCMH) in the three newly formed primary care Federations and PCMH services have low service capacity.

Recommendations

Perinatal Mental Health

It is recommended that:

- The Clinical Commissioning Group **(CCG) leads the Specialist Perinatal Mental Health Service** implementation in order to obtain optimal support for people with perinatal mental health issues.
- **All services** need to consider identifying those women at risk of poor mental health before, during and after pregnancy to ensure equity of access to provision, preventing the escalation of problems to support early access to treatment.
- During routine antenatal and postnatal appointments, **all health professionals** should discuss emotional wellbeing with women and identify potential mental health problems.
- The **CCG and NAViGO** should ensure that partners of women with perinatal mental health issues are also offered support at times of extreme stress and anxiety; as caring for a partner suffering mental ill health when a new baby arrives is a difficult and often lonely experience.
- **All healthcare professionals** referring a woman to a maternity service should ensure that information on any past and present mental health problem is shared. Also, the mental health of father's should be recorded where possible.
- Improved data collection across **key services** needs to identify the local incidence rate of perinatal mental health during and after pregnancy, rather than basing local need and service design on national estimated prevalence.
- All practitioners are familiar with case law and how this impacts on care delivery such as: NHS Trust 1 v G Practice Note [2014] EWCOP 30 http://www.bailii.org/ew/cases/EWCOP/2014/30.html

Children and Young People

It is recommended that:

- North East Lincolnshire Council continue to implement the Future in Mind Strategy to address the lack of support available for lower level emotional wellbeing through the commissioning of the Young Minds Matter Service and implementing the iThrive approach for C&YP in the area. Note**:** The Young Minds Matter service was commissioned in April 2018 (8 months ago).
- The **CCG & Council** and wider partners continue to work together to consider how the application of the Mental Capacity Act (MCA) impacts those in transition.

Adults and Older Adults

It is recommended that:

- The **CCG** commissions early intervention in psychosis service for people aged 35 years and over to the national model and standard as part of the implementation of the 5YFV.
- **NAViGO** implements and evaluates the mental health hub project (Safe Space) to help people who are in crisis but not mental health crisis who turn up at night at the acute specialist rehabilitation service based at Harrison House.
- The **CCG and the Council** take a joint commissioning approach to address the issue of people misusing drugs and alcohol who present in acute crisis at Harrison House (the acute specialist rehabilitation service) and in the community.
- The **CCG and NAViGO** address the gap in psychological therapists' trainees in the Open Minds: IAPT service by implementing further expansion of the IAPT programme in line with the 5YFV.
- The **CCG, NAViGO, Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Addaction** undertake work to understand relapse of those who have mental health problems and attend the variety of services (including Accident and Emergency (A&E) / IAPT / Addaction) for example those with alcohol and drug dual diagnoses and those who self-harm.
- **NAViGO** considers the need of 'light touch' support to prevent a relapse at times when those with mental health problems are faced with extreme stress such as; trauma / bereavement.
- The **CCG** undertakes a comprehensive review of the Adult Clinical Psychology services to ensure it best meets provision across the wide range of mental health support.
- The **CCG** undertakes a commissioning review of the mental health crisis house (Field View) and the crisis telephone helpline (Lincsline) managed by Rethink.
- The **CCG, NAViGO and Care Plus** should agree clear pathways for people who have a mental health problem in addition to pre-existing vulnerabilities (e.g. people with learning disability or autism)
- The **CCG and NAViGO** implement integrated IAPT in Primary Care setting across all federations to reduce the gap in equity and access to service provision and ensure that all practices are providing the same standard of service as stated in the 5YFV.
- The **CCG** ensures that IAPT waiting time standard are maintained in GP Practices (Primary Care MH services) where therapist provision is commissioned in line with recommended guidelines.
- **All providers** should review processes to establish the degree to which they comply with the Local Mental Capacity Act Policy and where necessary create an action plan to address any gaps.
- The **CCG and NAViGO** to implement and audit against the Memorandum of Understanding (MOU) Deprivation of Liberty in Hospitals: Agreed Principles.
- All **health and care partners** to work with the CCG to ensure that support and advice is offered to service users to proactively plan for their future including the potential of a time where they may lack the capacity to make decisions about their care and treatment.
- The **CCG** should explore options for more local provision of services for older people with complex long-term mental health conditions rather than sending them out-of-area.
- The **council and the CCG** should recognise the increased demands being placed on NAViGO and other providers and include this in the action plan going forward.

Public Health and Community

It is recommended that:

- Before the end of 2019 **Public health** will produce a new prevention framework for mental health in North East Lincolnshire, taking a population health management approach closely aligned to the new prevention framework for North East Lincolnshire.
- The **CCG** completes the implementation of social prescribing to address various underlying issues that lead to poor mental wellbeing/low level mental health issues. Social prescribing can address loneliness, help to build aspirations and build peer support network. It can also support perinatal women with low level mental health problems.
- The **CCG** understands more about why mental health medication is given without referrals to IAPT for talking therapies.
- The **CCG, Public Health and NAViGO** should run a primary care Protected Time for Learning (PTL) event on mental health and wellbeing during 2019.
- **Public Health/ CSSU** undertakes the follow on study on Financial Resilience Needs Assessment as recommended in the first study to assess the impact of Universal Credit on the mental and physical health of people receiving this in NEL.
- The **CCG and the Council** should ensure that the right support is in place to address the mental health needs of carers. The Director of Public Health report for 2018 focused on vulnerable groups and included a chapter on carers. Recommendations can be found in the report https://www.nelincs.gov.uk/wp-content/uploads/2018/05/6.-Director-of-Public-Health-Annual-Report-2018.pdf Actions from these recommendations should be implemented by the identified organisation/s.
- The **CCG and the Council** should ensure that the right support is in place to address the mental health needs of older people. The Director of Public Health report in 2016 focussed on older people and social isolation and various recommendations on how to tackle this issue are contained in this report http://www.nelincsdata.net/resource/view?resourceId=380
  Recommendations made in this report should be implemented by the identified organisation/s.
- **All local health and community services** should encourage people to follow the five ways to wellbeing, in particular to talk about their mental health.
- **Public Health** should include a focus on social isolation in the new over 75 health check which is being piloted next year.
- The weakness of community and voluntary sectors on mental health support and mental illness prevention was a common theme throughout the needs assessment. The **council, the CCG and NAViGO** should work in partnership with the voluntary sector, in particular those organisations that have a particular interest in mental health such as MIND, to better understand the issues that they face and identify how this sector can be strengthened.
- The **council's Wellbeing service** should identify community and voluntary sector groups where Mental Health First Aid training could be delivered.
- Absence associated with mental health problems is having a major impact on workplaces across North East Lincolnshire. The **council's Wellbeing service in partnership with local employers, employment organisations and Job Centre Plus** should explore how best to deliver programmes to improve the mental wellbeing of employees and those seeking to return to work.

Intelligence and Future Needs Assessments

It is recommended that:

- It proved extremely difficult to access some key intelligence sources in this needs assessment. **CSSU** should work with sectors such as primary care and schools to ensure that effective intelligence is collected and shared on mental health and wellbeing in North East Lincolnshire and data sharing agreements should be established where appropriate.

- **NELC Public Health/ CSSU** should organise an event that brings together intelligence analysts and leads across key local organisations and undertake a piece of work to establish a minimum dataset for mental health and wellbeing intelligence in North East Lincolnshire.
- Vulnerable children have been identified as being at particularly high risk of mental health problems in this needs assessment and these vulnerabilities often persist into adult life. However we were not able to explore some of the detail around the sort of adverse childhood experiences impacting on these children. It is important therefore that **NELC Public Health/ CSSU** undertake a needs assessment focused on these children immediately.
- A number of other groups have been identified where it is believed that there are particularly acute mental health issues, examples include homeless people, military veterans, carers, older people living alone and people with dementia living in the community. **NELC Public Health/ CSSU** should prioritise these groups for future needs assessment programmes.

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ABBREVIATIONS

A&E	Accident and Emergency
ACEs	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ALS	Adolescent Lifestyle Survey
AMHP	Approved Mental Health Professional
APMS	Adult Psychiatry Morbidity Survey
APS	Annual Population Survey
ARMS	At risk mental state
BFPS	Breast Feeding Peer Supporters
BPSD	Behavioural and Psychological Symptoms of Dementia
C&YP	Children and Young People
CAMHS	Children and Adolescent Mental Health Services
CAT	Community Assessment Team
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CIC	Community Interest Company
CMHTs	Community Mental Health Teams
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CSSU	Commissioning and Strategic Support Unit
DBT	Dialectical Behaviour Therapy
DoLs	Deprivation of Liberty Safeguards
DSR	Directly Age Standardised Rate
DWP	Department of Work and Pension
ECT	Electric Convulsive Therapy
EFT	Emotional Freedom Techniques
EIP	Early Intervention in Psychosis
ESA	Employment and Support Allowance
EUPD	Emotionally Unstable Personality Disorder
FFAP	Family First Access Point
GAD	General Anxiety Disorder
GP	General Practitioner
HES	Hospital Episode Statistics
IAPT	Improving Access to Psychological Therapies
ICD10	International Classification of Diseases
IMD	Indices of Multiple Deprivation
LPFT	Lincolnshire Partnership Foundation Trust
LSOA	Lower Super Output Area
LTC	Long Term Condition
MCA	Mental Capacity Act
MCS	Millennium Cohort Study
MH	Mental Health
MOU	Memorandum of Understanding
NBAS	Neonatal Behavioural Assessment Scale
NBO	New-born Behavioural Observations
NEL	North East Lincolnshire
NELC	North East Lincolnshire Council
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Clinical Excellence
NLAG	Northern Lincolnshire and Goole NHS Foundation Trust
OCD	Obsessive Compulsive Disorder
ONS	Office of National Statistics
PCMD	Primary Care Mortality Database
PCMH	Primary Care Mental Health
PCMH	Primary care mental health
PHE	Public Health England
PHQ	Patient Health Questionnaire
PNMH	Perinatal Mental Health
POPPI	Projecting Older Peoples Population Information
POS	Place of Safety
PTSD	Post-Traumatic Stress Disorder
QOF	Quality Outcomes Framework
SEND	Special Education Needs and Disability
SMI	Serious Mental Illness
SPA	Single Point of Access
STP	Sustainability Transformation Plan
SUS	Secondary User Service
SWEMWBS	Short Warwick Edinburgh Mental Wellbeing Scale
TMS	Transcranial Magnetic Stimulation
UK	United Kingdom
WHISe	Wellbeing Health Improvement Service
WHO	World Health Organisation
YMM	Young Minds Matter

1. INTRODUCTION

World Health Organisation (WHO) defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”.[1] It also defines mental health as “a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.[2] Mental health is therefore an essential part of overall wellbeing and therefore cannot be separated from physical health.[2]

Good mental health is not just the absence of mental health problems, but about how an individual copes with life, that is, how situations are handled and how an individual relate to others and make choices.[2] Poor mental health can negatively impact on physical health and similarly, poor physical health can lead to an increased risk of developing mental health problems. Evidence shows that people with mental health problems are three times more likely to develop diabetes and twice as likely to die from heart disease.[2]

Mental wellbeing describes an individual’s mental state. It describes how an individual is feeling and how well they can cope with day-to-day life. Mental wellbeing is therefore dynamic and can change anytime.[3] Mental wellbeing helps people to achieve their potential, realise ambitions, cope with adversity, work productively and contribute to their community and society.[4,5]

2. BACKGROUND

It is over 12 years since a mental health needs assessment was completed in North East Lincolnshire (NEL). The last assessment which was undertaken in 2005 followed a traditional needs assessment model and was largely focused on diagnosed mental health problems and the impact of mental health problems on health services in North East Lincolnshire.

In recent years, there has been growing interest in mental health and a widespread realisation that mental health impacts on a wide range of factors in our lives across all stages of the life course. Similarly there are many things in our lives which can contribute to poor mental health including, for instance, our financial and employment circumstances, housing and community issues and family and relationship positions. In order to provide a broad understanding of mental health and wellbeing, this need assessment gets beyond traditional needs assessment models and establishes what the underlying causes of poor mental wellbeing are in North East Lincolnshire by taking a life course approach across the population. Taking this approach will help in understanding mental health and mental being across the population. This approach will ensure that children are protected against mental health problems as early as possible, thereby ensuring that investments are made upstream rather than downstream and reducing later distress and cost.

Mental health is a public health issue and reducing the prevalence of mental health problems is still a major public health challenge.[6] Promoting mental wellbeing and preventing mental health problems is therefore crucial as mental health influences all other health outcomes. Ignoring this undermines public health interventions to reduce health inequalities and prevent premature death from conditions that are preventable.[7]

3. EPIDEMIOLOGY AND IMPACT OF MENTAL HEALTH PROBLEMS

Mental health problems is one of the most occurring health conditions affecting people in the United Kingdom (UK)[8] and impacts negatively on a range of domains through the life course. Mental illness is responsible for a larger burden of disease than any other health problem. It is responsible for 23% of the total burden of disease in England compared to 16% each for cardiovascular disease and cancer.[9] Mental illness is one of the major causes of life years lost[10] and around one in four people in the UK will experience this in their lifetime.[11]

Mental health problems can be classified into common mental disorders such as anxiety and depression and severe disorders such as schizophrenia and bipolar disorder; and the various behavioural disorders.[5] In most cases, two or more mental health disorders occur in an individual, depression and anxiety being a common combination. Depression alone accounts for 7% of the disease burden, more than any other health condition.[9]

It is estimated that over four million people in England with a long-term physical health problem also have a mental health problems[12] and that 70% of patients with 'medically unexplained symptoms' also live with depression and/or anxiety related conditions.[13] People with mental health conditions have a lower life expectancy and poorer physical health outcomes than the general population.[14] Evidence suggests that this is due to a combination of clinical risk factors, socioeconomic factors, health system factors, and the lack of integrated treatment when care is required across several service settings.[14] However there is some overlap in the risk factors for physical and mental health problems which explains why the physical health of people with severe and long-term mental health problems is often poor.[15]

Poor mental health causes significant suffering to individuals and impacts negatively on those around them. It also impacts on the society as a whole through costs to health, social care, housing, educational attainment, criminal justice, public services, social security and the wider economy.[16] People with mental health problems are more likely to experience physical health problems and have higher rates of health risk behaviours such as smoking, drug and alcohol misuse, being overweight and having unplanned pregnancy. These group pf people are also more likely to have a disrupted education, be unemployed; take time off work; fall into poverty; have poorer social skills and be over-represented in the criminal justice system.[16]

Mental health problems are the leading cause of sickness and absence from work with 70 million workdays lost in the UK every year as a result of this.[17] Absence from work creates a burden on employers by impacting on productivity and quality of output. In 2013 in the UK, 41% of people receiving Employment and Support Allowance (ESA) had a mental or behavioural disorder.[18] Evidence suggests that the costs for treating the physical health condition of people with mental health problems are more likely to be higher due to the complexity of dual conditions, the severity of the physical condition, and the lack of integrated treatment.[12]

4. POLICY CONTEXT

In recent years, there has been a growing recognition of the importance of preventing mental health problems and promoting mental wellbeing. There has also been the realisation that a great deal can still be achieved and this has led to mental health treatment and care being increasingly prioritised within policy.[16] In 2013, the Chief Medical Officer pointed out in his annual report, *Public Mental Health: Investing in the Evidence,* that despite this prioritisation, investment in mental health has fallen.[19]

In 2010*,* the report *Healthy Lives, Healthy People: Our strategy for public health in England*[20] acknowledged the need to reduce inequalities and improve health. The report acknowledged that this is possible if a life stage approach is taken by including key transition stages and also highlighted that mental health should be a key component of this. The report again highlighted the need to give every child in every community the best start in life, improve their development and health in order to reduce the risk of mental ill health. Also in 2010, Marmot Review: *Fair Society, Healthy Liv*es,[21] gave some recommendations that put wellbeing at the centre of policy and also warned of the consequences of not acting on health inequality.

No Health Without Mental Health,[22] was published in 2011 by the Coalition Government. This strategy sets out six objectives to improve the mental health and wellbeing of people of all ages and to improve outcomes for people with mental health problems. The strategy is underpinned by the concept of "parity of esteem"[i] between mental and physical health. The objectives set out in the report are improvement in outcomes, physical health and experience of care of people with mental health problem and a reduction in avoidable harm, stigma and discrimination. The document also emphasises the links between mental health, housing, employment, and the criminal justice system. It described the societal and healthcare costs of mental ill health, and the true economic costs of not tackling mental ill health.

A number of documents on health and social care including crisis documents were later published in 2012. These include the *Health and Social Care Act (2012)* [23] which puts parity of esteem into legal context; the *Prime Minister's Challenge on Dementia*[24] which draws attention to improvements in health and social care including dementia care and research and inspire the development of dementia friendly communities; and *Transforming Care: A National Response to Winterbourne View Hospital* (December 2012).[25] This crisis document highlighted the need for vulnerable people and their families, including people with mental health problems, to receive appropriate care and also sets out the responsibilities of all organisations and the staff involved in providing this care.

In 2014, the *Crisis Care Concordat*[26] was published to accompany the crisis document above. The Concordat laid down a clear set of principles for all staff in all organisations that signed the agreement to work together in supporting and improving the standards of care for people when in crisis, for example, when people are having suicidal thoughts or have significant anxiety. The *Care Act*[27] was also published in 2014 to reform and simplify the law relating to care and support for adults in England. The Act helps to improve support for carers, including carers for people with mental health issues and to improve people's independence and wellbeing.

In 2015, NHS England and the Department of Health published *Future in Mind.*[28] This document highlights the importance of promoting good mental health from the earliest ages and protecting and improving children and young people's mental health and wellbeing. The document laid out the approaches to make it easier for children and young people to access high quality mental health care when and where it is needed. The importance of early intervention in young people is also acknowledged in this report.

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[i] In England, the term parity of esteem is being used for mental health to be given equal priority to physical health, that is, "valuing mental health equally with physical health[16]

In 2016, the *Five Year Forward View (FYFV) for Mental Health*[29] also reported the significant underfunding of mental health services. It highlighted that many people with mental health problems do not get the help they need and the stigma and discrimination associated with having mental health problems.

Again, to show its commitment to improving children and young people's mental health, the Government produced *Transforming Children and Young People's Mental Health Provision: a Green Paper* in 2017. This green paper sets out the ambition that children and young people who need help for their mental health are able to get it when they need it.

Many policy developments have also been produced in recent years and some of these are targeted at specific stages of the life course. There have been some focus on perinatal mental health and the mental health of older people; and themes have focussed on early intervention, choice, control and equality.[16]

5. MENTAL HEALTH AND THE LAW

The Mental Capacity Act 2005[30] gives caregivers and professionals a legal framework within which they can make decisions in the best interests of those in their care who are aged 16 or over, and who lack the capacity to make particular decisions themselves at the time the decision needs to be made.

Under the Mental Capacity Act, someone lacks capacity if there is an impairment or disturbance in their cognitive functioning which is sufficient to prevent them from making a decision. The impairment or disturbance might arise from having a learning disability or dementia, although by no means everyone with these conditions will lack capacity.

Lacking capacity is not necessarily a permanent state, as mental capacity can come and go depending on the nature of someone's condition. As a result, the number of people who lack capacity at any one point is not known. However, it is estimated that around 4% of the UK population lack capacity to make decisions for themselves[31], at the time the decision needs to be made. This is equivalent to around 6,000 people in North East Lincolnshire.

Where a person's care and treatment amounts to a deprivation of liberty, and they lack capacity to consent to it, the deprivation must be authorised if it is to be lawful. As part of the Mental Capacity Act, the Deprivation of Liberty Safeguards[32] (DoLS) provide the mechanism for reviewing applications and ensuring they are in the person's best interests. Most often, DoLS applications are for older people in care homes – of the 685 individuals that DoLS applications were made for in the 2016/17 financial year, the vast majority have been for older people in nursing or residential care homes[33]. Where a deprivation of liberty for someone lacking capacity occurs outside of the care settings covered by the DoLS framework, applications to authorise the deprivation are made to the courts.

The Mental Health Act 1983[34] allows for the detention of people with a mental disorder in the interests of their own safety or the safety of others. On March 31, 2017, 50 people were subject to detention under the Mental Health Act 2007 in North East Lincolnshire[35].

6. AIMS

The aims of this needs assessment are to:

- Identify the incidence and prevalence of common mental health disorders using available data at all the major stages of the life course.
- Provide a comprehensive assessment of the factors that are associated with poor mental health and wellbeing at all the major stages of the life course in North East Lincolnshire.
- Understand how mental health and wellbeing issues are manifesting and presenting to public services, schools, employers etc. and
- Review the range of services that are currently available to assist people with their mental health and wellbeing and assess whether this reflects the needs of our community

7. OBJECTIVES

I. Through surveys of a wide range of professional groups identify the major underlying causes of mental health and wellbeing problems in NEL across the major stages of the life course. These will include at least the following life course stages: Perinatal/ maternal, early years, school years (including primary, secondary and tertiary), young adults, working age in and out of work, older people. Where possible we will also look to identify particular mental wellbeing issues affecting specific groups such as people with long term conditions and disabled people. We will also consider gender related issues separately where appropriate.

II. Through surveys of a wide range of professional groups identify how mental health and wellbeing problems are manifesting themselves across the major stages of the life course in North East Lincolnshire, e.g. through risky behaviours, addictions, gambling, self-harm etc.

III. Review the range of statutory services that are provided locally to address these issues.

IV. Through evidence review identify the sort of support mechanisms that assist with positive mental health and wellbeing issues across the various stages of the life course.

V. Using routine and service based data sources and prevalence estimates, identify the extent of mental health problems across the various stages of the life course in North East Lincolnshire. This will include an analysis, where possible, of how mental health varies between, wards, socioeconomic groups, gender, age groups, ethnicity etc.

VI. Using the State of the Borough survey as a vehicle to provide a snapshot of the current state of mental health and wellbeing in North East Lincolnshire at the current time.

VII. Carry out appropriate community engagement activities with local forums that cover children, adults, workplaces older people etc. e.g. Healthwatch, CCG community forum, Friendship at home, Voice of the child (this need not be dependent on us to do)

VIII. Map local assets relating to mental health.

8. METHODS

A steering group was set up to oversee the project. This group comprised of representatives from Public Health, the Commissioning and Strategic Support Unit (CSSU), the Clinical Commissioning Group (CCG), CCG Accord Ambassador, NAVIGO and FOCUS.

A scoping exercise was undertaken by the steering group to identify and agree the aims and objectives of the study and the study population, the inclusion and exclusion criteria. The group also agreed the research method to be used and also the form of consultation to be undertaken for primary data collection. Both qualitative and quantitative research methods were used to undertake the study and all data collected were analysed using the appropriate method. Quantitative data were analysed using Excel and SPSS statistical computer software packages while qualitative data was analysed by grouping responses into different themes. MapInfo, a geographical mapping package, was also used to present some of the data collected and those obtained from other sources. A comprehensive literature review was also undertaken to evaluate the available literature in the project area.

Routine and service based data sources and prevalence estimates were used to identify the extent of mental health problems across the various stages of the life course in North East Lincolnshire. This included an analysis, where possible, of how mental health varies between, wards, socioeconomic groups, gender, age groups, ethnicity etc. Readily available data sources relevant to the study were analysed and reviewed. These data sources include: Office for National Statistics (ONS), Public Health England (PHE), Index of Multiple Deprivation (IMD), Quality Outcomes Framework (QOF), Annual Populations Survey (APS), Adult Psychiatry Morbidity Survey, OpenPrescribing, Projecting Older Peoples Population Information (POPPI) and NHS Digital. Locally sourced and non-readily available data sources include: NAViGO, Primary Care Mortality Database (PCMD), Hospital Episode Statistics (HES), East Midlands Ambulance Service, Coroner's office and Humberside Police.

The locally conducted Adolescent Lifestyle Survey (ALS) and Our Place survey were also used as a vehicle to provide a snapshot of the current state of mental health and wellbeing in North East Lincolnshire.

Service and stakeholder consultation surveys were designed by members of the steering group to gather information from a wide range of professional groups such as GPs, teachers, and other stakeholders etc. on:

- the major underlying causes of mental health and wellbeing problems in NEL across the major stages of the life course, that is, perinatal/ maternal, early years, school years (including primary, secondary and tertiary), young adults, working age in and out of work, older people.
- how mental health and wellbeing problems are manifesting themselves across the major stages of the life course in North East Lincolnshire, e.g. through risky behaviours, addictions, gambling, self-harm etc.

These questionnaires contained both closed and open questions and were produced as an online survey for the wide range of professional groups to complete (see Appendix 16.1). Further to the surveys, semi-structured face to face interviews were conducted with a selection of survey respondents to explore community mental wellbeing in more detail (see Appendix 16.2)

A community engagement exercise was undertaken and this involved speaking to people mainly who attend groups with the aim of improving their or their family's health and wellbeing. A variety of groups were contacted, however a high proportion of the individuals who engaged with this element of the project were older people or new parents.

A review of the range of statutory services that are provided locally to address mental health and wellbeing issues across the life course was undertaken through face to face interviews with mental health and wellbeing service providers/commissioners using a semi-structured questionnaire (see Appendix 16.3). This was to help identify gaps in mental health service provision. Those interviewed include commissioners of perinatal mental health services, children and young people mental health services (Young Minds Matter services)[ii] and service Leads from NAViGO - the Adults and Older Adults service provider. Providers of other services that support these statutory services were also interviewed. These include the Wellbeing Service, FOCUS, Single Point of Access, Rethink, Primary Care Mental Health Service and MIND.

An evidence review was undertaken to identify the types of support mechanisms that assist with positive mental health and wellbeing issues across the various stages of the life course.

Finally, based on the findings of the project, areas of focus for various population across the life course were identified and recommendations made.

[ii] Commissioners of mental health services were interviewed to gain insight into: i) what services they intend to put in place to address perinatal mental health issues as there are currently no dedicated perinatal mental health services in North East Lincolnshire: ii) the services to be provided by the newly commissioned Young Minds Matter service for children and young people with mental health, emotional and wellbeing issues. The Young Minds Matter service was commissioned two months to the start of this project.

9. LITERATURE REVIEW

Most studies that focus on mental wellbeing often focus on the symptoms of mental health problems.[36] For instance, if an individual experiences low mental wellbeing over a long period of time, it is more likely that they would develop a mental health problem and conversely, if an individual already has a mental health problem, they are more likely to experience periods of low mental wellbeing than someone without a mental health problem. This does not imply that the former would not have periods of good wellbeing.[3] There is growing evidence suggesting that some common risk factors known to be predictors of mental health problems, such as ethnicity, low income and educational underachievement, do not appear to predict mental wellbeing. For example, some Black and Ethnic Minority groups have been shown to have higher levels of mental wellbeing than expected.[37]

9.1. CHILDREN AND YOUNG PEOPLE

Mental health problems are a leading cause of health-related disabilities in children and young people and these can have adverse and long-lasting effects.[38] Evidence shows that almost half of mental disorders begin before the age of 14 years[39] and 75% begin by the age of 24 years.[16] About 10% of children aged 5-16 years suffer from a clinical mental health problem (39,500 suffer with anxiety, 10,800 with depression, 18,900 with Attention deficit hyperactivity disorder (ADHD) and 68,100 with conduct disorder)[iii]. However, only 25% of children who need treatment receive it.[40] In 2012/13, NHS spend on children and adolescent mental health problems was £700 million or 6% of the total spend on mental health.[38]

Mental health problems in children and young people can vary from behavioural problems and temporary periods of anxiety, to severe and long-term conditions such as eating disorders, persistent self-harm, or psychosis. The UK Millennium Cohort Study (MCS)[36] emphasises the importance of examining the causes of mental health earlier in the life course. This is mainly because the determining factors of mental health in earlier life are sometimes not the same as those of mental health in adulthood.

Results from the UK Millennium Cohort Study[36] showed that some factors that affect mental health also affect wellbeing. Similar to previous studies,[41,42,43] the MCS showed an association between living in single-parent household and an increase in symptoms of mental health problems and lower wellbeing. It also showed that arguing with parents was a significant predictor of mental health problems in children. Other findings from this study and other studies on significant predictors of mental health problems in children include bullying by siblings,[44] poorer parental mental and general health including chronic health problems,[45,46] parent-reported peer problems, communication difficulties and special educational needs.[36] All these predictors are also associated with decrease in wellbeing and greater symptoms of ill-health.

UK research shows that parental mental health problem is a significant factor in around 25% of new referrals to social service departments.[47] It shows that 10-20% of women develop a mental health problem during pregnancy or within the first year after having a baby[48] and that paternal depression has a negative impact on children.[49] Adverse childhood experiences (ACEs)[iv] have also been shown to be important predictors of adult mental and physical health and has been linked with significantly higher risk of suicide in adolescence, adulthood and later life.[50] Forms of ACE's include:

[iii] Numbers do not add up as individuals may meet the criteria for more than one category

[iv] The term is used to describe the occurrence of abusive or neglectful parenting, drug and alcohol misuse, parental mental health problems, divorce or bereavement

Source: Addressing Adversity: Trauma and Adverse Childhood Experiences https://youngminds.org.uk/media/2142/ym-addressing-adversity-book-web.pdf

ACE's impact a child's development, their relationships with others, and increase the risk of engaging in health-harming behaviours, and experiencing poorer mental and physical health outcomes in adulthood.

Source: Addressing Adversity: Trauma and Adverse Childhood Experiences
https://youngminds.org.uk/media/2142/ym-addressing-adversity-book-web.pdf

The MCS found that other factors including wider environmental factors are strongly linked with wellbeing and do not significantly predict mental health problems. These factors include children being overweight, having arguments with friends, child-reported peer difficulties, bullying by friends, spending time with friends outside of school, school engagement, perceiving their neighbourhoods as being unsafe, and perceived inequality are all associated with lower wellbeing.[36] Most UK studies have found no differences on the effect of urban-rural location on children's mental health.[36] However, evidence shows that looked-after children are four times more likely to have a diagnosable mental health condition than their peers.[51]

Transition into adolescence and adulthood are central to children and young people's wellbeing and experience of childhood.[52] Young people at this age are more at risk of experiencing specific mental health problems such as self-harm, eating disorders and body dysmorphia.[53] Loneliness in adolescence is linked with higher levels of smoking, body dysmorphia and of suffering from mental health problems such as depression during adulthood.[54]

An independent review of the system of services that support children and young people's mental health indicates that many children and young people experiencing mental health problems do not get the kind of care they deserve and the system is complicated with no easy or clear way to get help or support.[55]

9.2. ADULTHOOD

Unlike other health conditions such as cancers and heart disease, most mental health problems begin at an early age and may persist over a lifetime and causes disability when people affected would normally be at their most productive.[8] A wide range of determinants are associated with mental health problems in adulthood. Research suggests that 18% of working age adults are affected by mental health problems at any one point in time; and that over a third of adults are affected by mental health problems during the course of a year. However, only 32% of adults with clinical levels of mental health problems receive treatment.[56]

Predictors of mental health problems in adulthood include negative life events (such as bullying, violence, bereavement, job loss); childhood adversity including emotional neglect, physical and sexual abuse.[57] Research suggests that one in three diagnosed mental health conditions in adulthood are directly related to adverse childhood experiences[58] and these experiences are associated with lower levels of mental wellbeing and life satisfaction.[59] Some other known predictors of mental health problems in adulthood are poor physical health; institutional care,[60] being female;[61] work stress[62]; social isolation, and being a member of some ethnic groups.[63]

Being in a stable relationship has both physical and mental health benefit and is associated with greater life satisfaction than being single. However, unhappy relationships have been found to be strong predictors of mental health problems than not being in a relationship.[64]
Studies have also shown that poor housing and fuel poverty,[65,66] having a family history of depression, poor interpersonal and family relationships, having a partner in poor health, being a carer and problems with alcohol and illicit drugs are all predictors of mental health problems.[67] Debt and financial strains are also associated with mental health problems- mainly depression and anxiety, and increasingly the evidence is tending towards these being a cause of mental health problems.[68]

Research has shown an association between lack of paid employment and mental health problems, however no significant association was found with part-time working.[62] This suggests that part-time working is not necessarily a risk factor for poor mental health. However, evidence shows that poor mental health may cause people to work fewer hours[69] and that working excessive hours is potentially more of a concern.[70]

Work-life balance has been linked to working hours, and various studies[71,72,73] have shown that very long working hours (over about 40-50 hours a week) have a damaging effect on wellbeing and mental health. Evidence again shows that job quality has a very strong effect on wellbeing[74] with several reviews identifying the key determinants of job quality. Jeffrey et al. (2014) highlighted that the key determinants of job quality are work-life balance, job security, fair pay, clarity, sense of purpose, management systems, work environment, sense of progress, sense of control, and relationships.[75]

A strong and most consistent finding in the wellbeing literature is that unemployment has a negative impact on wellbeing and mental health. Unemployment affects wellbeing by reducing an individual's sense of purpose and also their social connections.[62] Evidence shows that people in Great Britain who are unemployed are between four and ten times more likely to develop anxiety and depression.[76] There is uncertainty however as to whether or not poverty and unemployment are a cause of mental health problems, however evidence shows that they both tend to increase the duration of episodes of mental health problems and that the negative effects of unemployment are lasting.[62] Also associated with low wellbeing is having a very low income or experiencing economic deprivation.[74]

People with longstanding mental health problems are more than twice as likely to be in poverty as those without a longstanding health problem. They are especially also at risk of income poverty and material deprivation, especially if they have an additional health problem. Overall, 33% of those in poor health are materially deprived. But this rises to 40% for those with a mental health problem (and no other conditions), and 56% for those with a mental health problem and at least one other condition.[77]

Limited evidence has emerged on links between mental health problems and social media exposure[78] and also on the association between excessive use of mobile phones and computers and a higher risk of mental disorder in young women, due to lost sleep or sleep disturbances.[79] More research is needed in these areas. The onset of recession around 2008 in the United States and Europe has also been linked to increasing rates of mental disorder[80] and suicide[81].

9.3. LATER LIFE

Mental health and wellbeing of older people is often neglected across the spectrum of mental health improvement interventions and services.[82] To ensure mental wellbeing for all, preventing mental health problems in later life is important. Relationships and connecting with others is important for a mentally healthy later life. Most people will feel lonely at some point in their lives and mostly for people in later life; loneliness can have a major impact on their wellbeing.[83] In 2015, Age UK found that over 1 million older people were socially excluded and that nearly one fifth of older people in the UK do not receive the help they need to get out of their house or flat.[84] Loneliness can have a negative impact on health and is also associated with sleep problems, impaired cognitive health, heightened vascular resistance, hypertension, psychological stress and mental health problems.[84] Loneliness has also been found to lead to a higher risk of developing dementia and experiencing depression.[85]

Research shows that mental disorder is lower in older people than in the younger age group[86] in spite of poorer physical health and the increasing social isolation that growing old brings.[87] However, prevalence of depression in older people has often been overlooked. Depression affects one in five older people living in the community and two in five living in care homes. Depression has been linked to dementia, which can compound isolation, disempowerment and cognitive decline.[16]

Evidence shows that many older carers, with a caring role for a disabled, seriously ill or older relative or friend; struggle to get the support and advice they need, which in turn increases the risk to their own health and wellbeing, both physical and mental.[16] Many of these older carers face their own health problems in addition to coping with the needs of the person they are caring for.

Being engaged in meaningful activity is important for wellbeing. Retirement can be associated with a period of high wellbeing when people pursue leisure activities and volunteering which has many benefits as paid employment. However, for some older people, compulsory retirement due to lack of choice, or feeling compelled to continue to work for economic necessity beyond the intended retirement age can have a negative impact on their wellbeing.[88]

10. INTERVENTIONS TO REDUCE MENTAL HEALTH PROBLEMS AND PROMOTE MENTAL WELLBEING

Robust evidence exists for a wide range of interventions across the life course which prevents mental disorder, promote well-being and help strengthen resilience against adversity.[8] These interventions include:

- interventions to improve parental health
- pre-school and early education interventions
- school-based mental health promotion and mental health problems prevention
- prevention of violence and abuse
- prevention of suicide
- early intervention for mental health problems
- alcohol, smoking and substance abuse reduction and prevention
- promoting healthy lifestyle behaviours
- promoting healthy workplaces
- prevention of mental health problems and promotion of well-being in older years
- addressing social inequalities
- enhancing social cohesion
- housing interventions
- reduced stigma and discrimination
- positive mental health and recovery from mental health problems.

Some other public mental health interventions that have also been shown by WHO[89] to give very good excellent returns on investment within one or two years are:

- Early intervention for depression in diabetes
- Health visitor interventions to reduce postnatal depression
- Early intervention for depression in diabetes
- Early intervention for medically unexplained symptoms
- Early diagnosis and treatment of depression at work
- Early detection of psychosis
- Screening for alcohol misuse
- Suicide training courses provided to all GPs
- Suicide prevention through bridge safety barriers

Promotion of mental health and prevention of mental disorder

- Prevention of conduct disorder through social and emotional learning programmes
- School-based interventions to reduce bullying
- Workplace health promotion programmes

Addressing social determinants and consequence of mental disorder

- Debt advice services
- Befriending for older adults

11. DATA & INTELLIGENCE

11.1. Mental Health Prevalence

11.1.1. Children and Young People data from CAMHS Needs Assessment (2016)

The children and adolescent emotional wellbeing and mental health needs assessment was commissioned by NELC in 2016 and was undertaken by 'Unique Improvements'. The needs assessment was part of a local transformation plan and was used to influence the Children and Adolescent Mental Health Services (CAMHS) re-procurement in 2018 as well as shape the future of the emotional wellbeing and mental health local offer. Key data is included in Table 1.

Table 1 Vulnerable Groups and Number of Children and Young People in North East Lincolnshire

Vulnerable Group	Number	Rationale/Evidence
Looked After Children	265 (Actual). The number has grown significantly since 2011.	Nationally validated figure as at 31/03/15. 2016 figure not yet publicly available
CYP with Learning Disabilities	550, of which 225 are estimated to have mental health problems (Estimate)	CHIMAT
CYP with Special Educational Needs	481 children/young people with a statement of EHC Plan (Actual). The number with a statement (or EHC Plan) has decreased significantly since 2007.	Nationally validated data for 2016
CYP with ADHD	385 aged 5-16, predominantly boys (Estimate)	CHIMAT
CYP on the autistic spectrum	200 aged 5-10 (Estimate)	CHIMAT
Young people not in education, employment or training	230 (Actual)	Nationally validated figure data for 2015-2016 figure not yet publicly available
CYP with parents in prison	Not possible to estimate	
Young people who've offended	441 (Actual)	Public Health England CYP Mental Health and Wellbeing Profile
Young Carers	277 (Actual)	Census 2011 – 0.91% of under 15s provide unpaid care
CYP from Black and Minority Ethnic communities	750 (Actual)	School Census
Asylum seeker and refugees	Figure suppressed due to low volume	Public Health England CYP Mental Health and Wellbeing Profile
Gypsy, Roma and Traveller Children	Figure suppressed due to low volume	Public Health England CYP Mental Health and Wellbeing Profile
LGBT young people	750 (Estimate)	Census 2011 – nationally, 2.6% of 16-24 year olds self-identified as LGB. We have applied this % to the number of 16 and 17 year olds.
CYP with physical disabilities	2,277 (Estimate)	The DWP and Office for Disability Issues estimates that 6% of children are disablers

Table 2 shows the estimated number or prevalence of children with mental health disorders in North East Lincolnshire by age group and sex. These rates have been further broken down into the estimated number of children with conduct, emotional, hyperkinetic and less common disorders. Note: the number of children for the different groups does not add up to the numbers with mental disorders because some children have more than one disorder.

Table 2 Estimated number of children with mental health orders by age group and sex and broken down into various disorders*

Disorders	Age Group								
	5-10			11-16			5-16		
	All	Boys	Girls	All	Boys	Girls	All	Boys	Girls
Conduct Disorders	635	455	185	805	495	310	1440	950	495
Less common disorders	155	130	30	140	95	50	295	225	80
Emotional disorders	305	145	165	605	250	355	910	395	520
Hyperkinetic disorders	220	195	30	165	145	25	385	340	55
Any Mental health disorder	980	655	325	1,340	755	600	2,320	1,395	925

Source: Local authority mid-year resident population estimates for 2014 from Office for National Stataistiscs. CCG population estimates aggregated from GP registered population's (Oct 2014)[90]

* Note: the number of children for the different groups does not add up to the numbers with mental disorders because some children have more than one disorder.

11.1.2. Personal Wellbeing

The Annual Population Survey (APS) estimate self-reported personal wellbeing for North East Lincolnshire residents on four key areas; life satisfaction, worthwhile, happiness and anxiety. Compared with England and the Yorkshire and Humber region, North East Lincolnshire had a lower proportion of people whose self-reported life satisfaction, worthwhile and happiness score was classed as high or above. Furthermore, North East Lincolnshire had a considerably greater proportion of people with a self-reported anxiety score than the region and the England average (Table 3).

Table 3 Self-reported wellbeing - % of people scoring themselves High or Very High[v], 2018

Measure	North East Lincolnshire	Yorkshire and Humber	England
Life satisfaction	81.0%	81.5%	82.0%
Worthwhile	83.7%	84.1%	84.2%
Happy	73.5%	74.6%	75.3%
Anxiety	40.0%	36.5%	36.6%

Source: Annual Population Survey, 2018

11.1.3. Common Mental Health Disorders

The Adult Psychiatry Morbidity Survey in 2014 (AMPS[vi]) provides national prevalence estimates for common mental health disorders. Using these prevalence estimates coupled with 2016 local authority population estimates it is possible to determine the approximate number of people suffering from common mental health disorders in the last week; as shown in Table 4. In total, an estimated 21,757 people in North East Lincolnshire aged 15 to 74 years suffered at least one common mental health disorder episode in the last week with a higher proportion of females and males reporting an episode.

[v] A score of 7-8 is classed as High and 9-10 is classed as Very High

[vi] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014

Table 4 Prevalence of any common mental health disorder in the last week, AMPS 2014

Disorder	Males	Females	All
Generalised anxiety disorder	3057	4509	7566
Depressive episode	1826	2445	4271
Phobia	1077	1943	3020
Obsessive compulsive disorder	643	984	1627
Personality disorder	211	553	765
Other	3640	6333	9973
Any common mental health	8174	13583	21757

Source: NHS Digital - AMPS, Office of National Statistics

11.1.4. Depression

Depression prevalence amongst North East Lincolnshire 18+ registered patients was recorded as 8.2% for 2016/17, the 4th lowest CCG prevalence in the Yorkshire and Humber NHS region (out of 23 CCG areas). The Yorkshire and Humber regional prevalence was 9.4% and the national prevalence was 9.1%. In total, 11,202 patients in North East Lincolnshire were registered with depression.

Data received from 360 Care[vii] suggests that of those diagnosed with depression, females make up almost two thirds (63.5%) and males make up around a third (36.5%). Less than 1% were aged under 18 years and 14.2% of patients are aged over 65 years. However, the proportion of older people suffering from depression is likely to increase significantly over the next 25 years given the projected older people population increases. POPPI[viii] suggests that the number of older people with depression could increase by 34% by 2041.

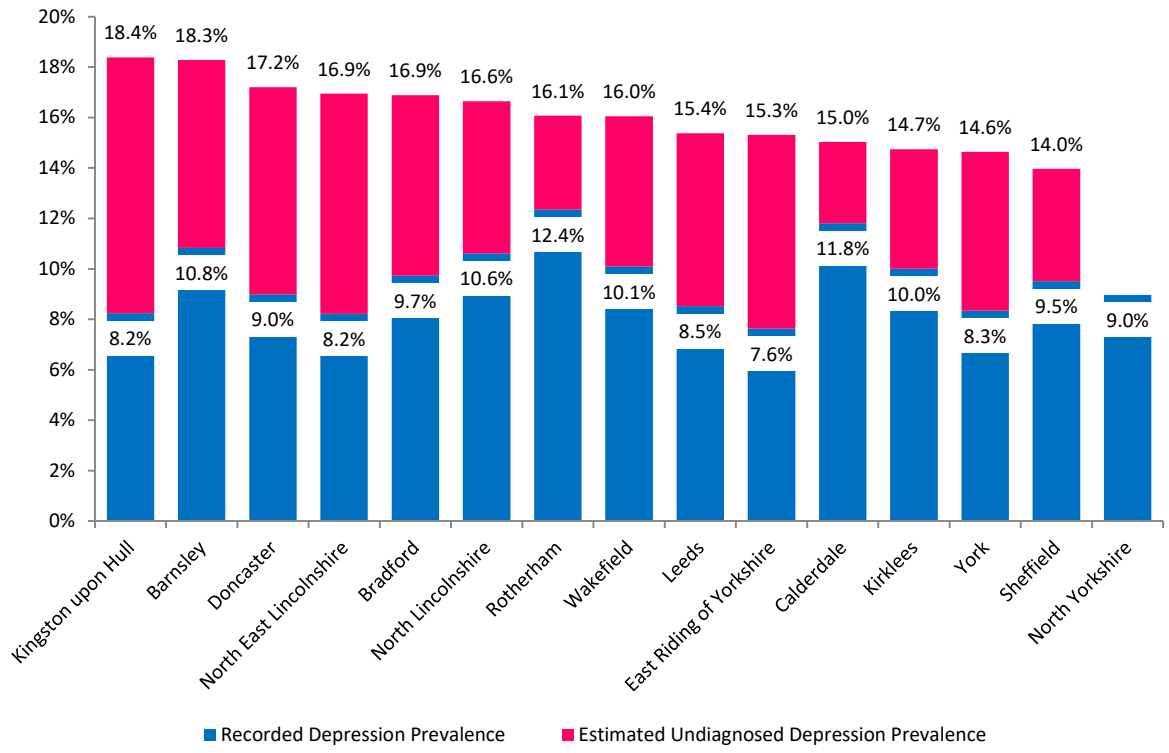
New diagnoses of depression are also occurring at a lower rate in North East Lincolnshire compared to nationally and regionally. Depression incidence for North East Lincolnshire was 1.4% (1,858 new diagnoses in 2016/17) compared to 1.5% for the Yorkshire and Humber region and England.

Modelled estimates provided by PHE suggest North East Lincolnshire's depression prevalence is 16.9%; significantly higher than the actual recorded local QOF prevalence of 8.2%. Applying the modelled depression prevalence estimates to the North East Lincolnshire population aged 18 years and over would assume that we should expect to have in the region of 21,000 residents suffering from depression and an undiagnosed depression percentage of 47.1% locally (51.5% of North East Lincolnshire registered population); equivalent to 10,000 people aged 18 and over.

Figure 1 shows the modelled estimated depression prevalence compared to recorded prevalence for local authorities in the Yorkshire and Humber region. North East Lincolnshire has the 4th highest estimated depression prevalence in the region and the 2nd highest undiagnosed prevalence % in the region; only Hull had a greater proportion of undiagnosed depression.

[vii] 360 Care is a federation of several General Practices in North East Lincolnshire covering a population of approximate 60,000 patients.
[viii] POPPI – Projecting Older Peoples Population Information (http://www.poppi.org.uk/)

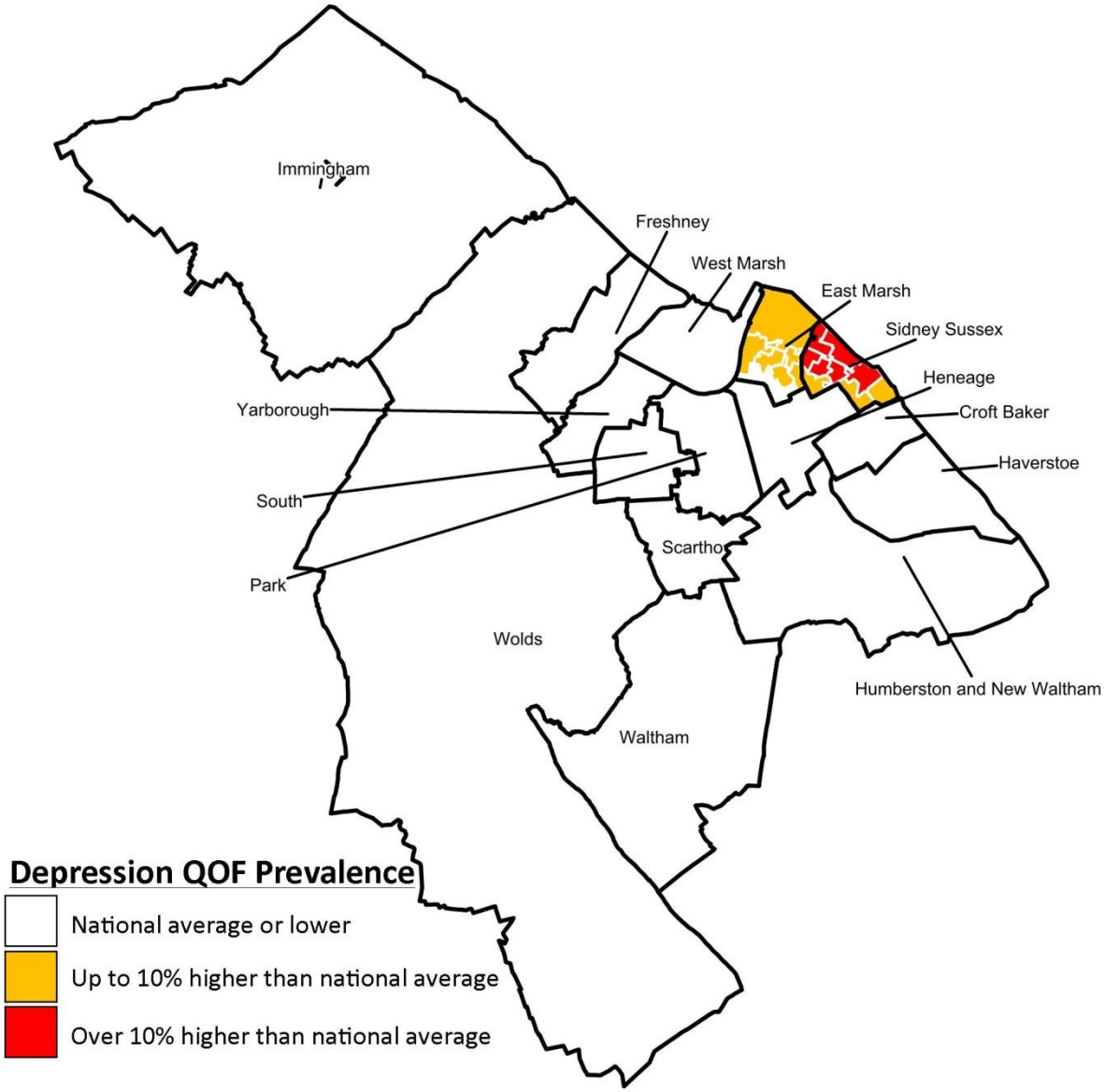
Figure 1 Modelled depression prevalence estimates compared to recorded prevalence for Yorkshire and Humber region local authorities



Source: PHE Fingertips 2015, NHS Digital 2016/17

GP practice depression prevalence was modelled at LSOA geographies for North East Lincolnshire and compared against the overall national prevalence rate (as shown in Figure 2). The map shows that for the majority of areas of North East Lincolnshire, depression prevalence is similar or lower than the national prevalence. The majority of LSOAs within Sidney Sussex ward had a depression prevalence of at least 10% greater than the national prevalence percentage and most of the East Marsh ward had a prevalence of up to 10% greater than the national percentage. Given the demographic and social composition of the resident population of North East Lincolnshire, we would typically expect to see a greater depression prevalence rate locally. This map, coupled with the data presented in Figure 1, indicates that depression diagnosis is far lower than expected in North East Lincolnshire and it appears only a handful of GPs in the East Marsh and Sydney Sussex wards are diagnosing depression at a greater rate than observed nationally.

Figure 2 North East Lincolnshire LSOA depression prevalence (modelled) compared to the national average 2016/17



Source: NHS Digital, Public Health England, Office of National Statistics

11.1.5. Perinatal Mental Health

Table 5 shows the estimated prevalence of mental health disorders in the perinatal period (the time immediately before and after birth), the numbers are based on national prevalence applied to the local birth rate and no other factors have been taken into account therefore there are some concerns regarding the quality of this data.

Table 5 Estimated prevalence of mental illness in the perinatal period in North East Lincolnshire, 2015/16

NHS North East Lincolnshire CCG		Estimated Number
Postpartum psychosis		5
Chronic serious mental illness (SMI) in perinatal period		5
Severe depressive illness in perinatal period		60
Post-traumatic stress disorder (PTSD) in perinatal period		60
Mild-moderate depressive illness and anxiety in perinatal period	Lower estimate	190
	Upper estimate	285
Adjustment disorders and distress in the perinatal period	Lower estimate	285
	Upper estimate	565

Source: Public Health England

Whooley questions are used by Health visitors in North East Lincolnshire with postnatal women to screen for postnatal depression. Out of 836 women screened between Q1 and Q3 of 2017/18, 7% said they had been bothered by feeling down depressed or hopeless and 4% said they had little interest or pleasure in doing things, 4% had answered yes to both questions.

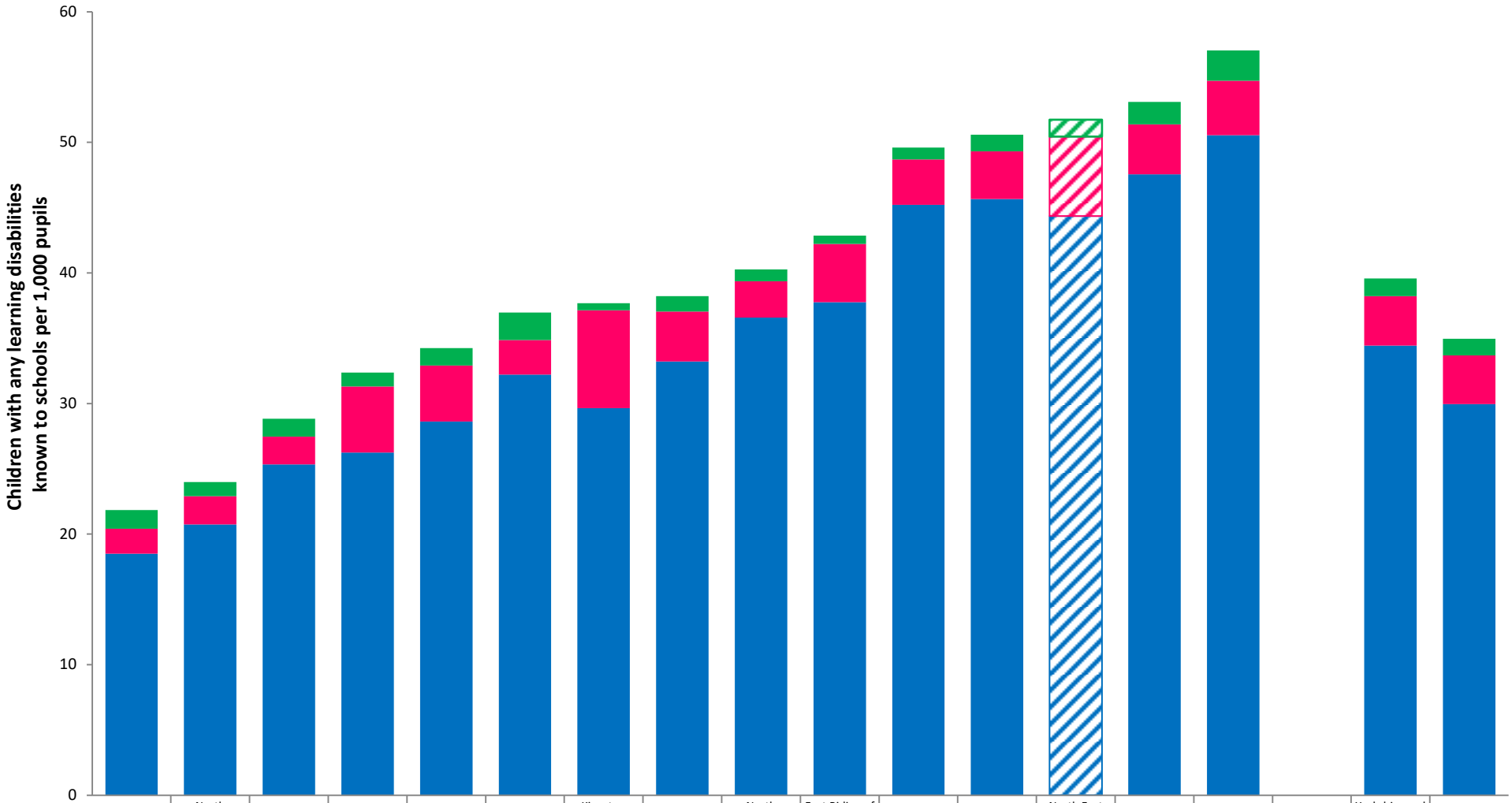
Whooley questions	Yes	
	Number	%
During the past month have you often been bothered by feeling down, depressed or hopeless	60	7%
During the past month have you often been bothered by having little interest or pleasure in doing things?	31	4%
Yes to both	29	4%
Is this something you feel you need or want help with?	20	69%

11.1.6. Learning Disability

Between 2016/17 there were a total of 976 patients registered to North East Lincolnshire CCG recorded as having a learning disability; an overall prevalence of 0.6% which is higher than the England national prevalence of 0.5%.

North East Lincolnshire has the third highest rate of pupils with a learning disability known to school in the Yorkshire and Humber region (51.7 per 1,000 pupils); higher than both the regional rate of 39.6 and the national rate of 35.0 (see Figure 3). For severe learning disabilities, North East Lincolnshire has the second highest rate in the region (6.1 per 1,000 pupils).

Figure 3 Primary and Secondary aged children with learning disabilities known to school, rate per 1,000 pupils, 2017



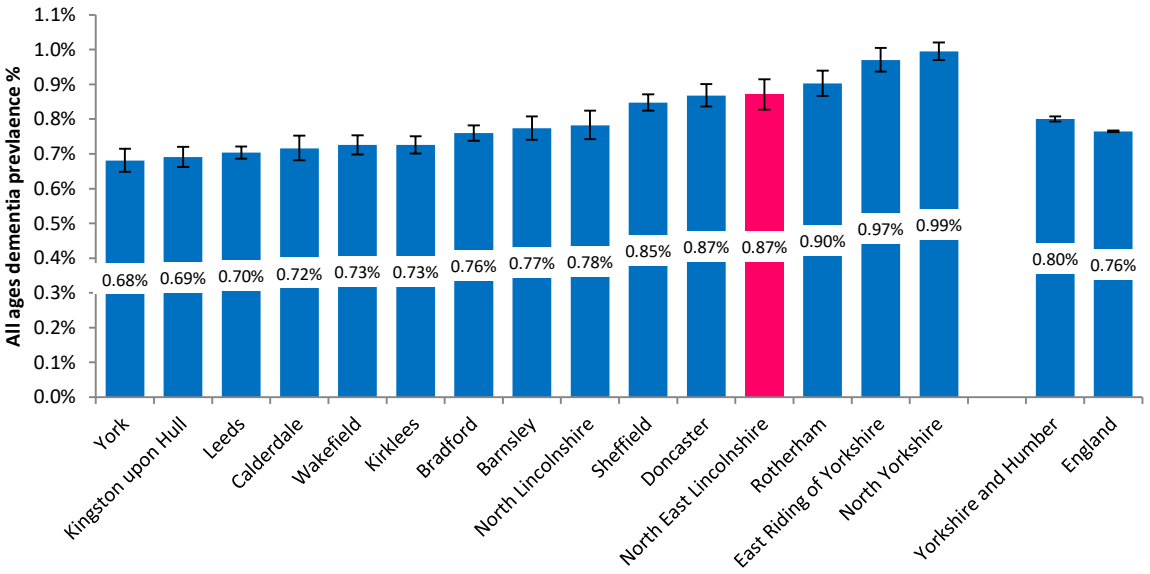
	York	North Yorkshire	Rotherham	Wakefield	Sheffield	Kirklees	Kingston upon Hull	Leeds	North Lincolnshire	East Riding of Yorkshire	Doncaster	Barnsley	North East Lincolnshire	Calderdale	Bradford		Yorkshire and Humber	England
Any LD	21.9	24.0	28.8	32.4	34.2	37.0	37.7	38.2	40.3	42.9	49.6	50.6	51.7	53.1	57.0		39.6	35.0
Profound & Multiple LD	1.4	1.1	1.4	1.1	1.3	2.1	0.5	1.2	0.9	0.6	0.9	1.3	1.3	1.7	2.3		1.4	1.3
Severe LD	1.9	2.2	2.1	5.1	4.3	2.6	7.5	3.8	2.8	4.5	3.5	3.6	6.1	3.8	4.2		3.8	3.7
Moderate LD	18.5	20.7	25.3	26.2	28.6	32.2	29.6	33.2	36.6	37.8	45.2	45.7	44.3	47.6	50.5		34.4	30.0

Source: PHE Fingertips 2017

11.1.7. Dementia

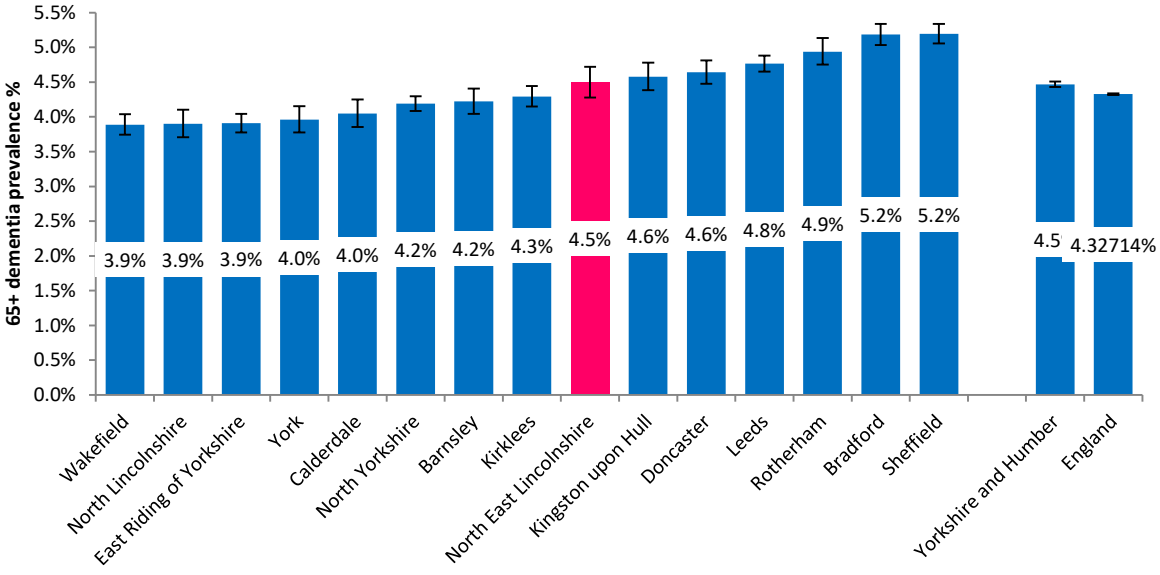
North East Lincolnshire has the fourth highest all age dementia prevalence (0.87%, 1494) in the Yorkshire and Humber region and is significantly higher than the regional (0.8%) and national (0.76%) prevalence percentages (see Figure 4). For those aged 65 and over North East Lincolnshire has a dementia prevalence of 4.5% which is the seventh highest in the region although the prevalence is not significantly higher than the national (4.3%) or the regional (4.5%) percentages (see Figure 5).

Figure 4 Dementia prevalence for all ages, Yorkshire and Humber region, 2016/17 (registered population)



Source: PHE Fingertips

Figure 5 Dementia prevalence for 65 years and over, Yorkshire and Humber region, Sept 2017 (registered population)

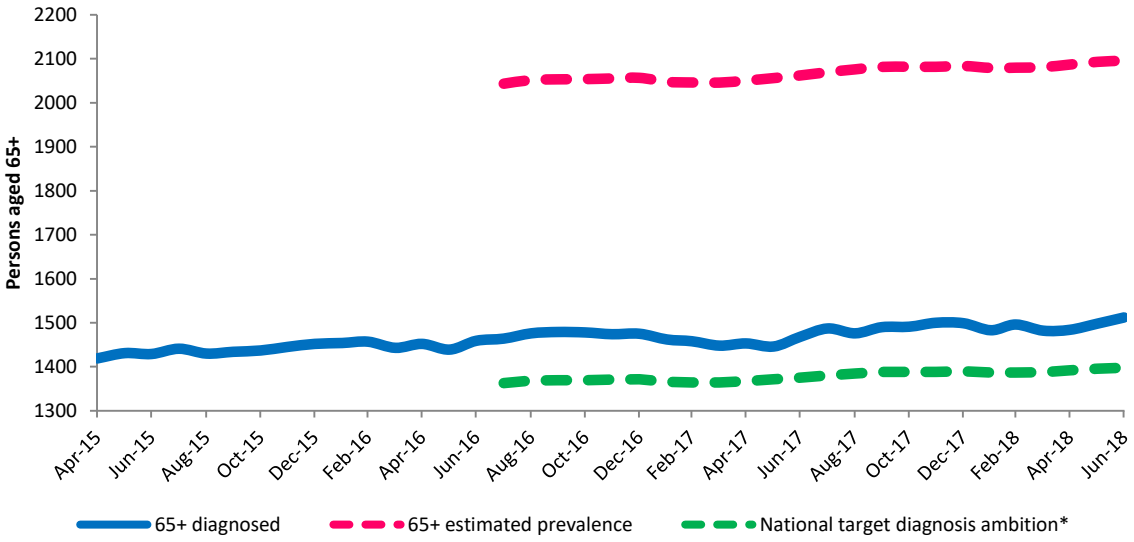


Source: PHE Fingertips

Local trends for the number of individuals aged 65 and over recorded as being diagnosed with dementia have steadily increased from 1419 in April 2015 to 1512 June 2018. Estimated dementia prevalence in the over 65s has largely increased at the same rate as local dementia diagnoses with North East Lincolnshire continuing to remain above the national dementia diagnosis target of 66.7%. Current estimates suggest

that as many as 2097 people aged 65 and over are living with dementia in North East Lincolnshire giving a dementia diagnosis rate in the over the 65s as of June 2018 was 72.1%.

Figure 6 North East Lincolnshire recorded dementia diagnoses, estimated 65+ dementia prevalence and, national diagnosis target in the over 65s, trend April 2015 to June 2018



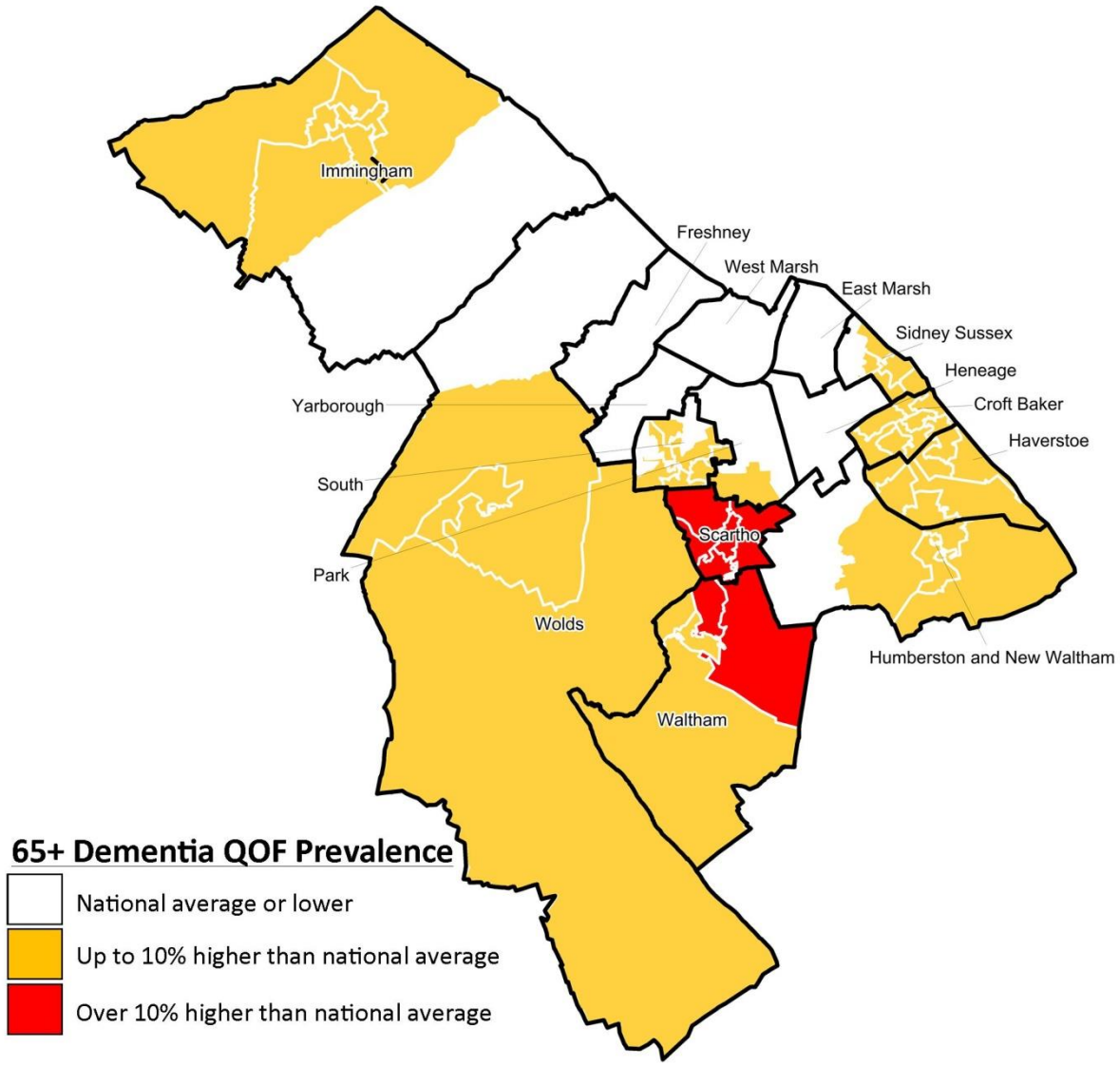
*based on North East Lincolnshire estimated target diagnosis (66.7%)

Source: NHS Digital

The number of older people (65+) estimated to be living with dementia is expected to increase significantly over the coming years. By applying todays dementia prevalence estimates, POPPI[viii] predict that we should expect to see a 67.4% increase in the number over 65s with dementia; equivalent to almost 1500 more people locally. These estimates only take in to account projected population increases and not increases in disease prevalence amongst those age groups.

GP practice dementia prevalence was modelled at LSOA geographies for North East Lincolnshire residents aged over 65 years and compared against the overall national prevalence rate (as shown in Figure 7). The map clearly shows that dementia diagnoses are lower or equivalent to national prevalence average in the more urbanised areas of Grimsby and greater in Cleethorpes and the rural areas of North East Lincolnshire. There appears to be greater diagnosis rate in Scartho and parts of Waltham ward which may suggest GP's in those areas are diagnosing at a greater rate than in other areas of North East Lincolnshire. Despite most of the areas highlighted in yellow and red being areas typically associated with a greater population density of older people, this model attempts to account for older people population variation between LSOAs. Therefore, any differences can be assumed to be valid.

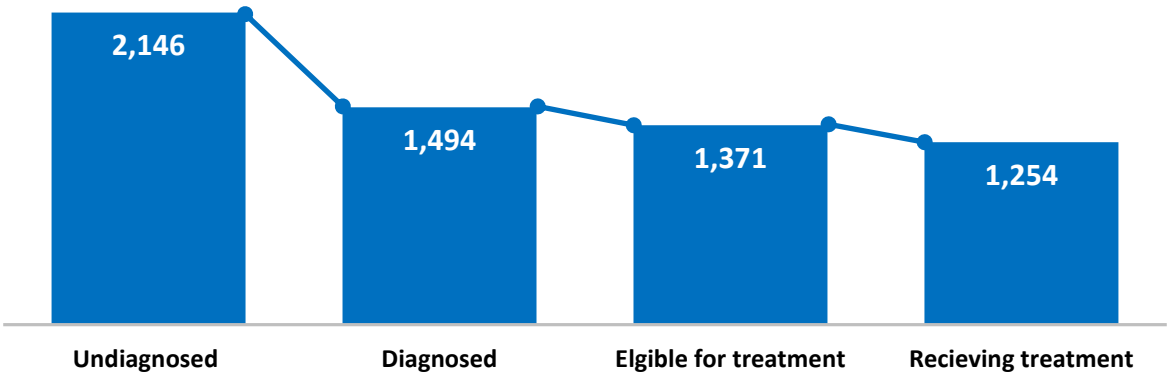
Figure 7 North East Lincolnshire LSOA dementia prevalence for persons aged 65+ (modelled) compared to the national average 2016/17



Source: NHS Digital, Public Health England, Office of National Statistics

Using dementia estimates (total population expected to be living with dementia) and Quality Outcomes Framework data it is possible to estimate the number and proportion of people who are yet to be diagnosed with dementia (652, 30.4%), the proportion who have been diagnosed and are eligible for dementia treatment (1371, 63.9%) and the proportion of the estimated dementia population who are receiving treatment (1254, 58.4%); see Figure 8.

Figure 8 Estimates of dementia prevalence - including undiagnosed, diagnosed and disease management in North East Lincolnshire, 2016/17



Undiagnosed – *Estimated total number of people expected to be living with dementia (assumed from 65+ estimates)*
Diagnosed – *Total number of people diagnosed with dementia*
Eligible for treatment – *Total number of people who are eligible for treatment (Exceptions)*
Receiving treatment – *Number of patients whose dementia care plan has been reviewed in a face-to-face review in the preceding 12 months*
Source: NHS QoF 2016/17, NHS Digital

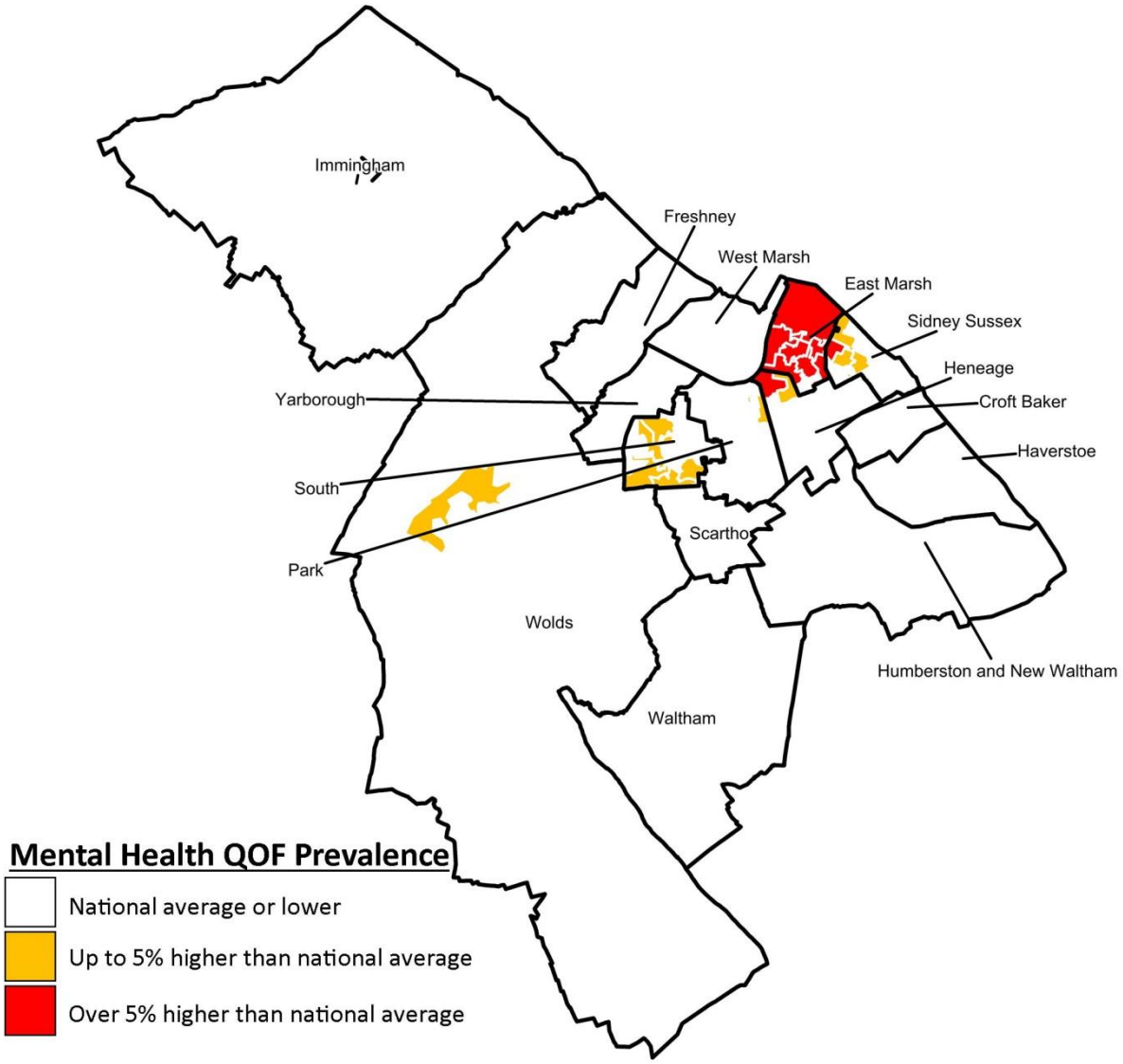
11.1.8. Severe Mental Health

Between 2016/17 there were a total of 1,409 patients registered to North East Lincolnshire CCG recorded as having a severe mental illness[ix]; an overall prevalence of 0.82% which is significantly lower than the England national prevalence of 0.92%. National prevalence of severe mental illness has incrementally increased between 2012/13 and 2016/17 whereas locally the prevalence has remained consistently lower than figures reported nationally.

GP practice severe mental health prevalence was modelled at LSOA geographies for North East Lincolnshire residents and compared against the overall national prevalence rate (as shown in Figure 9). The modelled data shows that East Marsh ward has the highest prevalence of severe mental health in North East Lincolnshire. Parts of Sydney Sussex ward and South ward also had a prevalence greater than that the national prevalence.

[ix] QOF indicator for severe mental illness includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses recorded on practice disease registers

Figure 9 North East Lincolnshire LSOA severe mental health prevalence (modelled) compared to the national average 2016/17



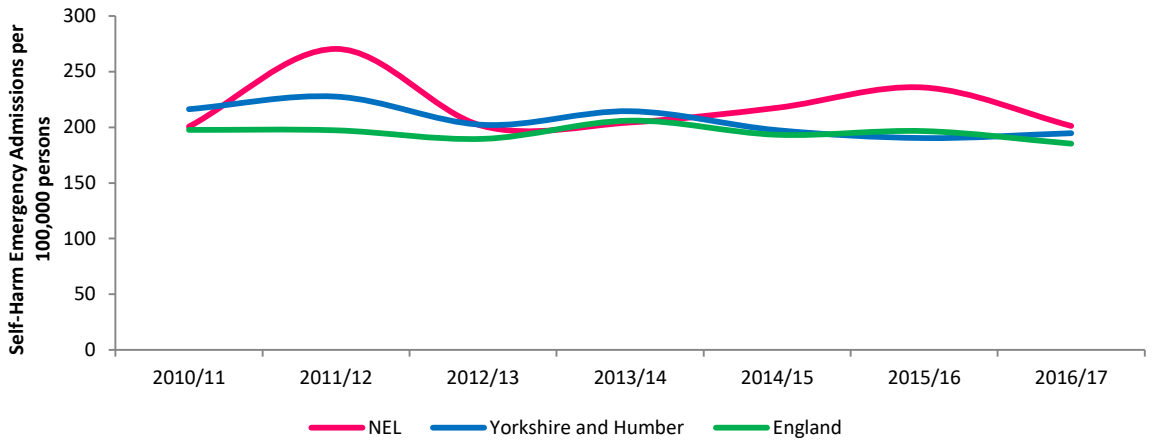
Source: NHS Digital, Public Health England, Office of National Statistics

11.1.9. Self-Harm

In 2016/17 there were 305 emergency admissions for self-harm in North East Lincolnshire at a rate of 201.2 per 100,000 persons. North East Lincolnshire's rate is the 7th highest in the region and is higher than the national and regional rates of 185.3 and 194.7 respectively; although the differences were not significant (Figure 11). North East Lincolnshire has largely matched the national trend in self-harm emergency admissions despite fluctuating more drastically in 2011/12, 2014/15 and 2015/16. During these years the local rate was significantly higher than the national rates (Figure 10).

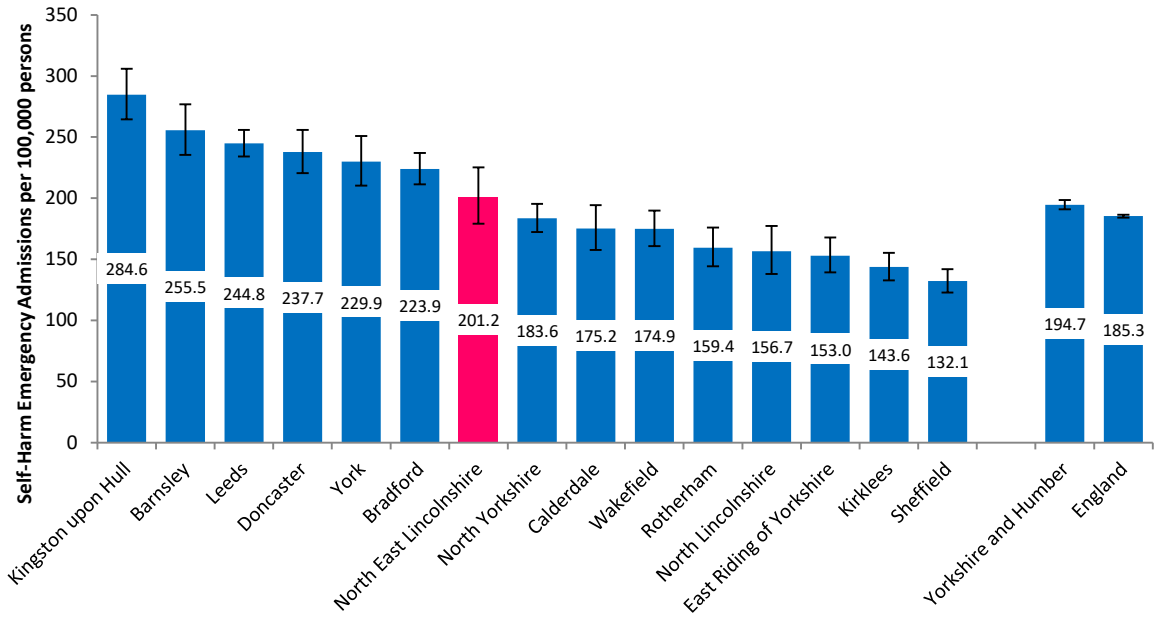
There were 69 hospital admissions as a result of self-harm for young people ages 10 to 19 in 2016/17. Nationally the rates of self-harm in young people have generally increased whereas locally the rates have stayed relatively constant despite some fluctuations in numbers over the last 5 years.

Figure 10 Emergency self-harm admissions rate per 100,000 persons, 2010/11 to 2016/17



Source: Public Health England, 2017

Figure 11 Emergency self-harm admissions rate per 100,000 persons for the Yorkshire and Humber region, 2016/17

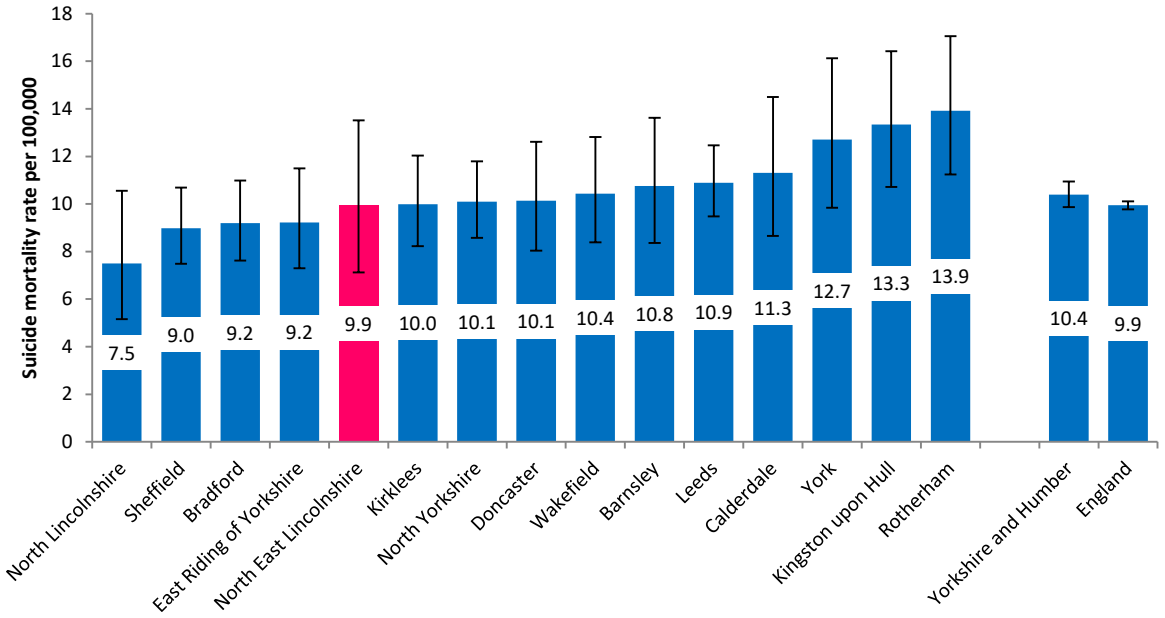


Source: Public Health England, 2017

11.1.10. Suicide

The latest suicide and undetermined injury intent rate (2014-16) for England is 9.9 per 100,000 and the Yorkshire and Humber region has a slightly higher rate of 10.4 per 100,000; both showing a similar rate to the previous 3 year pooled figure (see Figure 12). Within the Yorkshire and Humber region, North East Lincolnshire has the 5th lowest suicide and undetermined injury intent rate with 9.9 per 100,000, lower than the national rate and the same as the regional rate; although any difference was not statistically significant. Similarly, North East Lincolnshire was not statistically different from any other local authority rates in the Yorkshire and Humber region.

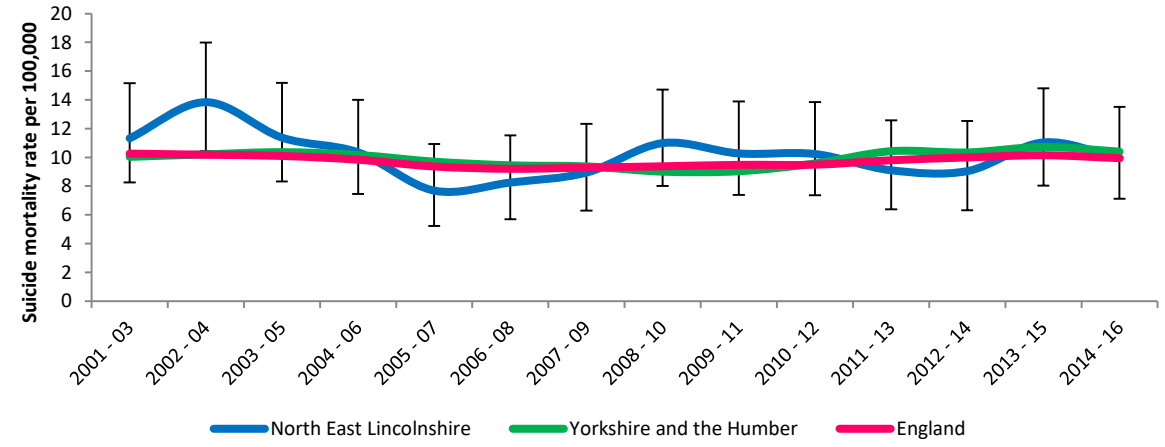
Figure 12 3 year pooled directly age-standardised mortality rate from suicide and injury of undetermined per 100,000 population[x], Yorkshire and Humber region, 2014-2016



Source: Public Health England, 2017

Figure 13 shows that the latest available suicide and injury from undetermined intent trend for North East Lincolnshire has largely matched national and regional fluctuations. The local rate had recently overtaken national and regional rates despite these also showing an increase. North East Lincolnshire had shown a reduction in suicide rates since 2008-10 but in 2013-15 the suicide rate reached its highest in 10 years. Despite the recent increase in local suicide mortality, North East Lincolnshire has not shown a statistically significant difference to the Yorkshire and Humber regional and England national rates and has since fallen below the national rate.

Figure 13 3 year pooled directly age-standardised mortality rate from suicide and injury of undetermined per 100,000 population[x], trend for North East Lincolnshire, Yorkshire and Humber region and England



Source: Public Health England, 2017

[x] Includes deaths from suicide and injury of undetermined intent classified by underlying cause of death recorded as ICD10 codes X60-X84 (age 10+ only), Y10-Y34 (ages 15+ only) registered in the respective calendar years.

The 2014 AMPS[vi] estimates the national prevalence of suicidal thoughts and suicide attempts. Using these prevalence estimates it can be assumed that 11,767 men and 14,884 women have had suicidal thoughts in the past year and 3,398 men and 5,316 women have attempted suicide in the past year.

Mental Health Prevalence - Key Points

- An estimated 2,320 children aged 5 to 16 years have a mental health condition locally.
- An estimated 21,757 people aged 15 to 74 in North East Lincolnshire have suffered a common mental health disorder episode in the last week.
- A lower proportion of local people believe they have good life satisfaction, a worthwhile life, are happy and who have low anxiety compared to national and regional proportions.
- Depression prevalence is 8.2% with females more likely to be diagnosed than males. Locally, new depression diagnoses are at a lower rate than national and regional rates and it is estimated that nearly half of depression is undiagnosed locally. Depression appears to be underdiagnosed in many parts of North East Lincolnshire.
- It is estimated that as many as 565 women suffer adjustment disorders and 285 women suffer mild-moderate depression in their perinatal period locally.
- It is estimated that there are 2097 older people living with dementia locally, of which 1512 have been diagnosed. The diagnosis rate in North East Lincolnshire of 70% is higher than the national target of 66.7%. Of the total dementia prevalence locally, it is possible to estimate the proportion of people who are yet to be diagnosed with dementia (30.4%), the proportion that have been diagnosed and are eligible for dementia treatment (63.9%) and the proportion of the estimated dementia population who are receiving treatment (58.4%).
- There are an estimated 1409 people living with severe mental illness (i.e. schizophrenia, bipolar affective disorder and other psychoses) with the highest numbers of people with severe mental illness living in the most deprived areas of North East Lincolnshire.
- There were 69 hospital admissions as a result of self-harm for young people ages 10 to 19 in 2016/17. Nationally the rates of self-harm in young people have generally increased whereas locally the rates have stayed relatively constant despite some fluctuations in numbers over the last 5 years.
- The local suicide rate is currently lower than both the nationally and regional rates.

11.2. Our Place Survey

In 2017/18 the “Our Place” survey was undertaken which consolidated Council, CCG and community safety partnership public perception questions. Aligned to the outcome framework, the aim was to obtain public perception information, rather than consulting on service change. It incorporated engagement exercises that already exist for public perception/opinion and fill some gaps in community insight. Questions were asked against numerous themes, one of which focussed on health and self-care. The local Our Place survey was run from the 6th December 2017 to the 19th February 2018 receiving a total of 1018 responses. The survey gained a representative demographic spread of North East Lincolnshire.

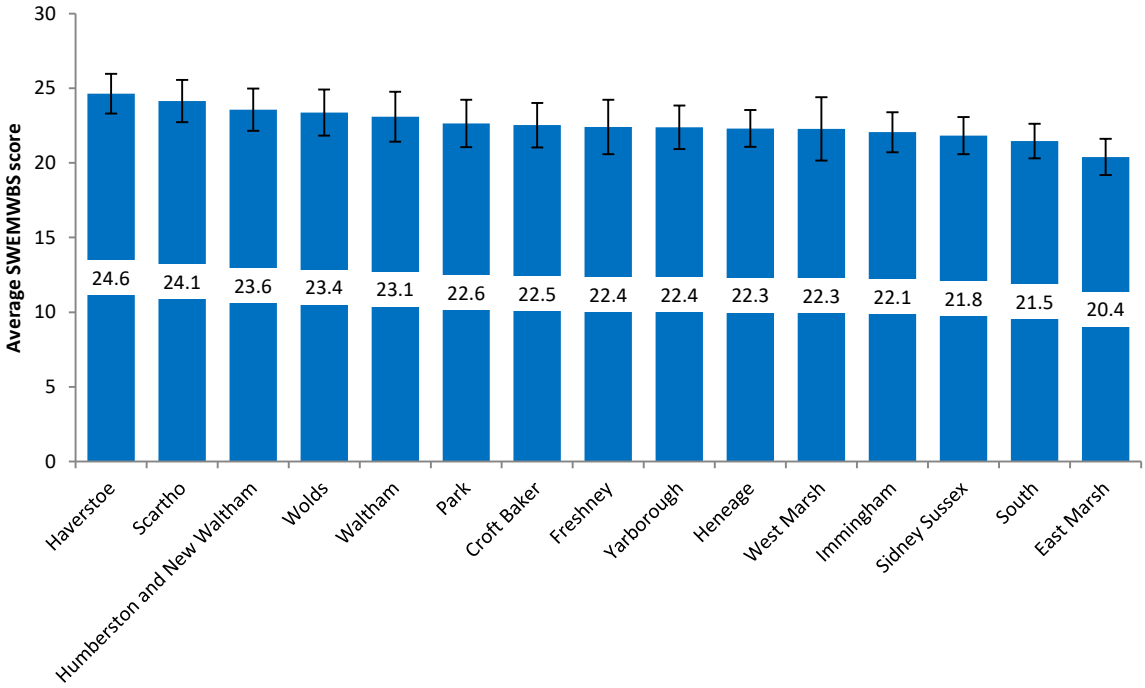
Mental health and wellbeing questions asked as part of the survey were analysed and results are presented below.

The short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) is a seven item scale, and is a shortened version of the 14 item scale Warwick Edinburgh Mental Wellbeing Scale. The scale was developed to enable the monitoring of mental wellbeing in the general population. The maximum score that can be achieved on the seven item SWEMWBS is 35 points with a higher score associated with better mental wellbeing.

Of the 1018 responses, 570 people completed all 7 questions on the 7 item SWEMWBS survey. The average score for respondents was 22.6; however there were considerable variations depending on where people live, age, gender, health status, tenancy and education level.

There was a clear correlation between where people live and their SWEMWBS score. Those who lived in the most deprived areas of North East Lincolnshire were significantly more likely to score lower than those who lived in the least deprived areas of North East Lincolnshire (21.1 compared to 23.7). Haverstoe, Scartho and Humberston and New Waltham wards have the highest SWEMWBS scores whereas Sidney Sussex, South and East Marsh wards had the lowest average scores.

Figure 14 Average SWEMWBS for North East Lincolnshire wards, 2018



Source: North East Lincolnshire Our Place, Our Future Survey 2018

Females had a score that was marginally higher than males (22.7 compared to 22.5) but the difference was not found to be significant.

Older respondents were more likely to score higher on the scale with those aged 65 and over scoring, on average, 24.9 compared to those aged 15 to 34 scoring an average of 21.9. No significant differences were found between people aged 15 to 34 through to those aged 50 to 64 despite scores increasing with age.

Level of educational attainment was also found to be an indicator of mental wellbeing amongst survey participants. People who said they no qualifications scored an average of 21.9 on the scale whereas those who had achieved at least degree level education (level 6 to 8) scored 23.6.

Home owners had higher SWEMWBS scores than those who privately or socially rent (23 compared to 21 and 21.4 respectively).

Those who reported they had a disability or long term health condition had an average score of 21.6, significantly lower than those who did not have a disability or long term condition (23.1). Furthermore, those who self-reported their health as “very bad” only scored 15.3 on the scale whereas those who reported their health as “very good” scored 26.1.

Table 6 Average SWEMWBS scores for various demographics and sub categories, 2018[xi]

North East Lincolnshire	Number	SWEMWBS score	*Lower 95% CI*	*Upper 95% CI*
All respondents	570	22.62	*22.27* -	*22.97*
Deprivation				
Most Deprived	78	21.14	*20.18* -	*22.10*
2	97	21.56	*20.74* -	*22.38*
3	110	22.76	*21.97* -	*23.56*
4	93	23.32	*22.37* -	*24.28*
Least Deprived	133	23.71	*23.05* -	*24.36*
Gender				
Male	200	22.52	*21.90* -	*23.13*
Female	363	22.70	*22.27* -	*23.13*
Age				
15 to 34	138	21.92	*21.28* -	*22.55*
35 to 49	184	22.26	*21.68* -	*22.84*
50 to 64	161	22.62	*21.93* -	*23.31*
65+	85	24.49	*23.50* -	*25.49*
Educational Attainment				
No Qualification	45	21.89	*20.55* -	*23.24*
Entry Level	19	22.77	*20.70* -	*24.83*
Level 1	19	20.33	*18.66* -	*22.00*
Level 2	55	22.14	*20.97* -	*23.31*
Level 3	109	22.22	*21.44* -	*23.00*
Level 4	62	22.07	*20.91* -	*23.23*
Level 5	62	22.66	*21.67* -	*23.64*
Level 6	116	23.27	*22.50* -	*24.05*
Level 7	53	23.90	*22.69* -	*25.12*
Level 8	13	24.60	*22.22* -	*26.98*
Tenancy				
Home Owner	429	23.04	*22.63* -	*23.45*
Private Renter	89	21.09	*20.34* -	*21.84*
Social Renter	43	21.39	*20.12* -	*22.66*
Self-reported Disability or Long Term Condition				
Yes	167	21.60	*20.91* -	*22.28*
No	401	23.06	*22.66* -	*23.46*
Self-reported Health Status				
Very bad	6	15.34	*11.65* -	*19.02*
Bad	46	18.44	*17.48* -	*19.40*
Fair	169	21.09	*20.57* -	*21.62*
Good	240	23.23	*22.80* -	*23.67*
Very good	100	26.08	*25.24* -	*26.93*

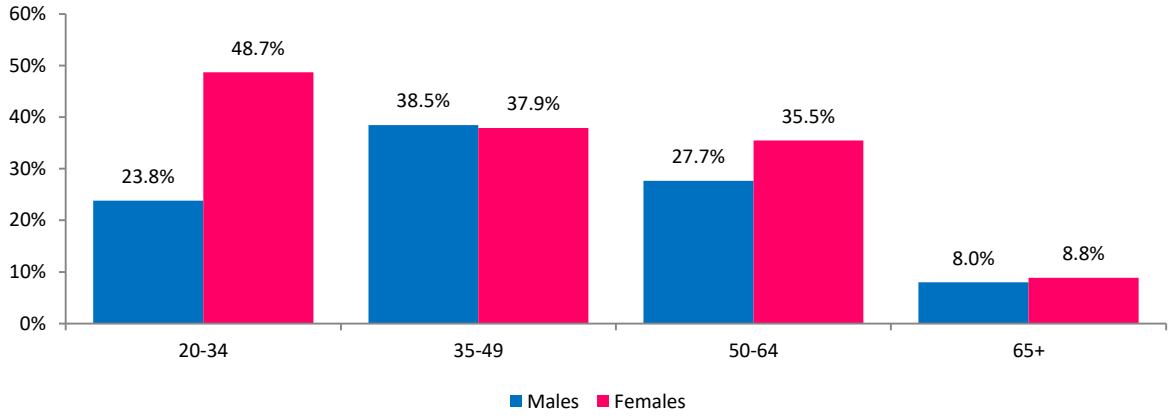
Source: North East Lincolnshire Our Place, Our Future Survey 2018

A third of people (33.4%) felt that their mental health had had a bad impact on their life in the previous 12 months. There were considerably differences between males and females with 26.8% of men and 36.6% of women saying that mental health had affected them in the last year. Overall, older people were less likely to say mental health had affected them than younger people. Males aged 20 to 34 were half as likely to

[xi] Not all sub categories total 570 due to respondents not answering all qualifying questions to undertake cross tabulation analysis.

report mental health had impact on their life compared to females of the same age (23.8% compared to 48.7%).

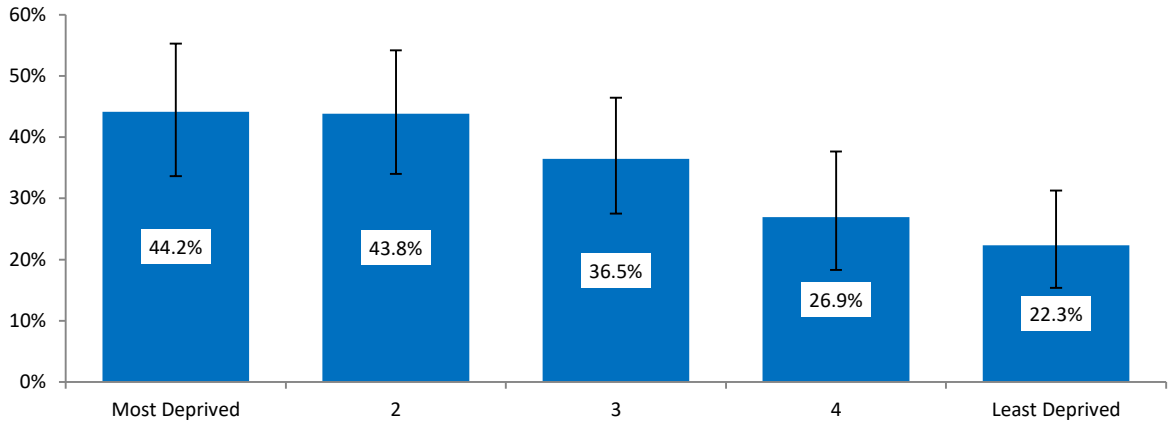
Figure 15 % of people who felt mental health had a bad impact on their life in the last year by age group, 2018



Source: North East Lincolnshire Our Place, Our Future Survey 2018

Those who live in the two most deprived quintiles in North East Lincolnshire were almost twice as likely to report that mental health had a negative impact on their life in the previous 12 months compared to those who live in the least deprived quintile (44.2% and 43.8% compared to 22.3%).

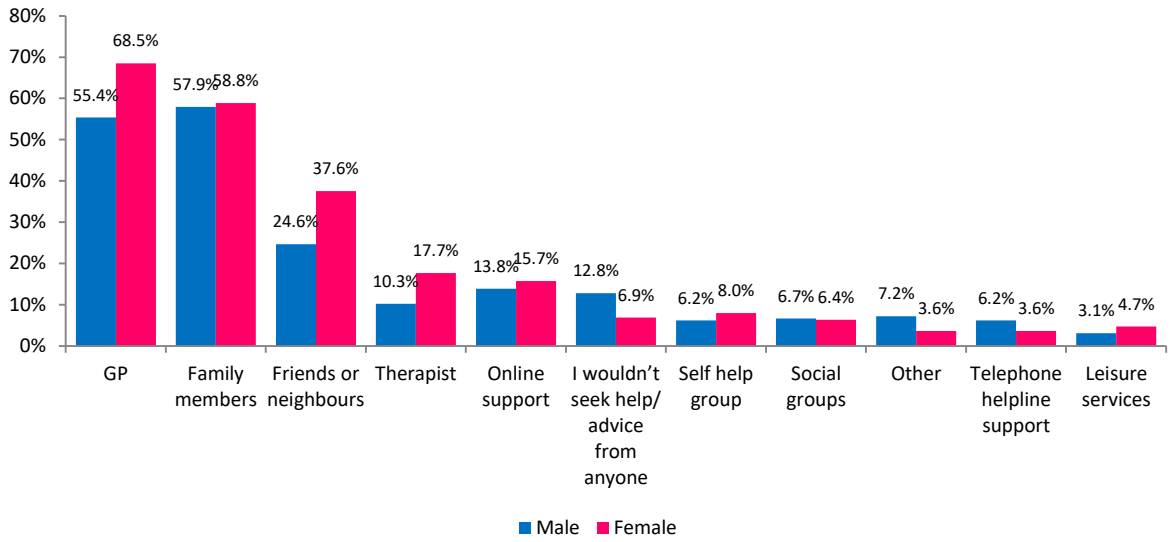
Figure 16 % of people who felt mental health had a bad impact on their life in the last year by local IMD quintile, 2018



Source: North East Lincolnshire Our Place, Our Future Survey 2018

Participants were asked “If you felt low for long time, who would you seek help and advice from?”. Most people said they would speak to their GP, family members, friends or neighbours. People were least likely to consider seeking advice from local leisure services, a telephone helpline or social groups. There were considerable differences between the type of support men and women would seek. Men would more likely go to family members than the GP where women would more likely go to their GP. Almost twice as many males said they wouldn’t seek advice compared to females (12.8% compared to 6.9%) and males would be more likely to use a telephone helpline than females (6.2% compared to 3.6%).

Figure 17 Where people would seek advice if they felt low for a long time, by gender, 2018



Source: North East Lincolnshire Our Place, Our Future Survey 2018

Our Place Survey – Key Points

- A third of people (33.4%) felt that their mental health had had a bad impact on their life in the previous 12 months with older people less likely to say mental health had affected them than younger people.
- Males aged 20 to 34 were half as likely to report mental health had impacted on their life compared to females of the same age.
- Those who live in the two most deprived quintiles in North East Lincolnshire were almost twice as likely to report that mental health had a negative impact on their life in the previous 12 months compared to those who live in the least deprived quintile.

11.3. Adolescent Lifestyle Survey

An Adolescent Lifestyle Survey (ALS) was undertaken in North East Lincolnshire during 2015. The ALS was offered to all young people of secondary school age (years 7 to 11; ages 11 to 16 years), and was facilitated by the academies with eight of the ten secondary academies in North East Lincolnshire participating. The final report included an analysis of the responses of 52% of the registered secondary school population.

This data summary provides analysis of the questions relating to emotional health and wellbeing from the ALS at a local deprivation quintile level. Analyses are intended to show where, if any, differences occur between the emotional health and wellbeing status of adolescents living in different deprivation quintiles in North East Lincolnshire. Deprivation quintiles were calculated using the 2015 Indices of Multiple Deprivation (IMD) based on postcodes given by survey respondents and analyses were grouped for each question by quintile. Not all respondents to the survey gave their postcode, therefore it was only possible to undertake analysis on a proportion of the dataset; 59% of those who responded to the survey gave a recognisable postcode which equated to 30% of the registered secondary school population. However, the minimum response rate for each quintile were as follows:

Local 2015 IMD Quintile	Minimum number of responses
1 Most Deprived	368
2	496
3	452
4	491
5 Least Deprived	698

The data presented below should be interpreted along with information provided in the 'Happiness and Home Life' section in the main Adolescent Lifestyle Report (available from the link provided in the key points). This will give clarity and context to the information provided in this data summary.

Figure 18 ALS emotional wellbeing deprivation analysis

ALS 2015 Emotional Health and Wellbeing	Local 2015 IMD Quintile					
Please read the following statements and tell us whether they are true for you right now. *Proportion who answered 'Yes'*	**1 Most Deprived**	**2**	**3**	**4**	**5 Least Deprived**	**All respondents***
I usually feel happy about life	80.1%	81.9%	82.0%	85.9%	89.7%	84.3%
I often feel sad or tearful	28.9%	30.5%	32.6%	23.5%	22.7%	27.2%
I have one or more good friends	95.5%	97.1%	95.9%	96.1%	97.5%	96.6%
My parent(s) and family look out for me	97.4%	95.6%	97.9%	96.5%	97.8%	96.4%
I am often bad tempered or get angry	47.6%	43.6%	43.3%	37.3%	27.0%	39.7%
I often feel anxious or depressed	29.0%	29.9%	30.4%	24.3%	22.1%	26.7%
I seem to worry a lot of the time	47.9%	46.3%	52.1%	43.8%	46.8%	46.6%
I feel I have a lot to be proud of	64.5%	65.5%	66.9%	67.3%	68.3%	66.7%
I like trying new things	76.4%	75.2%	73.3%	75.3%	77.6%	76.2%
I wish I had a different kind of life	27.2%	26.6%	26.0%	19.3%	18.5%	23.2%
If you had a problem, would you talk to someone about this?	**1 Most Deprived**	**2**	**3**	**4**	**5 Least Deprived**	**All respondents***
Problem with school	65.4%	70.1%	70.5%	73.0%	74.2%	69.0%
Family problem	48.3%	55.1%	52.9%	54.4%	54.5%	51.1%
Health problem	56.7%	65.7%	66.0%	63.4%	63.2%	63.3%
Body changes and growing up	37.5%	42.0%	39.2%	37.0%	38.1%	38.0%
Problem with friends	60.2%	62.8%	63.4%	63.7%	66.5%	61.7%
Bullying problem	66.3%	68.0%	72.2%	73.2%	72.6%	69.3%
In the last month, how much have you worried about the following? *Proportion of have worried 'a little' or 'a lot'*	**1 Most Deprived**	**2**	**3**	**4**	**5 Least Deprived**	**All respondents***
School work/ exams	69.8%	80.4%	77.7%	79.4%	80.2%	77.7%
The way you look	61.5%	65.6%	65.6%	67.0%	65.5%	64.8%
Your weight	59.0%	58.1%	55.7%	54.1%	53.1%	54.8%
Friendships	59.1%	57.0%	54.5%	53.1%	52.3%	55.3%
Girlfriends/ boyfriends	36.8%	45.9%	34.3%	41.3%	36.7%	39.8%
Being bullied	31.7%	29.1%	26.1%	24.0%	24.2%	27.0%
Problems at home/ family	37.3%	41.8%	38.0%	38.6%	32.4%	38.6%
Sexual health	12.5%	18.0%	12.4%	11.0%	9.8%	13.7%
Your future/ getting a job	66.8%	72.1%	70.9%	71.5%	72.0%	70.3%
Short Warwick Edinburgh Mental Wellbeing Scale[xii] (SWEMWBS)	**1 Most Deprived**	**2**	**3**	**4**	**5 Least Deprived**	**All respondents***

[xii] The short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) is a 7 item scale, and is a shortened version of the 14 item scale Warwick Edinburgh Mental Wellbeing Scale. The SWEMWBS has had more thorough testing for internal consistency, and questions offer a different perspective which relates more to functioning rather than to feeling to the 14 item scale WEMWBS. The maximum score that can be achieved on the seven item SWEMWBS is 35 points with a higher score associated with better mental wellbeing.

SWEMWBS Score *(Higher score is better)*	21.63	21.75	21.64	22.39	22.28	21.8

**All respondents to the question are included in the total regardless of whether or not they gave their postcode.*

ALS - Key Points

- The majority of young people feel happy about their life (84.3%), however those living in the most deprived quintiles were far less likely to feel happy compared to the least deprived quintile.
- Other differences were found between the most deprived and the least deprived; the most deprived young people were more likely to often feel sad and tearful, bad tempered or angry, anxious and depressed and wish they had a different kind of life.
- For emotional wellbeing measures relating to friendships, relationships with parents, worrying a lot, being proud and trying new things the differences between the most and least deprived were smaller.
- Young people are more likely to talk to someone about a problem if it relates to school, bullying or friends. More deprived children are less likely to talk to anyone about their problems.
- School work/ exams are the biggest worry for young people. Children in the most deprived quintile were less likely to worry though, compared to the others. The other main worries for young people included the future/ getting a job and the way they look.
- Children in the least deprived quintiles had a better score on the SWEMWBS.
- Generally, across the different measures of emotional wellbeing, emotional wellbeing declines as age increases, additionally there are differences between males and females with females reporting worse emotional wellbeing across the different measures, see full ALS report.

11.4. Hospital Admissions

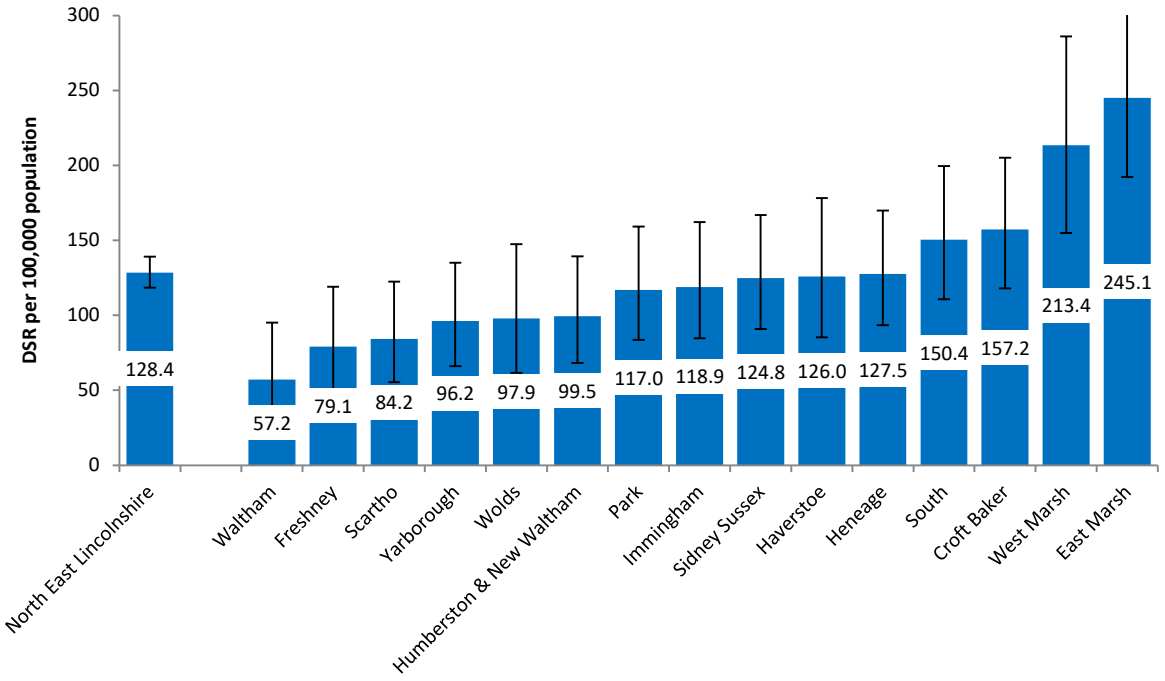
Data were extracted from the Secondary Uses Service (SUS) dataset for residents of North East Lincolnshire admitted to a hospital ward for a mental health condition using ICD10 codes F00-F99, between January 1st 2015 and December 31st 2017. This section does not include self-harm, for self-harm admissions see Section 11.4.1.

East Marsh ward has by far the highest admission rate to hospital for a mental health condition, with a rate of 245.13/100,000 it is significantly higher than the overall rate for North East Lincolnshire. Waltham, Freshney and Scartho had rates significantly lower than the North East Lincolnshire average, see Figure 19.

Admissions to hospital for a mental health condition increase with deprivation, the more deprived the higher the admission rate, see Figure 20. The most deprived quintile in North East Lincolnshire has a rate of 226.55/100,000 whilst the least deprived has a rate of 78.00/100,000.

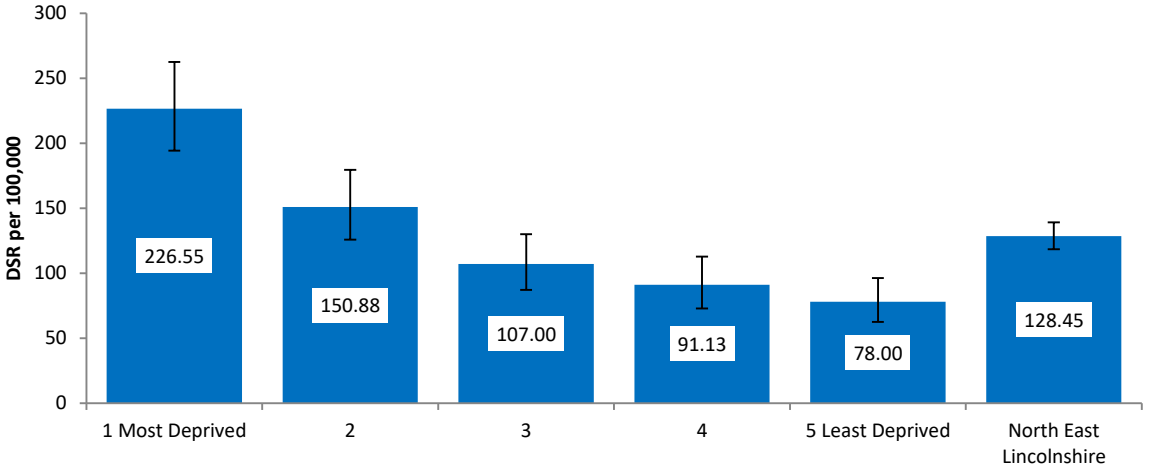
Males are more likely to be admitted to hospital for a mental health condition. With a rate of 166.82/100,000 males have a significantly higher rate than females with a rate of 91.54. 62% of all admissions for mental health were male and 38% were female.

Figure 19 Admissions to hospital for a mental health conditions (ICD 10 Codes F00-F99), all ages, North East Lincolnshire, by ward, 2015-2017, 3 years pooled. Direct age-standardised rate (DSR) with 95% confidence intervals.



Data Source: NEL CCG, SUS

Figure 20 Admissions to hospital for a mental health conditions (ICD 10 Codes F00-F99), all ages, North East Lincolnshire, local deprivation quintiles, 2015-2017, 3 years pooled.



Data Source: NEL CCG, SUS

The most common method of admission to hospital for a mental health condition was by emergency admission, mostly emergency via A&E, see Table 7.

Table 7 Admissions to hospital for a mental health conditions (ICD 10 Codes F00-F99), all ages, North East Lincolnshire, by admission method, 2015-2017, 3 years pooled.

Admission Method		%	
Emergency A&E	Emergency	86.0%	76.5%
Other Emergency Admission			3.3%
Emergency GP			2.1%
Emergency MH Crisis Resolution			1.8%
Emergency Other			1.8%
Emergency Bed Bureau			0.3%
Elective Plan	Elective	12.7%	6.9%
Elective Wait			4.5%
Elective Book			1.3%
Maternity Antenatal	Maternity	0.5%	0.3%
Maternity Postpartum			0.2%
Other Provider	Other Provider	0.8%	0.8%

Data Source: NEL CCG, SUS

Each admission to hospital has a main reason for admission using the ICD10 (International Classification of diseases 10th Revision[xiii]) codes, each individual code is grouped into a block and into a chapter. Table 8 shows mental health admission by blocks. By far the highest reason for admission to hospital was for mental and behavioural disorders due to psychoactive substance use, followed by organic mental disorders (including delirium and dementia) and neurotic stress-related disorders (including anxiety and phobias).

Table 8 Admissions to hospital for a mental health conditions (ICD 10 Codes F00-F99), all ages, North East Lincolnshire, by reason for admission, 2015-2017, 3 years pooled.

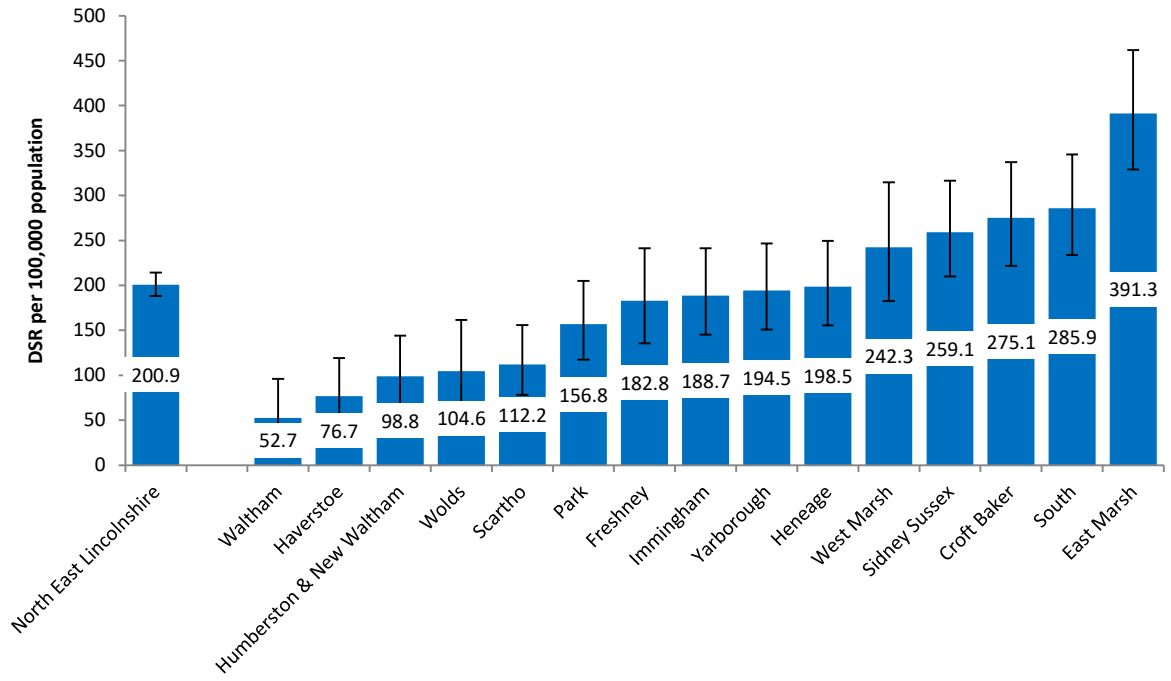
Reason for Admission by ICD10 Blocks	No.	%
Mental and behavioural disorders due to psychoactive substance use	260	43.0%
Organic, including symptomatic, mental disorders	118	19.5%
Neurotic, stress-related and somatoform disorders	110	18.2%
Schizophrenia, schizotypal and delusional disorders	28	4.6%
Disorders of psychological development	25	4.1%
Behavioural syndromes associated with physiological disturbances and physical factors	16	2.6%
Mood [affective] disorder	15	2.5%
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	12	2.0%
Unspecified mental disorder	12	2.0%
Disorders of adult personality and behaviour	9	1.5%
All Mental Health Admissions	**605**	100.0%

Data Source: NEL CCG, SUS

[xiii] The ICD10 is a system used by medical professionals to classify and code all diseases and health problems, it is used on health records and death certificates and is the standard diagnostic tool used in epidemiology.

11.4.1. Admissions to hospital for self-harm

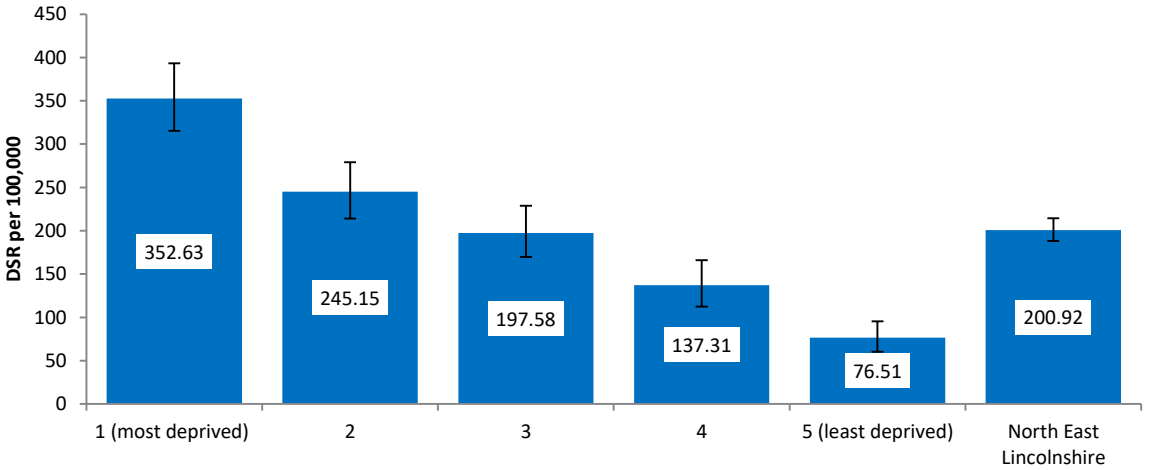
Figure 21 Admissions to hospital for Intentional Self-harm (ICD 10 Codes X60-X84), all ages, North East Lincolnshire, by ward, 2015-2017, 3 years pooled. Direct age-standardised rate (DSR) with 95% confidence intervals.



Data Source: NEL CCG, SUS

Those living in the most deprived quintiles in North East Lincolnshire have the highest admission rates for self-harm. The most deprived quintile has a significantly higher rate than North East Lincolnshire as a whole and every other quintile, see Figure 22.

Figure 22 Admissions to hospital for Intentional Self-harm (ICD 10 Codes X60-X84), all ages, North East Lincolnshire, by deprivation quintile, 2015-2017, 3 years pooled. Direct age-standardised rate (DSR) with 95% confidence intervals.

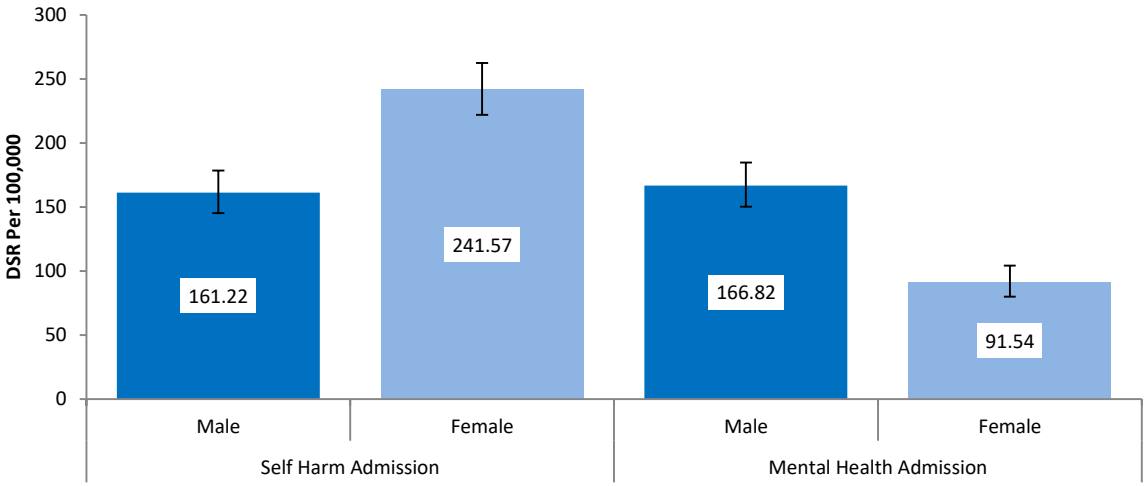


Data Source: NEL CCG, SUS

For self-harm admissions, females are far more likely to be admitted to a hospital ward than males and account for 60% of admissions compared to 40% of males. However, for mental health admissions, the opposite is true. Males have a significantly higher rate compared to females and account for 62% of all

mental health admissions compared to 38% of females. Directly age standardised rates are shown in Figure 23**Error! Reference source not found.**.

Figure 23 Admissions to hospital for mental health disorders and self-harm, by sex, North East Lincolnshire, 2015-2017, 3 years pooled, Direct age-standardised rate (DSR) with 95% confidence intervals.



Data Source: NEL CCG, SUS

Hospital Admissions – Key Points

- Those living in the most deprived parts of North East Lincolnshire are significantly more likely to be admitted to hospital for mental health illness (226.55/100,000 compared to NEL 128.45/100,000) and for self-harm (352.63/100,000 compared to NEL 200.92/100,000).
- 43% of all admissions for a mental health disorder were due to psychoactive substance use, the majority of which related to alcohol withdrawal and acute intoxication from alcohol.
- For mental health admissions, males accounted for 62% of admissions and have a significantly higher rate than females.
- For self-harm admissions, females account for 60% of admissions and have a significantly higher rate than males.

11.5. NAViGO Data

11.5.1. Referrals

In 2017/18 there were 16,147 referrals to Navigo services (Table 9). The main referral sources are listed in the table below. By far the highest referral source was GP with 20% of all referrals. 12% of referrals were IAPT self-referrals advised by a GP and self-referrals, Police and NAViGO older peoples community team each accounted for 10% of the referrals to NAViGO in 2017/18.

Table 9 Top referral sources to NAViGO, 2017/18

Top Referral sources for 2017/18	No. of referrals	% of all referrals
(GP) General Practitioner	3150	20%
IAPT Self- advised by GP without scores	1960	12%
Self-Referral	1608	10%
Police	1564	10%
NAViGO older peoples community team	1559	10%
NAViGO adult community team	1518	9%
SPA	840	5%
NAViGO adult inpatients	722	4%
DPOW Ward	589	4%
General Hospital 6CIT	489	3%
Accident and Emergency Department	419	3%
IAPT GP referral without scores	366	2%
Other referrals	1363	8%
Total referrals in 2017/18	*16,147*	

Source: NAViGO

Improving access to psychological therapies (IAPT) had the biggest proportion of referrals with 21% of all NAViGO referrals in 2017/18, followed by SPA with 15% and Adult Crisis with 10%, the top referrals are shown in the Table 12 below.

Table 10 Top 12 NAViGO teams referred into 2017/18

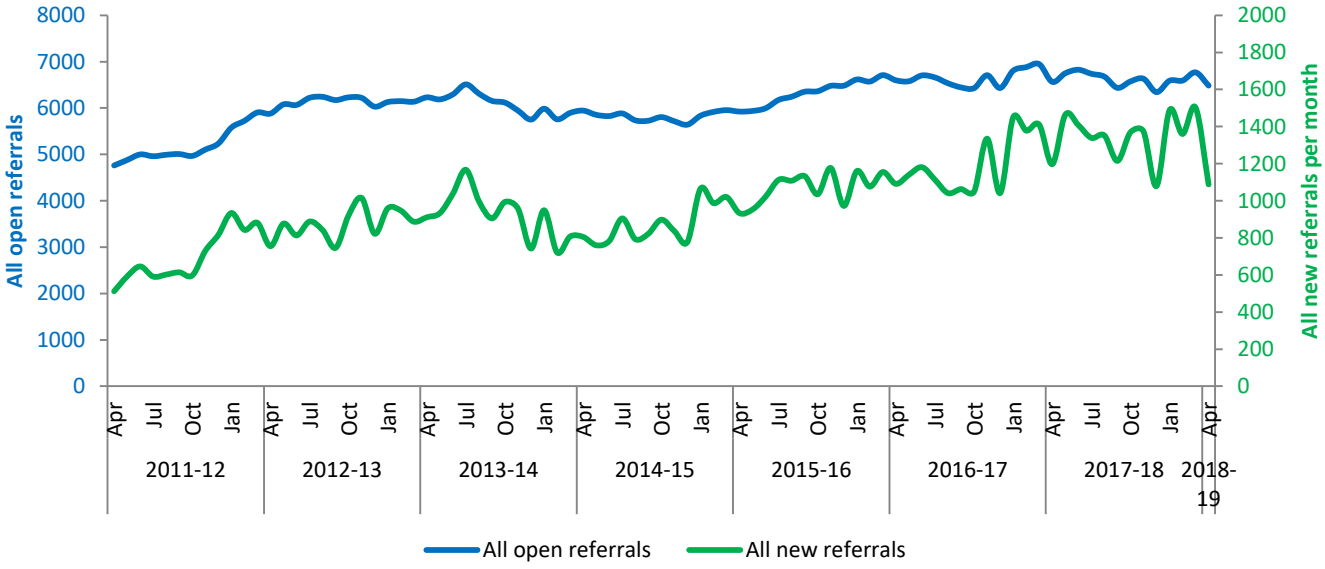
2017/18	No	%
IAPT	3375	21%
SPA	2487	15%
Adult Crisis	1622	10%
Dementia Assessment and Complex Case Management	696	4%
Older Peoples Acute Liaison	690	4%
Liaison and Diversion - Grimsby	658	4%
Community Assessment Team (CAT)	558	3%
Adult Acute Liaison	529	3%
AMHP Team	471	3%
Liaison and Diversion - Scunthorpe	456	3%
COPD Project	370	2%
Adult Acute Inpatients	349	2%
Other referrals	3885	24%

Total referrals in 2017/18	*16,147*	

Source: NAViGO

Over the last 5 years IAPT has received by far the highest number of referrals for NAViGO each year with a quarter of all referrals from 2013/14 to 2016/17 and 21% of referrals in 2017/18. Adult Crisis had been the second highest until 2017/18 when it was third highest. SPA is a new service and in 2016/17 was third highest and second highest in 2017/18. As of April 2018 there were a total of 6,483 open referrals within NAViGO. The number of open referrals has steadily increased around a 1000 open referrals in 2008 and has then hovered around 6000 open referrals from 2011 onwards. There were a total of 16,147 new referrals into NAViGO in 2017-18 and this has increased considerably year on year (Figure 24).

Figure 24 All open and new referrals per month within NAViGO Apr 2011 to Apr 2018

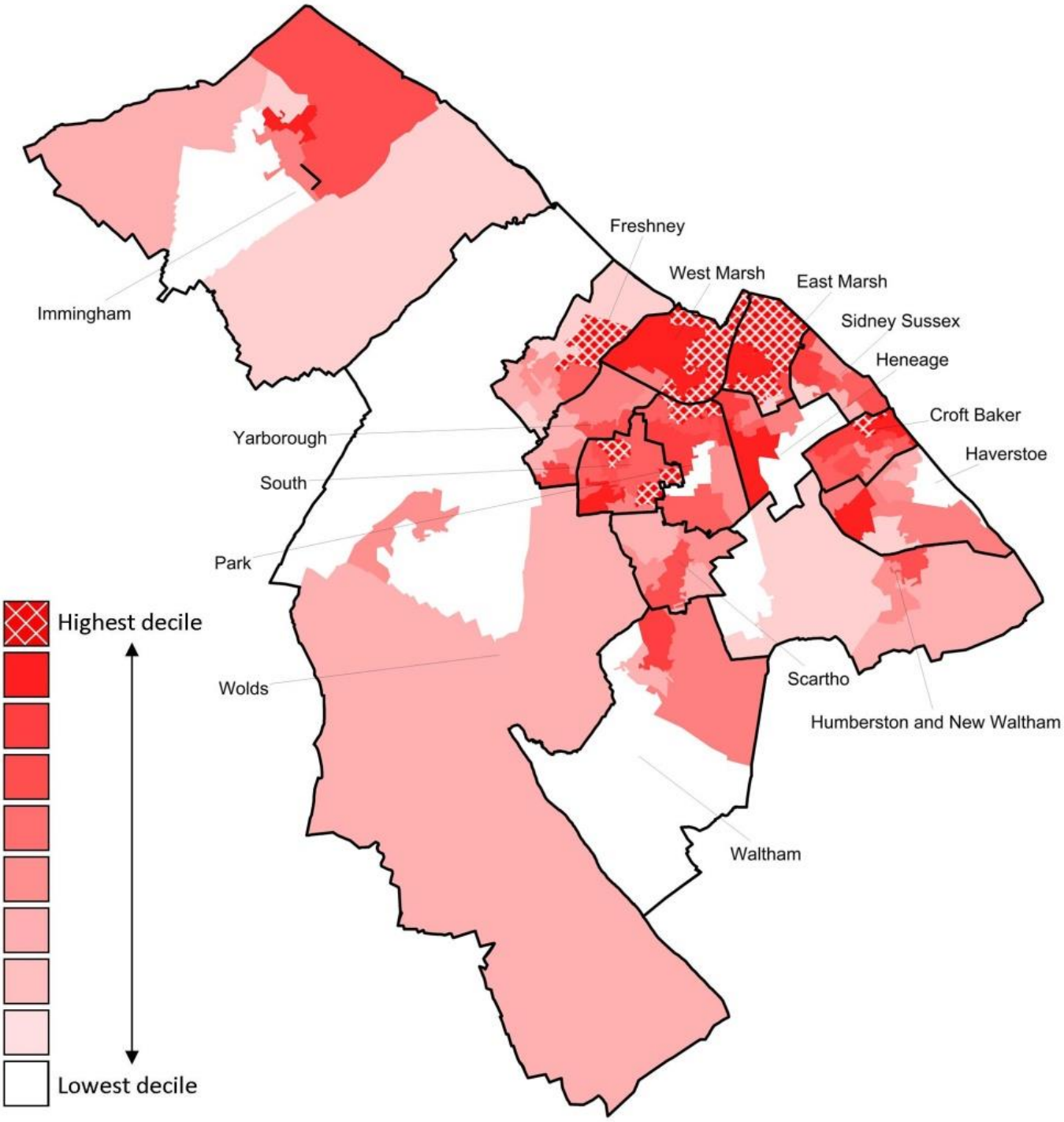


Source: NAViGO

Of the NAViGO referrals, 52% were female and 48% were male. The age group with the highest proportion of referrals were those aged 25 to 44 years (34.8%). Those aged 65 years and over made up 25.3% of referrals and 45 to 64 year olds made up 23.4%). 16.5% of referrals were for those aged 18 to 24 years. The highest proportion of referrals were from the East Marsh (9.3%) followed by South ward (8.7%). The lowest proportion of referrals were from the Wolds (2.5%) and Waltham (2.9%) wards. 13.8% of referrals were not residents of North East Lincolnshire.

Figure 25 shows the open referral rate to NAViGO per 1,000 residents at LSOA level within North East Lincolnshire. The highest rates of residents accessing NAViGO were those who lived in the more deprived areas of North East Lincolnshire; with large parts of the East Marsh and West Marsh wards within the highest decile locally for the rate of open referrals per 1,000 residents. Similarly, South ward also had a higher rate of referred residents whereas the Sidney Sussex ward appeared to have average rates of referrals despite being one of the more deprived areas of North East Lincolnshire.

Figure 25 Patients registered with Navigo by North East Lincolnshire LSOA, rate per 1,000 residents, 2017/18



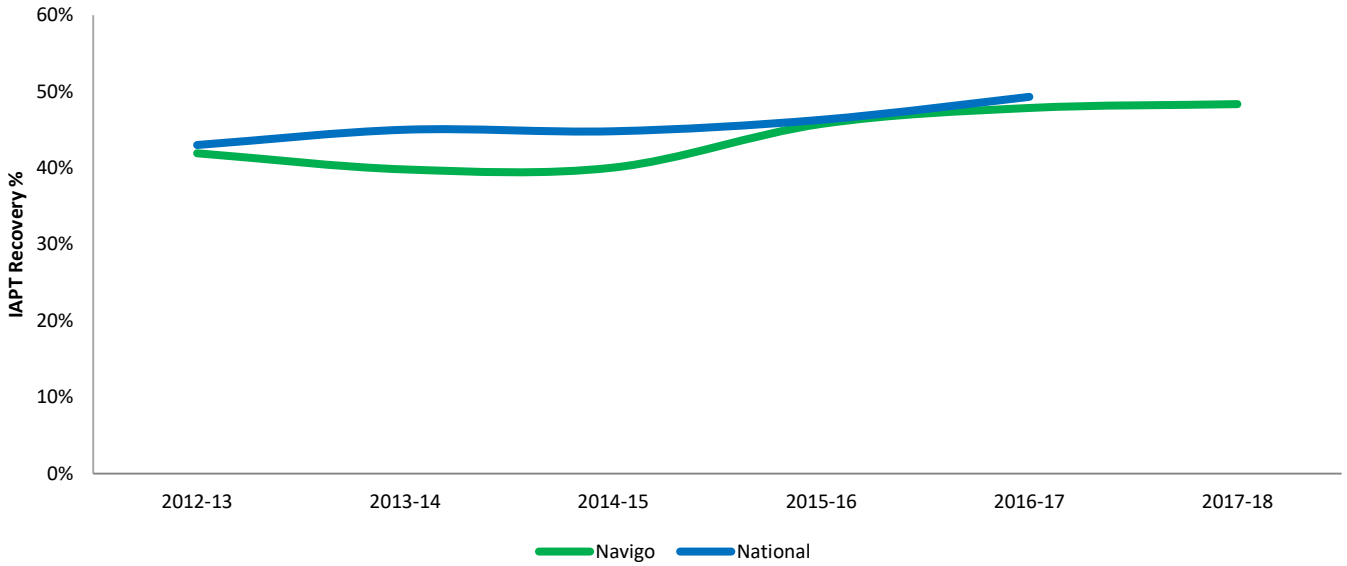
Source: NAViGO, Office of National Statistics

11.5.2. IAPT Recovery

Recovery in IAPT is measured in terms of 'caseness' – a term which means a referral has severe enough symptoms of anxiety or depression to be regarded as a clinical case. A referral has moved to recovery if they were a clinical case at the start of their treatment ('at caseness') and not a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition (NHS Digital, 2018)

Local IAPT recovery rates are slightly below the national average, however they have gradually improved over time and are now similar to the national average (Figure 26).

Figure 26 North East Lincolnshire (NAViGO) and national IAPT recovery rates



Source: NHS Digital

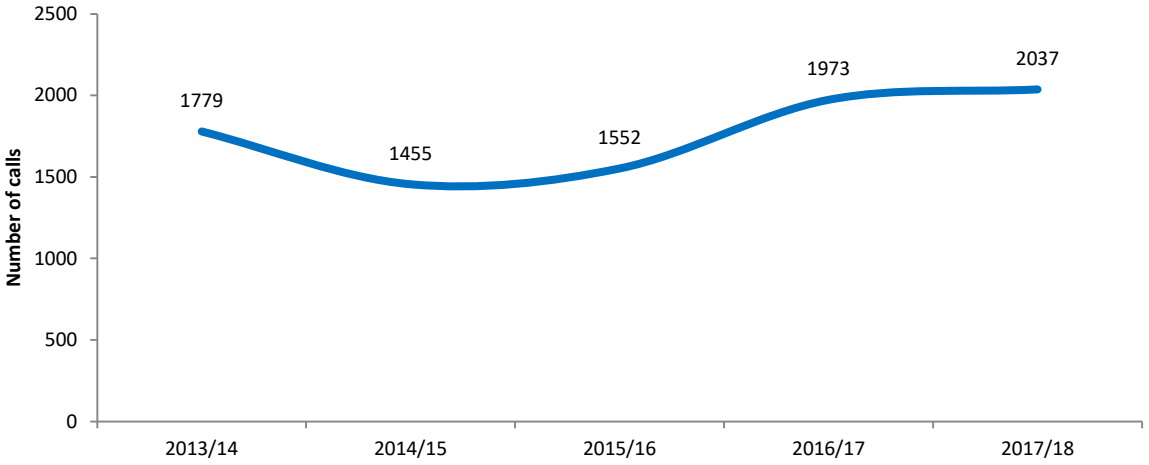
NAViGO – Key Points

- There were 6,483 open patient referrals with NAViGO in 2017/18 and a total of 16,147 new referrals in the last year. New referrals are increasing year on year.
- 52% of referrals are females and 48% were male. 35% were aged 25-44 years, 25% were aged 65+.
- The highest rates of referrals to NAViGO are from those who live in the most deprived areas of NEL.
- 20% of all in referrals into NAViGO came from GP's, followed by 10% of self-referrals and 10% from the Police.
- 21% of all patients were referred onto Improving Access to Psychological Therapies (IAPT), 15% were referred to the Single Point of Access (SPA) and 10% referred to Adult Crisis.
- IAPT rates are below national average despite recent improvements.

11.6. Police Data

Calls to Humberside Police for mental health related incidents have increased over the last five years, see Figure 27. In the most recent year, there were 2037 calls for mental health related incidents.

Figure 27 Calls to Humberside Police for mental health related incidents, North East Lincolnshire trend 2013/14- 2017/18

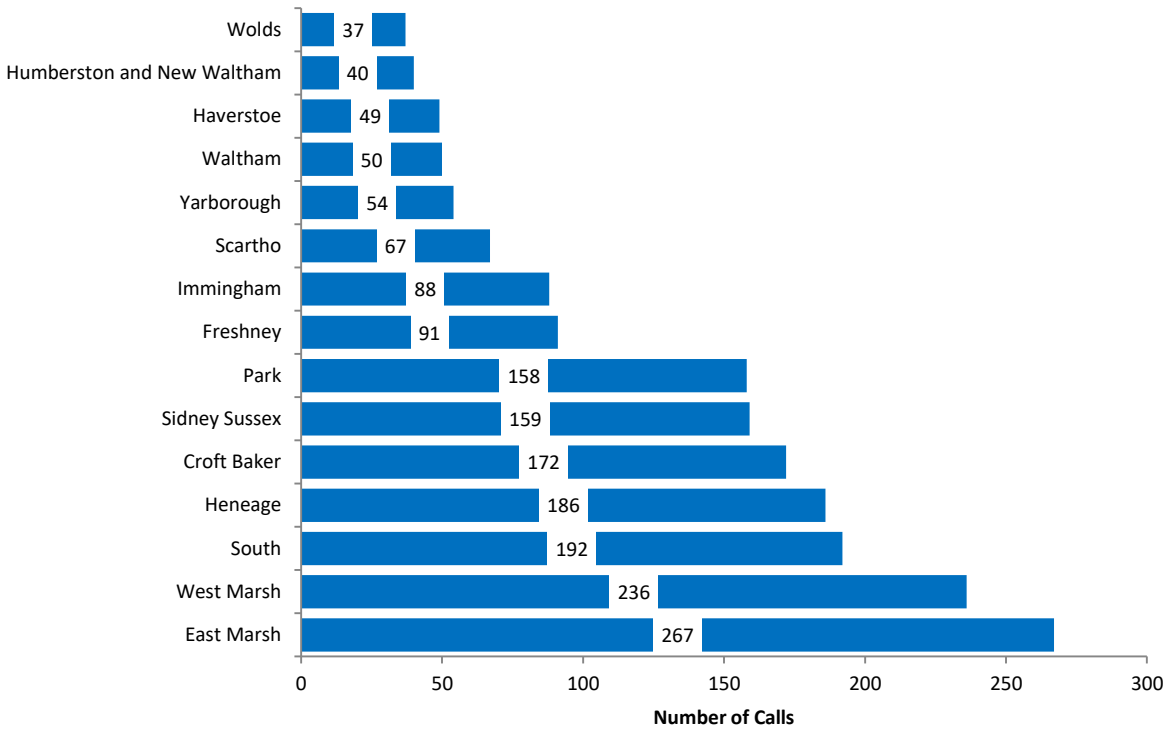


Source: Humberside Police

In 2017 (January 1st to December 31st inclusive) there were 1846 calls in North East Lincolnshire to Humberside Police for mental health related incidents. The majority of the calls (59.4%) were concerns for safety. East Marsh and West Marsh wards had the highest number of calls and together account for over a quarter (27%) of all metal health related calls to Police in North East Lincolnshire.

Calls to Humberside Police for mental health related incidents, North East Lincolnshire, by ward, 2017

Figure 28 Calls to Humberside Police for mental health related incidents, North East Lincolnshire, by ward, 2017



Source: Humberside Police

Section 136 of the Mental Health Act 1983 allows a Police Officer to remove a person to a place of safety, or if already in a safe place keep them there or take them to another place of safety if they believe the person is suffering from a mental health disorder and if it is in the interest of that person or for the protection of other persons. Since changes were made in 2017, the need for the place to which the public have access to and the need for the Police officer to find the person have been removed.

Section 135 of the Mental Health Act 1983 requires a magistrate to issue a warrant allowing a police officer to enter premises to remove a mentally disordered person. The new amendments allow the assessment to take place in the home/ premises.

In 2017/18 there were 79 section 136 referrals in North East Lincolnshire by Humberside Police. 91.1% were aged 18 or over and a larger proportion were males (62.0%) than females (38.0%). Most section 136 referrals were for concerns for safety, 84.8%. Alcohol was recorded as a factor in a quarter of all cases, drugs were recorded in 3.8% of cases and both alcohol and drugs were recorded in 3.8% of cases. Almost a third (32.9%) had alcohol and or drug use indicated.

The most common method of transport was by police vehicle (74.7%). The main reason for a police vehicle being used was because of a risk assessment of behaviour (37.3%) or there was no ambulance available. 64.6% were taken to a health based place of safety and none were taken to a police station.

For 70.9% of referrals a Police Officer stayed at the first place of safety for more than 30 minutes, in half of these cases it was because of the risk assessment and in 35.7% of cases it was due to a lack of staff at the place of safety.

Table 11 Reason for Police Officer staying at Place of Safety (POS) for more than 30 minutes, North East Lincolnshire, 2017.

Reason	Number	%
Bed/ cell watch	2	3.6%
Lack of staff at POS	20	35.7%
POS not warned of arrival	0	0.0%
Risk assessment, PC remain	28	50.0%
Other	6	10.7%

Source: Humberside Police

Callouts to the police for 136 referrals were highest between 17:00hrs and 23.59hrs, 71.4% of police callouts were between 17:00hrs and 05:59 hrs.

Table 12 Time of day for Police callouts for section 136 referrals, North East Lincolnshire, 2017

Time of Police Attendance 136 referrals	Number	%
00:00hrs 05:59 hrs	15	19.0%
06:00 hrs 11:59 hrs	10	12.7%
12:00 hrs 16:59 hrs	18	22.8%
17:00 hrs 23:59 hrs	31	39.2%
Time not recorded	5	6.3%

Saturdays were the most common day for Police callouts, with 21 .7% of all callouts for section 136 referrals.

Table 13 Day of callout for section 136 referrals, North East Lincolnshire, 2017

Day of callout	Number	%
Monday	11	13.9%
Tuesday	6	7.6%
Wednesday	10	12.7%
Thursday	15	19.0%
Friday	7	8.9%
Saturday	17	21.5%
Sunday	13	16.5%

Key Points Police

- Mental Health related calls to Humberside Police have increased over the last 5 years.
- East Marsh and West Marsh had the highest number of mental health related calls to police.
- In a third of all sections 136 referrals drugs or alcohol were recorded.
- No one was taken to a police station as a result of a section 136 referral, however a police car was the most common mode of transport to the place of safety rather than ambulance.
- The majority of section 136 referrals were after 5pm.

11.7. Prescribing for Mental Health

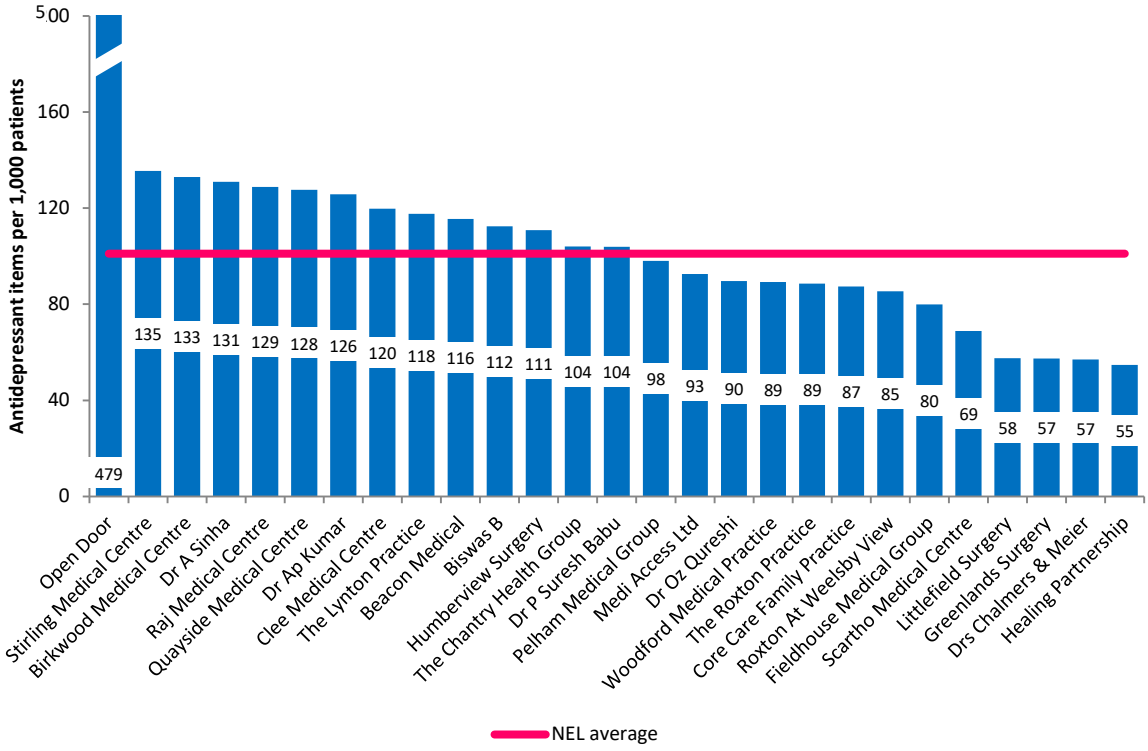
Prescribing data for North East Lincolnshire CCG was obtained from OpenPrescrbing.net. It should be noted that antidepressants can be used to treat a number of conditions including, sometimes, those with chronic pain. For the purposes of this analysis it was not possible to remove items prescribed for chronic pain treatment from the figures presented in the findings and therefore some figures are likely to be inflated.

11.7.1. Antidepressants

Between April 2013 and March 2018 there were a total of 1,001,471 antidepressant items prescribed by GPs in North East Lincolnshire at a total cost of £3.1million. The average number of antidepressants items prescribed during the 6 year period was 101 per 1,000 patients in North East Lincolnshire.

There were considerable differences in antidepressant prescribing rates by GP practice and the majority of practices have increased their antidepressant prescribing considerably between 2013/14 to 2017/18; an average of 30% across North East Lincolnshire practices.

Figure 29 Antidepressant items prescribed per 1,000 patients by NEL CCG GP, 2013-2018

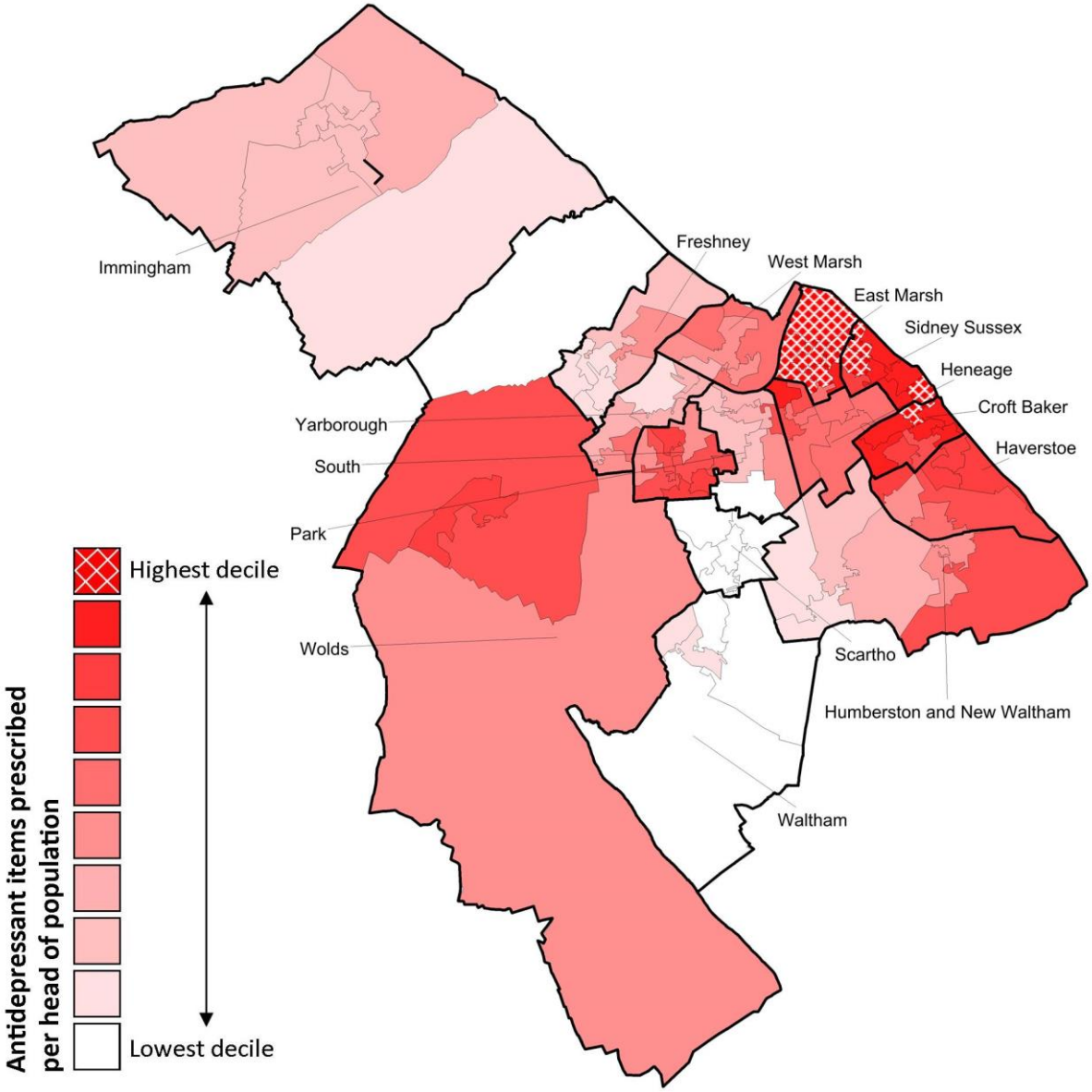


Source: OpenPrescribing.net

Prescribing data received from 360 Care[vii] indicates that females are twice as likely to be prescribed antidepressant items compared to males in North East Lincolnshire; 66.2% of total antidepressant items prescribed were to females.

Total prescribed antidepressants items per head of population were modelled at North East Lincolnshire lower super output area (LSOA). Figure 30 shows that the highest rate of antidepressant prescriptions were typically in the more deprived wards of North East Lincolnshire; i.e. West Marsh, East Marsh and Sidney Sussex wards. Also worth nothing are the higher levels of antidepressant prescriptions rates in Haverstoe, Humberston and New Waltham as well as parts of the Wolds wards which would not characteristically associated with poorer health outcomes.

Figure 30 North East Lincolnshire LSOA antipsychotic items prescribed per head 2013-18 (modelled)



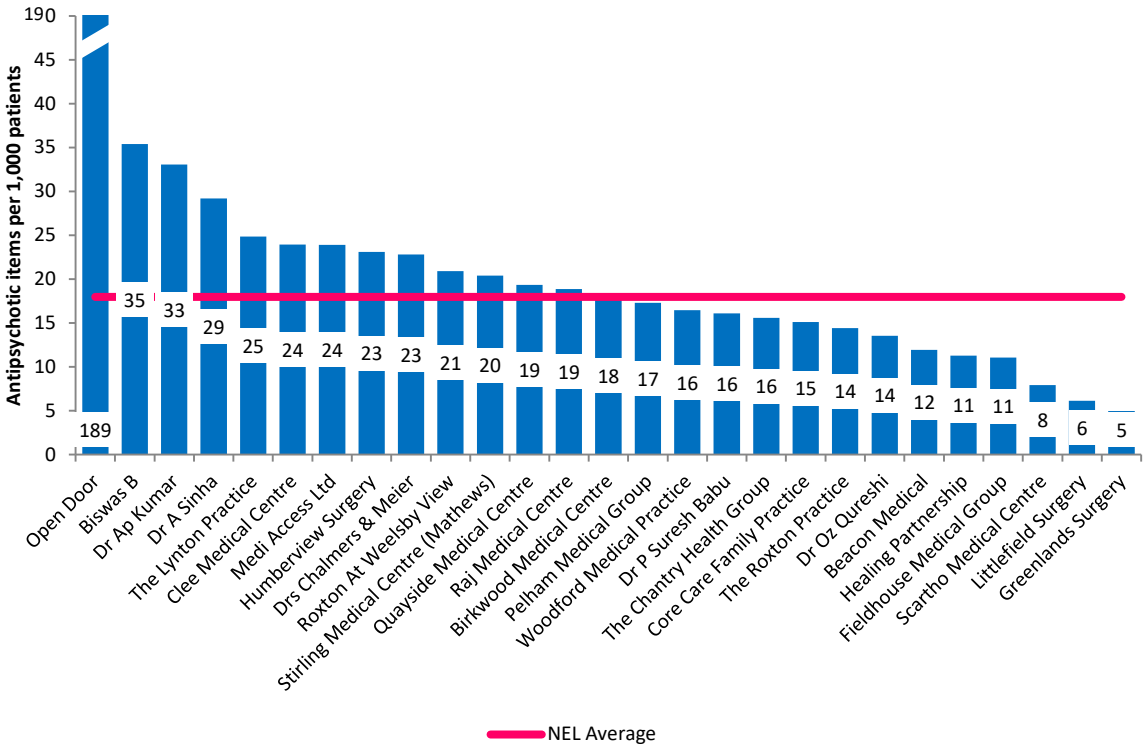
Source: OpenPrescribing.net; NHS Digital

11.7.2. Antipsychotics

Between April 2013 and March 2018 there were a total of 178,270 antipsychotic items prescribed by GPs in North East Lincolnshire at a total cost of £2.2million. The average number of antipsychotic items prescribed during the 6 year period was 18 per 1,000 patients in North East Lincolnshire.

As with antidepressant prescribing, there are considerable differences in number of antipsychotic items prescribed per head of patient population between GP practices across North East Lincolnshire (see Figure 31). Despite antidepressant prescribing increasing across all but one GP practice between 2013/14 and 2017/18, antipsychotic prescribing has only increased 5% over the previous 6 years and for five practices in particularly has decreased considerably.

Figure 31 Antipsychotic items prescribed per 1,000 patients by NEL CCG GP, 2013-2018

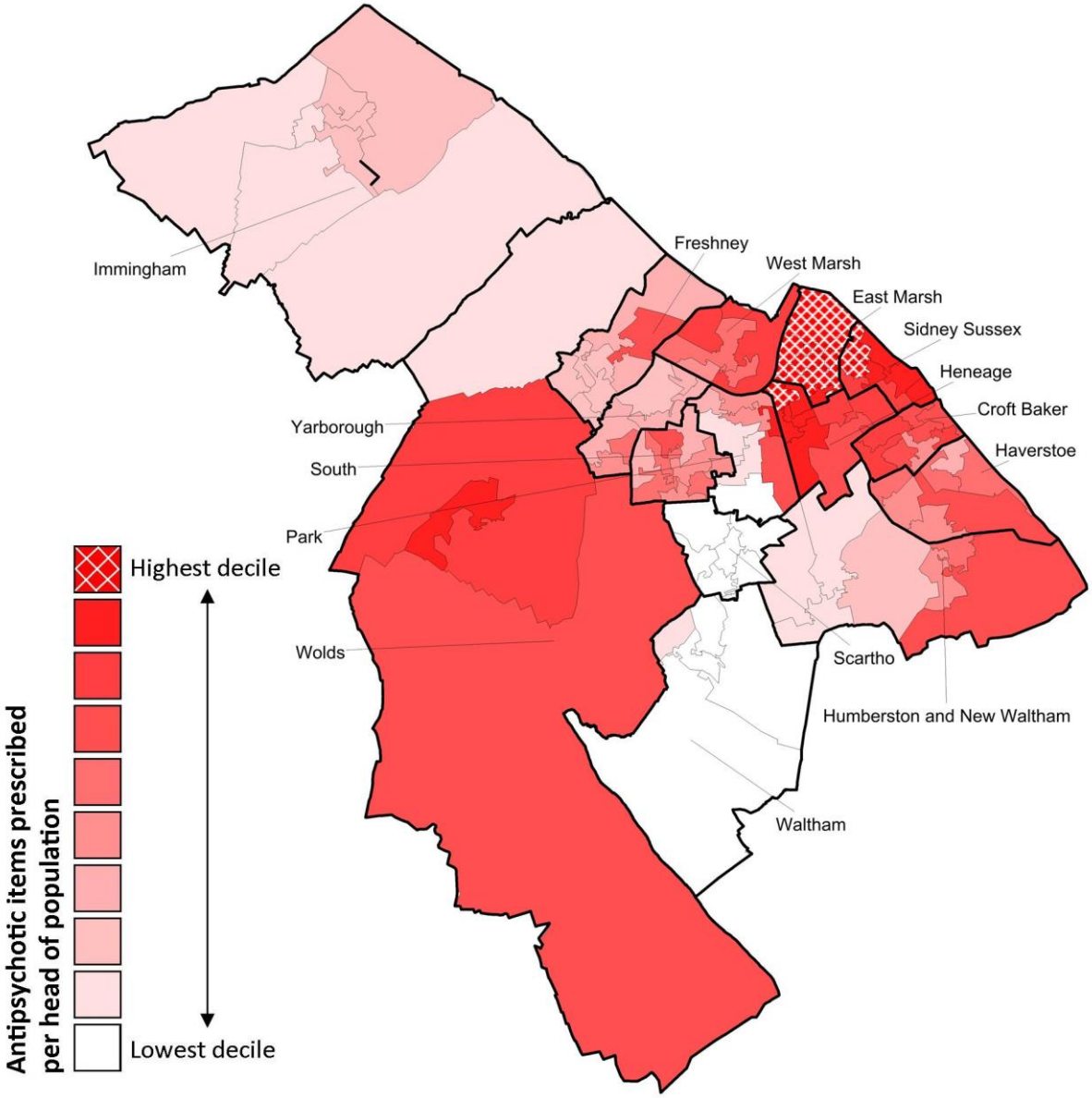


Source: OpenPrescribing.net

Prescribing data received from 360 Care shows that females are more likely to be prescribed antipsychotic items than males in North East Lincolnshire; gender differences in antipsychotic prescribing were not as stark as observed with antidepressant prescribing. There were a slightly higher proportion of males aged under 18 years prescribed with antipsychotics than females aged under 18 years.

The highest rates of antipsychotic prescribing are in the East Marsh and Sidney Sussex wards. As with antidepressant prescribing, there also appear to be higher than expected rates of antipsychotic prescribing in Wolds ward (see Figure 32).

Figure 32 North East Lincolnshire LSOA antipsychotic items prescribed per head 2013-18 (modelled)



Source: OpenPrescribing.net; NHS Digital

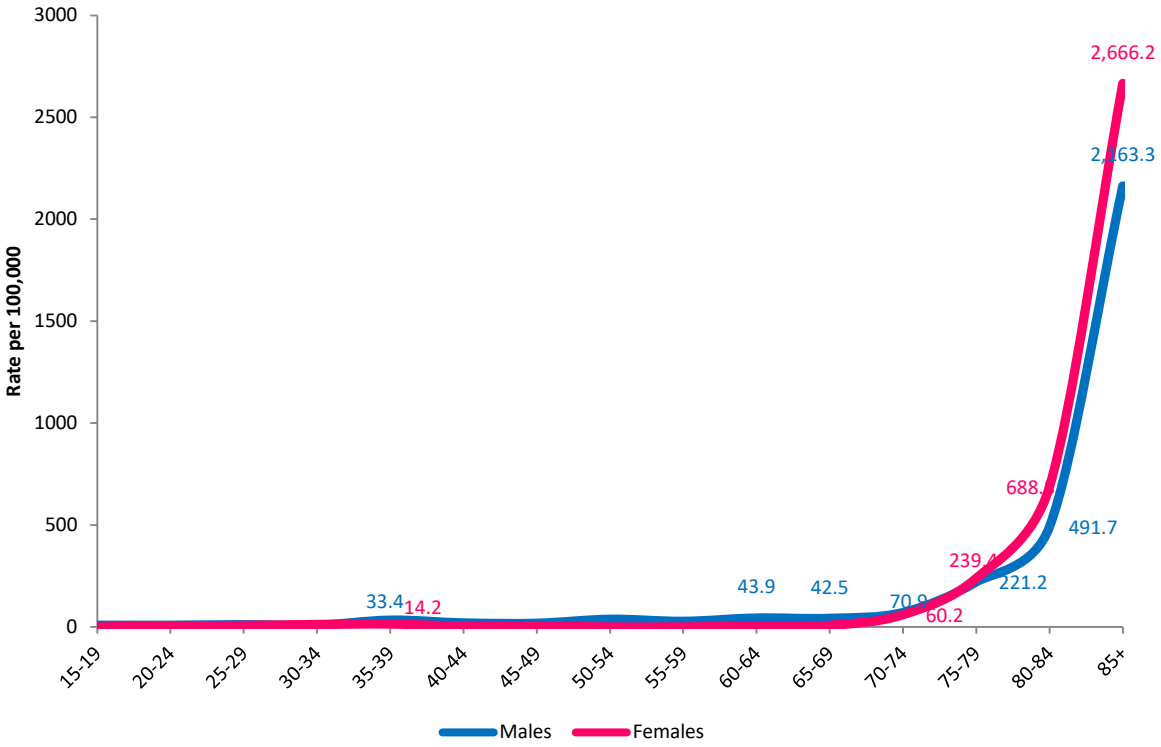
Mental Health Prescribing - Key Points

- 200,000 antidepressant items prescribed per year in North East Lincolnshire at a rate of 101 antidepressant items prescribed per month per 1,000 patients and a total cost of £3.1 million for 2013-2018.
- 35,000 antipsychotic items prescribed per year in North East Lincolnshire at a rate of 18 antipsychotic items prescribed per month per 1,000 patients and a total cost £2.2 million for 2013-2018.
- Antidepressant and antipsychotic prescribing were highest in the more deprived areas of North East Lincolnshire (e.g. East Marsh and Sidney Sussex).

11.8. Mental Health Mortality

There were a total of 810 deaths in North East Lincolnshire with an underlying cause of death code associated with mental health or suicide[xiv] between 2013 and 2017. The vast majority of mental health related deaths were in those aged 75 and over (87.5%) and a greater proportion of deaths associated with mental health were amongst females (62.3%). Mortality attributable to mental health increases significantly in later life (Figure 33). There were small increases in age specific mental health mortality rates in males and females aged 35 to 39 which is as a result of suicide related mortality being higher in that specific age band. Most mental health mortality in those aged 50 to 64 is suicide related. The vast majority of mental health mortality is associated with some degree of dementia for those aged 65 years and older.

Figure 33 5 year pooled mental health and suicide mortality rate for NEL residents by 5 year age band (2013-17)



Source: North East Lincolnshire Primary Care Mortality Database

Dementia and Alzheimer disease was the leading cause of all deaths (227 out of 1722) in 2017 amongst North East Lincolnshire residents; overtaking ischaemic heart diseases related mortality for the first time. Ischaemic heart diseases had been the leading cause of mortality both locally and nationally for some time.

Nine out ten deaths (89.9%) associated with mental health in North East Lincolnshire are related to dementia. However, these deaths largely dominated by deaths of those aged 75 and over. Mental health mortality causes vary for different age groups; see Table 14. Suicide and injury from undetermined intent were the main causes of death for those aged under 65 years whereas dementia was the main cause of death in those aged over 65 years. Although making up only small number of cases, deaths as a result of mental disorders due psychoactive substance use made up a greater proportion of total deaths in the younger population.

[xiv] Mental and behavioural disorder ICD10 codes F00-F99; Suicide and death from underdetermined intent ICD10 codes X60-X84, Y10-Y34 (Y33.9 excluded).

Table 14 Leading causes of mental health deaths in North East Lincolnshire by broad age band, (2013-17)

	Under 25	25 to 44	45 to 64	65 to 74	75 to 84	85+	All ages▲
1st	Suicide and Injury of Undetermined Intent*	Suicide and Injury of Undetermined Intent	Suicide and Injury of Undetermined Intent*	Dementia	Dementia	Dementia	Dementia (89.9%)
2nd	Mental Disorders due to Psychoactive Substances*	Mental Disorders due to Psychoactive Substances*	Mental Disorders due to Psychoactive Substances*	Suicide and Injury of Undetermined Intent*	Suicide and Injury of Undetermined Intent*	Suicide and Injury of Undetermined Intent*	Suicide and Injury of Undetermined Intent (7.8%)
3rd			Dementia*	Mental Disorders due to Psychoactive Substances*	Mental Disorders due to Psychoactive Substances*		Mental Disorders due to Psychoactive Substances (1.6%)

▲ *Not all causes of deaths were categorised in the table and therefore any remaining deaths were categorised as 'other' mental health mortalities*

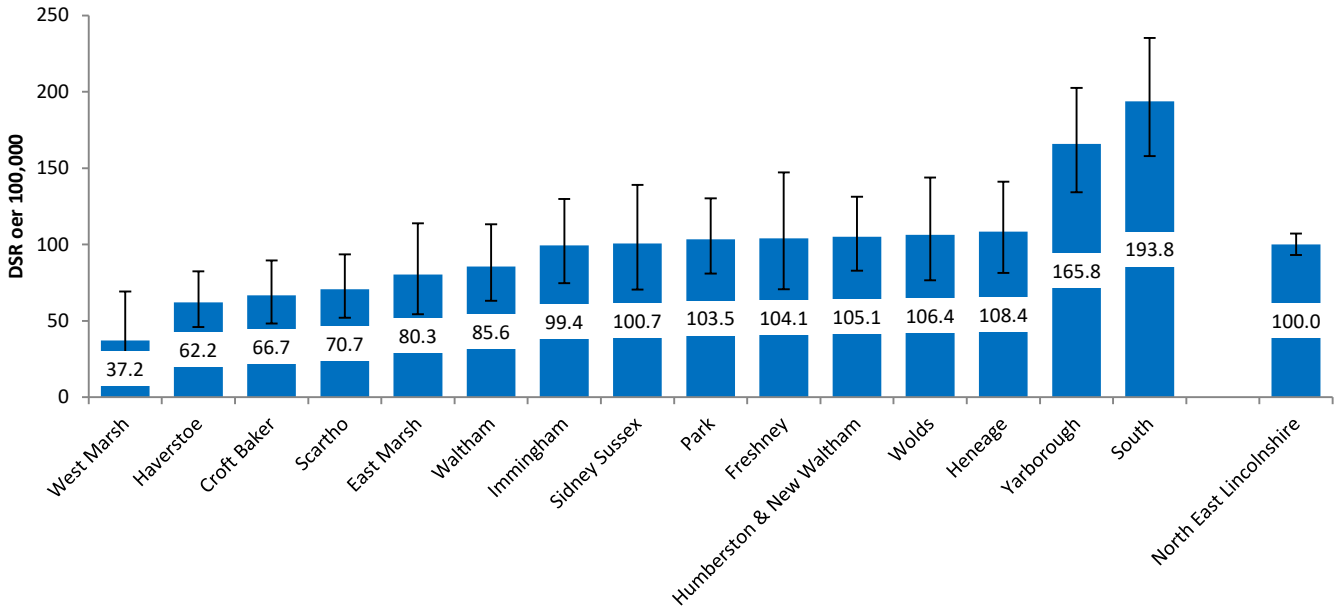
** denotes 5 or less deaths*

Source: North East Lincolnshire Primary Care Mortality Database

The average mental health mortality rate in North East Lincolnshire between 2013 and 2017 was 100 per 100,000 (Figure 34). South and Yarborough wards had the highest mortality rates in the borough with rates of 193.8 and 165.8 per 100,000 respectively (both significantly higher than the local average). West Marsh, Havertsoe and Croft Baker wards had significantly lower mental health mortality rate than North East Lincolnshire average (37.2, 62.2 and 66.7 per 100,000 respectively).

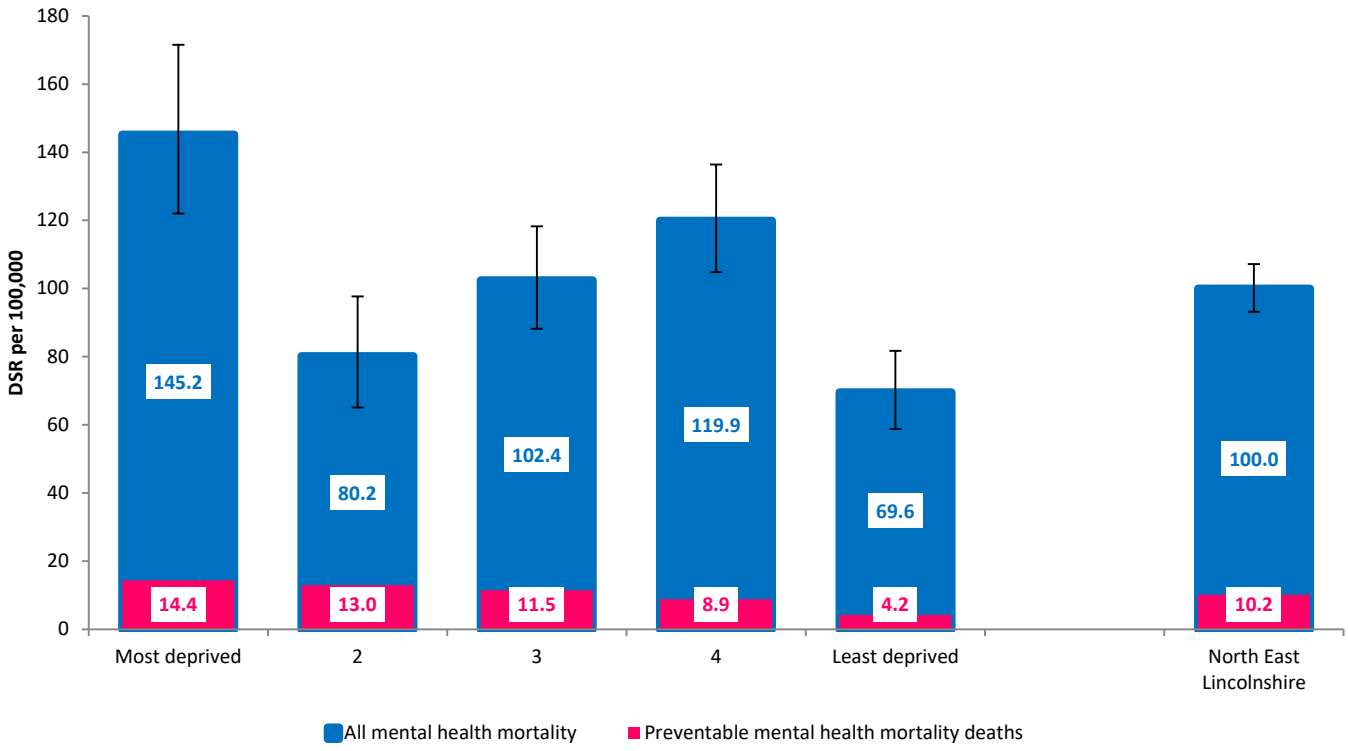
Mental health mortality rates were calculated by local deprivation quintile within North East Lincolnshire (Figure 35). Despite there being a significant difference between the highest and lowest deprivation quintiles for mental health mortality, a correlation was not observed between increasing deprivation score and increasing mental health mortality. However, small correlations were found, although not significant, when only deaths for preventable mental health mortality were analysed independently; preventable mental health mortality decreased with decreasing deprivation.

Figure 34 5 year pooled mental health and suicide mortality rate for NEL residents for NEL wards (2013-17)



Source: North East Lincolnshire Primary Care Mortality Database

Figure 35 5 year pooled mental health mortality and preventable mental health mortality[xv] rates for NEL deprivation quintiles (2013-17)



Source: North East Lincolnshire Primary Care Mortality Database

Mental Health Mortality - Key Points

- There were a total of 810 mental health related deaths locally between 2013 and 2017 with the majority of deaths in the under 65's being associated with suicide or mental disorders due to psychoactive substances.
- In the over 65's, dementia was the leading cause of mortality.
- In 2017 dementia became the leading cause of mortality for all persons of all ages for the first time, overtaking ischaemic heart disease.

11.9. Local Suicide Audit

Each year a suicide audit is carried out locally, it includes all cases which the North East Lincolnshire coroner has made a verdict of suicide or death from undetermined intent and pools together 5 years of data for a robust analysis.

Between 2012 and 2016[xvi] there were a total of 64 inquests in North East Lincolnshire for deaths recorded as suicide or undetermined intent with males accounting for the largest proportion of deaths (84.4%). Age-standardised mortality rates for North East Lincolnshire indicates that males are over five times more likely to die from suicide than females with a rate of 17.09 per 100,000 compared to 3.01 per 100,000. This

[xv] Preventable mental health mortality ICDO10 codes F10-F16, F18-F19, X60-X84, Y10-Y34 (Y33.9 excluded). Only deaths aged under 75 from the above causes are included except X60-X84, Y10-Y34 (all ages).

[xvi] Case notes in this audit relate to the year in which the Coroner's verdict was reached and not when the death occurred. This is due to the time delays that are often associated with undertaking a suicide inquest i.e. verdicts which were reached during the calendar years of 2012 to 2016. This will therefore include the majority (but not all) of deaths which occurred between 2011 and 2016.

difference is considerably greater than the national figures which found that for 2014-16 the male suicide rate was approximately three times greater than that of females (15.3 per 100,000 compared to 4.8 per 100,000) (Public Health England, 2017). It should be noted that due to the relatively small number of suicide cases in North East Lincolnshire it is not possible to calculate robust data.

Over a quarter of all deaths in North East Lincolnshire occurred in the 35 to 44 year old broad age band with the fewest number of deaths in the 15 to 24 year olds (12.1%); see Table 15. Nationally the highest rates of suicide in females were those aged 45-49 years whereas males were more likely to be aged 40-44 years old (HM Government, 2015).

Table 15 Proportion and rate of suicide in North East Lincolnshire by broad age band and gender, 2012-2016

Broad Age Group	Female Proportion of female deaths	Male Proportion of male deaths	All Persons Proportion of deaths
15-24	≤5%	≤5%	≤5%
25-34	≤5%	16.7%	17.2%
35-44	≤5%	25.9%	28.1%
45-54	≤5%	13.0%	12.5%
55-64	≤5%	20.4%	18.8%
65+	≤5%	16.7%	17.2%
Male:Female Split%	15.6%	84.4%	-
Age-standardised mortality rate (per 100,000)	3.01	17.09	9.77

Source: North East Lincolnshire coroner case notes, 2012-2016 *(Non publically available)*

It is widely recognised that there are specific inequalities in self-harm and suicide affecting lesbian, gay, bisexual and trans (LGBT) populations who are considered at greater risk of suicide due to their sexual orientation and identity (HM Governemnt, 2015). The latest figures from ONS suggest that in the Yorkshire and Humber region 1.9% of the population categorise themselves as lesbian, gay, bisexual or other[91]. Among the deaths in North East Lincolnshire, the proportion of people who were identified as LGBT is lower than that estimated in the general population. It was not possible to identify sexual identity for a relatively large proportion of suicides so there is significant potential for the number of suicides among the LGBT population to increase.

Table 16 Sexuality of all persons as determined from case notes

Sexuality	All persons %
Heterosexual	85.94%
LGBT/ Unknown	14.06%

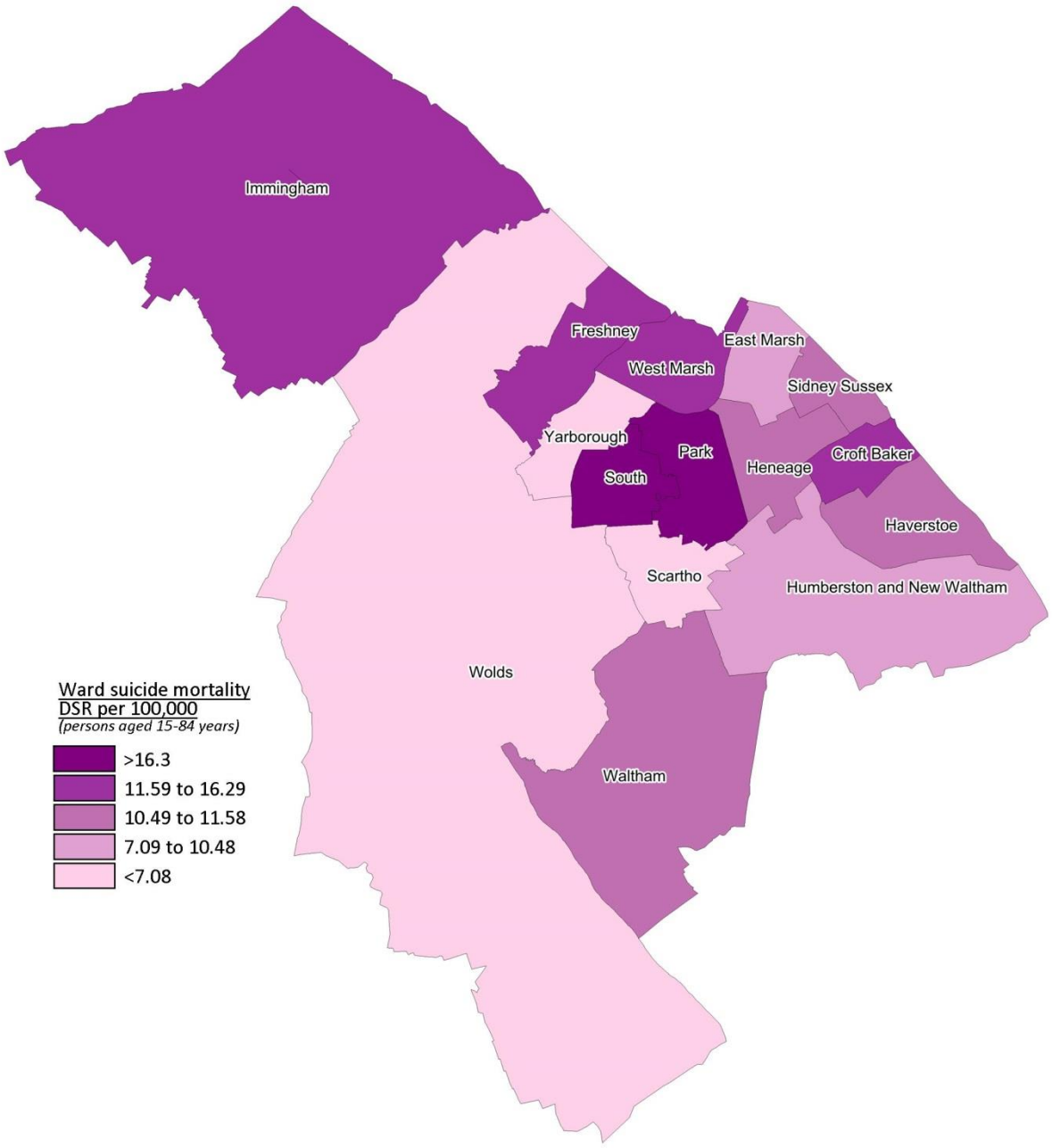
Source: North East Lincolnshire coroner case notes, 2012-2016 *(Non publically available)*

The age-standardised suicide rate calculated at ward level for North East Lincolnshire using case notes collected for coroner's inquests between the years of 2012 and 2016 is shown below in Figure 36. South ward and Park ward were found to have the highest 5 year pooled mortality from suicide and undetermined injury intent with rates of 16.31 per 100,000 and 16.29 per 100,000 respectively. The ward in North East Lincolnshire most associated with high levels of deprivation, the East Marsh, has a suicide mortality rate lower than the North East Lincolnshire average rate of 9.77 per 100,000. All wards in North East Lincolnshire were recorded with at least one death from suicide in the 5 year period. Despite these findings, due to the relatively small number of suicide attributable deaths no significant differences were found when

compared to the North East Lincolnshire rate or when individual wards were compared against one another.

As the case notes received from the coroner's office do not include deaths of those who died outside of North East Lincolnshire but weren't resident locally, a further analyses of the local Primary Care Mortality Database (PCMD) was undertaken. The PCMD analysis found that there were a total of 67 deaths registered to residents of North East Lincolnshire between 2012 and 2016; 58 males and 9 females. Considering that 3 of the deaths identified through case notes were non-residents, this suggests that 6 residents who died by suicide travelled out of the local area to die.

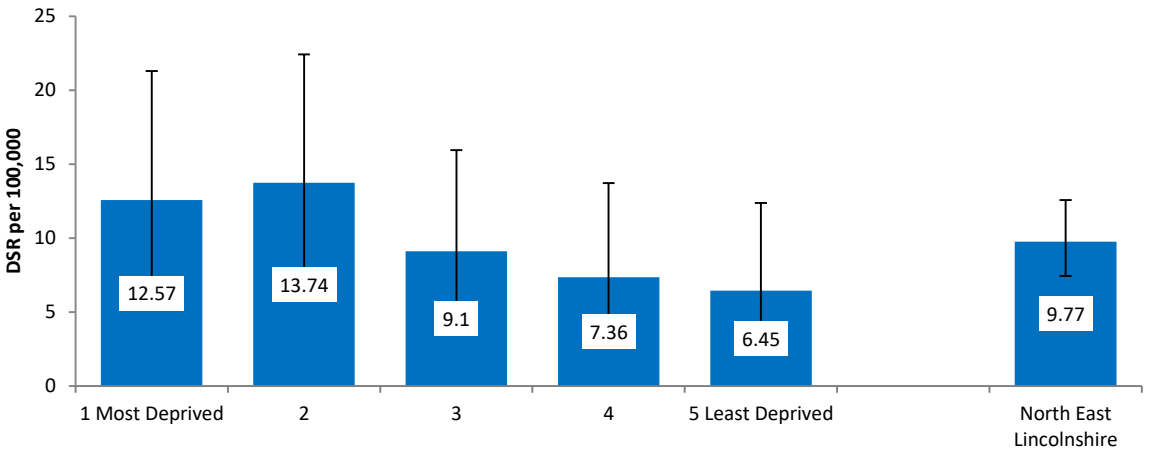
Figure 36 5 year pooled age-standardised rate of suicides and injury of undetermined intent (ICD10 codes X60-X84 & Y10-Y34) per 100,000 persons for North East Lincolnshire electoral wards (based on victims usual address), for coroner verdicts reached within the calendar years of 2012-2016



Source: North East Lincolnshire coroner case notes, 2012-2016 *(Non-publically available)*

Age-standardised rates of suicide and deaths from undetermined intent where calculated from suicide case notes and aggregated according to IMD 2015 deprivation quintiles at a local level. Figure 37 shows that areas of lower deprivation are more likely to have a lower rate of suicide compared to areas of higher deprivation. Figure 37 also clearly shows a trend between low and high deprivation areas with lowest 20% considerably lower than the highest 20% (6.45 per 100,000 compared to 12.57 per 100,000). Despite the differences between areas of low and high deprivation the variance was not found to be significant. Similarly the difference between the North East Lincolnshire age-standardised rate of 9.77 per 100,000 was not significantly different than any of the rates calculated for each deprivation quintiles.

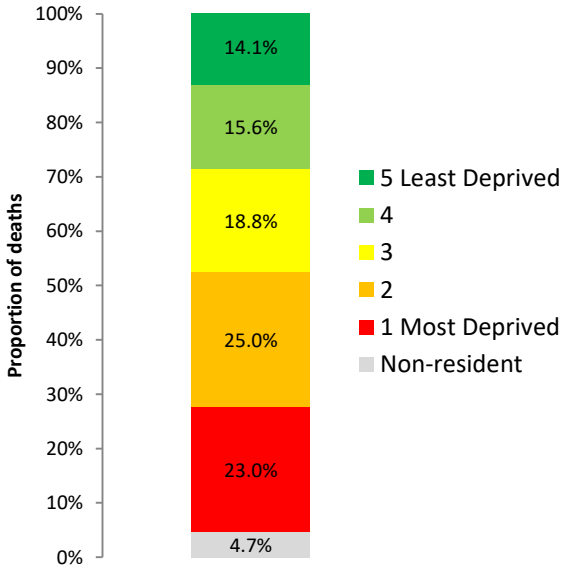
Figure 37 5 year pooled age-standardised rate of suicides and injury of undetermined intent (ICD10 codes X60-X84 & Y10-Y34) per 100,000 persons for North East Lincolnshire, for coroner verdicts reached within the calendar years of 2012-2016, ordered by 2015 IMD deprivation quintile



Source: North East Lincolnshire coroner case notes, 2012-2016 *(Non publically available)*

23% of all deaths from suicide in North East Lincolnshire were undertaken by those who lived in areas of the highest deprivation (as shown in Figure 38) compared to only 14.1% of deaths attributable to areas of the lowest areas of deprivation. This difference is much lower than in previous years and potentially suggests an increase in people in the least deprived areas of North East Lincolnshire taking their lives.

Figure 38 Proportion of suicide by deprivation quintile in North East Lincolnshire, 5 year pooled data for suicides and deaths from injury of undetermined intent (ICDO codes X60-X84 & Y10-Y34), for coroner's verdicts reached within the calendar years of 2012-2016



Source: North East Lincolnshire coroner case notes, 2012-2016 *(Non-publically available)*

Locally, hanging was by far the most common method of suicide, accounting for 70.3% off all suicides, nationally the proportion of suicides from hanging was 59.3% in males and 43.2% in females (ONS, 2016). The majority of suicides occurred in the home or a friend's home (73.4%), making it more difficult to prevent than deaths that occur in public areas. Further analysis found that there were no suicide 'hot spots', suicides occurring in park/ woodland, railway/ roads and other outdoor areas were fairly dispersed and no patterns were noted.

Toxicology reports are not always requested as part of the post mortem process. However, half of all suicides in North East Lincolnshire were recorded as having ingested alcohol and/ or drugs directly prior to their death (Table 17). Just over a third (34.4%) had consumed alcohol prior to their death. A quarter of suicides were recorded as having consumed drugs prior to their death. This included those who had taken illegal drugs or those who had taken (non)prescribed drugs in excess. 12.5% had taken a combination of drugs and alcohol prior to their death.

Very limited research was found to understand how North East Lincolnshire suicides compare with other areas alcohol and/or drug ingestion prior to death. Research from the US found that alcohol was detected in almost 36% of male and 28% of female decedents[92] suggesting that those who die of suicide North East Lincolnshire are more likely to have ingested alcohol prior to their death. Further research found that alcohol was detected in approximately 30% of suicides as a result of hanging[93]; alcohol was detected in 37% of hangings in North East Lincolnshire. This research[93] also found that drugs were detected in 36% of hangings; drugs were detected in 22% hangings in North East Lincolnshire.

Table 17 Count and proportion who had consumed alcohol and/or drugs directly prior to their death

Toxicology	All Persons*
	%
Alcohol	34.4%
Drugs	25.0%
Alcohol and/ or Drugs	50.0%
Alcohol and Drugs	12.5%
Total suicides	100%

Source: North East Lincolnshire coroner case notes, 2012-2016 *(Non-publically available)*

**All persons included in count and percentage regardless of whether a toxicology report was requested as part of the post mortem process*

People choose to end their life for complex reasons, in many cases there are several factors that contribute to increased vulnerability to suicide. National research has shown that many people who die by suicide have a mental illness, most commonly depression or an alcohol problem. Suicide, in many cases, is also linked to feelings of hopelessness and worthlessness[94].

The following sections explore factors which may have led to the suicides in our local area, these are based on factors experts believe to increase a person's vulnerability to suicidal thinking and behaviour[94].

11.9.1. Life History

Almost a third (31.3%) of all deaths had suffered a traumatic event occur at some time in their life. The most common traumatic event that occurred was the death of a parent or the suicide of a family member or friend. In some cases more than one traumatic event occurred. Losing a close family member or friend accounted for the majority of traumatic events, additionally other factors included being abused as a child.

11.9.2. Mental Health

Poor mental health is unsurprisingly one of the main risk factors for suicide. 39% of those who died from suicide in North East Lincolnshire had a diagnosed mental health condition. Over a third (37.5%) had an undiagnosed mental health condition and no other known mental health condition, 10% had both a diagnosed and an undiagnosed mental health condition, 23.4% had no recorded mental health condition prior to their death.

By far, the most common mental health condition was depression, with 87.8% (or 67.2% of all local deaths from suicide) of those who had a mental health condition (diagnosed or undiagnosed) having depression.

Previous self-harm, regardless of suicidal intent, is a particularly strong risk factor for suicide and suicide attempt; particularly in people with depression which increases the risk of suicide[95]. Up to 20% of those who have survived an attempted suicide will try again within a year and, as a group, are 100 times more likely to go on to die from suicide compared to those who have never attempted suicide[96].

Locally, almost half (32.8%) had previously attempted suicide and 53.1% had expressed suicidal thoughts (some had expressed suicidal thoughts and attempted suicide). 67.2% had either expressed suicidal thoughts and/or attempted suicide previously.

11.9.3. Lifestyle

Those who misuse substances (alcohol and/or drugs) are amongst those at highest risk of suicide[96]; people who misuse substances are 6 times more likely to attempt suicide compared to those who don't misuse substances[97]. Substance misuse along with other risk factors found in the general population such as depression indicate those most at risk[97].

The NCISH found that 45% of patients who died from suicide had a history of alcohol misuse and 32% had a history of drug use, over half (54%) had misused alcohol and/or drugs at some point in their life. 7% of patients had been in treatment with drug services and 7% in treatment with alcohol services at the time of their death[98].

Local trends are similar to national trends, although a slightly lower proportion (46.9%) had misused either alcohol or drugs at some time in their life. Locally 31.3% had misused drugs and 32.8% had misused alcohol in their life, the table below show the proportions who misused both drugs and alcohol together. The most commonly used drug was cannabis.

Table 18 Drug and alcohol misuse

History of alcohol/ drug use	All persons
	%
Not misused alcohol or drugs	53.1%
Misused both drugs and alcohol	17.2%
Alcohol misuse only	32.8%
Drug misuse only	31.3%
Total alcohol or drug misuse	46.9%

Source: North East Lincolnshire coroner case notes, 2012-2016 *(Non publically available)*

Nationally 18% had suffered serious financial difficulties in the 3 months prior to their death, locally 17% had been reported to have suffered from financial problems including redundancy or threat of redundancy from work. Additionally some had lost their job but financial pressures weren't specifically mentioned and so weren't included in the 17%. Other stresses in the time leading up to death also include court cases, losing custody of children and suffering from terminal illness.

7% nationally had been homeless (including living in a hostel, B&Bs, sofa surfing, having no fixed abode) at the time of their death, locally 6.3% were homeless at the time of their death or in the months leading up to their death.

11.9.4. Employment

Although unemployment has never been directly proven to be a cause of suicide there is a considerable body of research to suggest there is a strong association between those who are unemployed or have recently become unemployed (including redundancy and retirement) and risk of suicide[99]. Research has also found that higher suicide rates are proceeded by a rise in unemployment rates (lagged by 6 months). 17.2% locally were categorised as unemployed considerably higher than the latest national and regional unemployment rates (England 5.6%; Yorkshire and Humber 6.9%)[100]. This suggests that North East Lincolnshire is not different to other areas and in that those who are unemployed are more likely to be at a greater risk of suicide[99]. 10.9% of cases had either recently lost their job, been made redundant or were under threat of redundancy. However, it was not possible to determine a true picture of employment status for 15.6% of all cases.

Those who are serving or have served in the armed forces are also considered to be a greater risk of suicide due to potential exposure to traumatic experiences leading to post-traumatic stress disorder (PTSD). Recent research suggests that having a shorter term of service and having PTSD increase risk of self-harm and suicide amongst ex-service personnel[101]. However latest statistics from the Ministry of Defence suggest that serving personnel are statistically significantly less likely to undertake suicide than the general population[102]. 14.1% suicides in North East Lincolnshire were ex-service personnel and it should be noted that for a proportion of these, mental health conditions were observed during their service.

Suicide Key Points

- The male suicide rate in North East Lincolnshire is over five times higher than the female suicide rate compared to nationally where the male rate is only three times higher than the female rate.
- The highest proportion of suicides in North East Lincolnshire were in the 35-44 age band whereas nationally it is in the 40-49 age band.
- A highest proportion of suicides were recorded by those who had lived in areas of higher deprivation with those from the two most deprived quintiles more likely to die from suicide.
- The most common method of suicide in North East Lincolnshire was hanging and this proportion was considerably higher than at a national level suggesting that other methods of suicide are not as accessible locally.
- 31.3% had suffered a traumatic event in their life.
- 39% of those who died from suicide in North East Lincolnshire had a diagnosed mental health condition, 87.8% of which were diagnosed with depression.
- Locally, over a third (32.8%) had previously attempted suicide and 53.1% had expressed suicidal thoughts (some had expressed suicidal thoughts and attempted suicide). 67.2% had either expressed suicidal thoughts and/or attempted suicide previously.
- The proportion of people with a financial difficulty prior to their death appears to be increasing in North East Lincolnshire and is now similar to that of suicides recorded nationally who have suffered financial difficulty.

11.10. Suicide Attempt Ambulance Callouts

North East Lincolnshire Clinical Commissioning Group provided ambulance call out data relating to suicide attempts recorded in North East Lincolnshire between the 1st April 2016 and 31st March 2017. This included the following operational callout codes: 09E03 to 09E04 (cardiac arrest as a result of hanging or strangulation), chapter 23 (intentional overdose/ poisoning) and 25 (suicide attempt) inclusive.

There were a total of 1053 suicide attempt related calls in 2016-17, of which, 207 were duplicate calls, 63 were cancelled before the ambulance crew arrived, 39 were no patient was found at the scene, and 3 were hoax calls. 412 patients were conveyed to hospital and 237 were treated on scene.

For the purposes of all analysis presented in this report, duplicate and hoax calls were removed from all further analyses leaving a total of 843 records available for analysis.

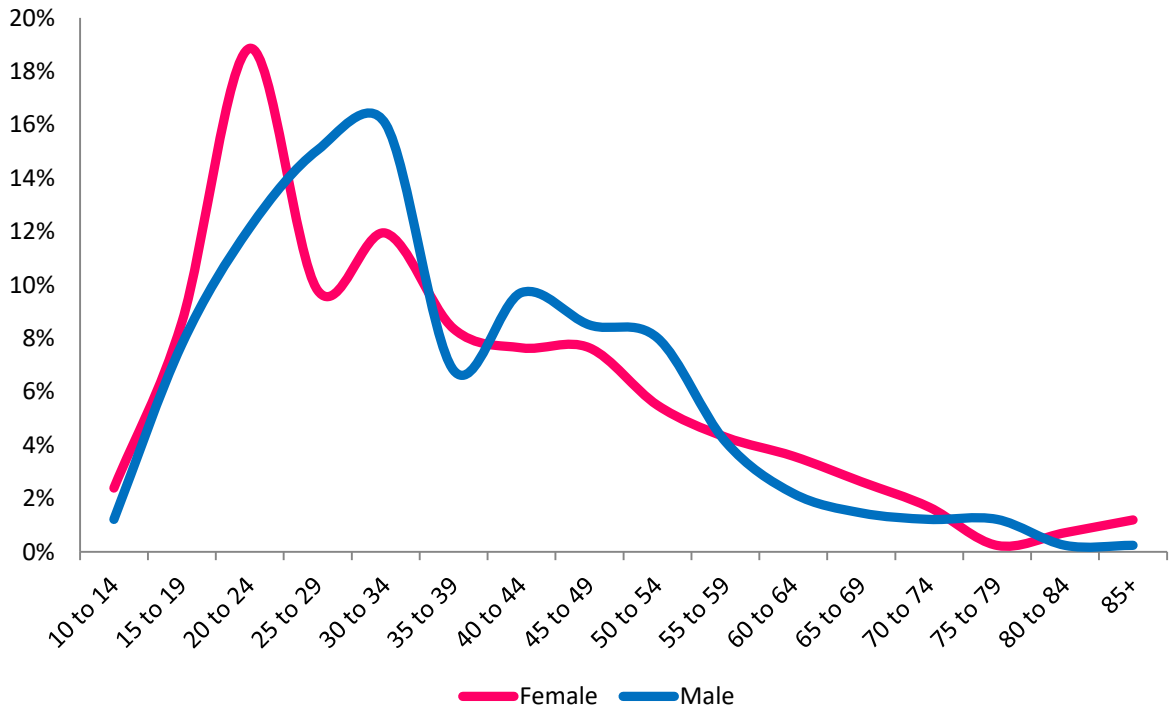
Of those whose gender was recorded, 50.4% were female and 49.6% were male with 12 records having no data on gender. The greatest proportion of suicide attempt callouts were for patients aged 20 to 29 years (29.2%) followed by those aged 30 to 39 years (22.5%). The proportion of callouts reduced as age increased. Over 10% of callouts were for those aged 10 to 19 years (Figure 39). Further analysis by age group and gender (Figure 40) shows that there were slight differences between males and females at different age bands. The greatest proportion of suicide attempt callouts for females were amongst those aged 20 to 24 years whereas for males the greatest proportion was amongst the 30 to 34 years. Female proportions appeared to reduce with age relatively linearly whereas there was a noticeably increase amongst males aged between 40 and 54 years.

Figure 39 Proportion of suicide related ambulance call outs by age band, 2016-17

	Age Group							
	10 to 19	**20 to 29**	**30 to 39**	**40 to 49**	**50 to 59**	**60 to 69**	**70 to 79**	**80+**
Proportion of callouts	10.6%	29.2%	22.5%	17.5%	11.6%	5.2%	2.3%	1.3%

Source: North East Lincolnshire CCG

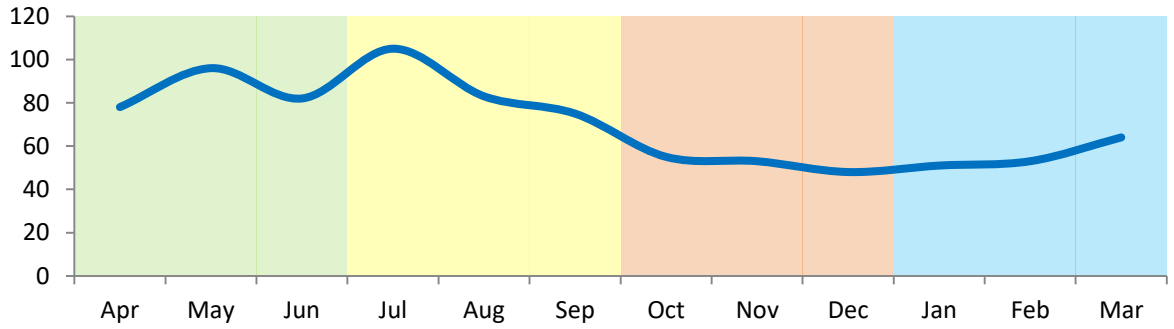
Figure 40 Proportion of suicide related ambulance call outs by age band and gender, 2016-17



Source: North East Lincolnshire CCG

There were on average 70 call outs per month in 2016-17. The number of suicide related call outs was greater in the spring and summer months compared to autumn and winter months. July had the greatest number of call outs (105) with lowest number of call outs occurring in the December (48).

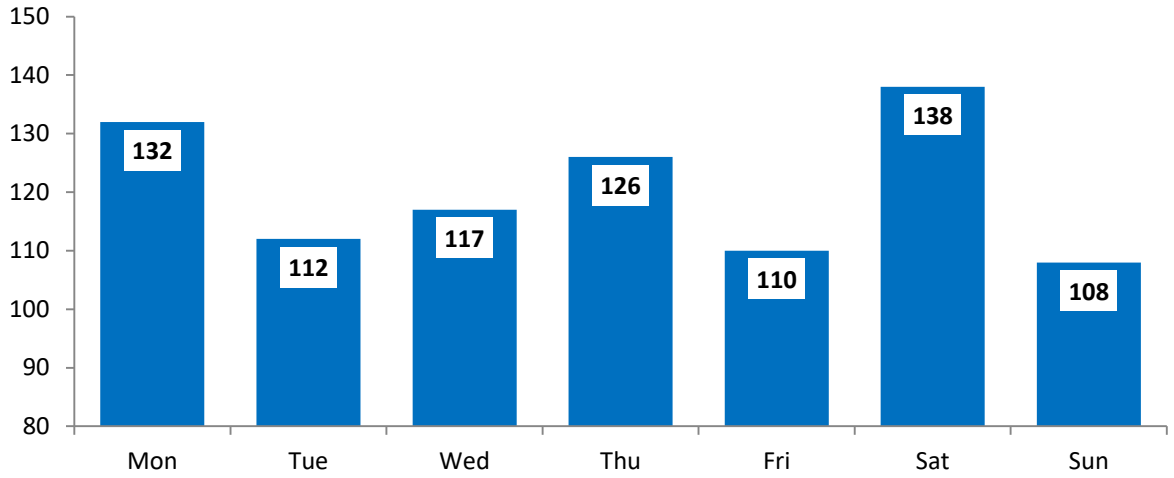
Figure 41 Number of suicide related ambulance by month, April 2016 to March 2017



Source: North East Lincolnshire CCG

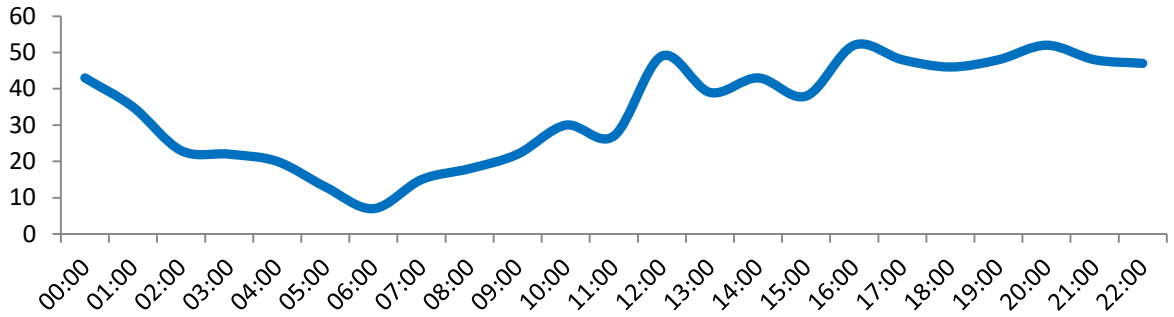
There were an average of 16 call outs per day and over an average weekly period there were a greater number of suicide related call outs on a Saturday (138) and Monday (132) and lower on Sunday (108), Friday (110) and Tuesday (112). There were also considerably fluctuations in the number of suicide related call outs depending on the time of day. The highest number of number of call outs on average occurred at midday and between 4pm and 12am. The lowest period of call outs occurred between 3am and 11am with the least number of call outs occurring at between 6 and 7am.

Figure 42 Average number of suicide related ambulance call outs by day, 2016-17



Source: North East Lincolnshire CCG

Figure 43 Average number of suicide related ambulance call outs per hour, 2016-17

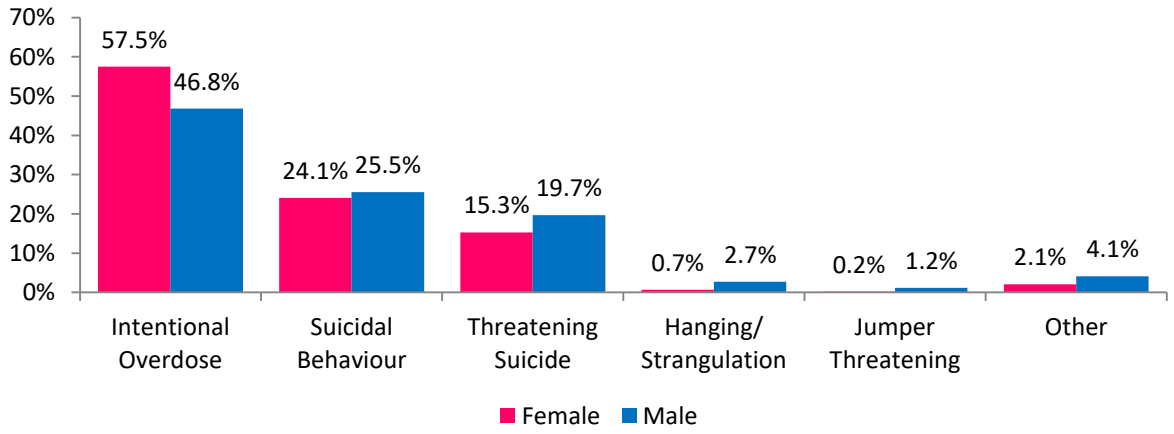


Source: North East Lincolnshire CCG

Almost two thirds (65%) of calls were received from the public calling 999, over a quarter (26%) were received from the police and the remaining calls were received from mental health professionals, other emergency services including the coastguard and fire service as well as from care and nursing homes.

The majority of despatch categories were categorised as intentional overdose (52.2%), suicidal behaviour (e.g. cutting etc.) (24.6%), threatening suicide (17.3%) and hanging/ strangulation (2.1%). A small proportion were categorised as' a jumper threatening'. Overall, despatch categories for women were more likely to be for an intentional overdose than those reported for men whereas men were more likely than women to have a despatch category of suicidal behaviour, threatening suicide or hanging/ strangulation.

Figure 44 Callout category by gender

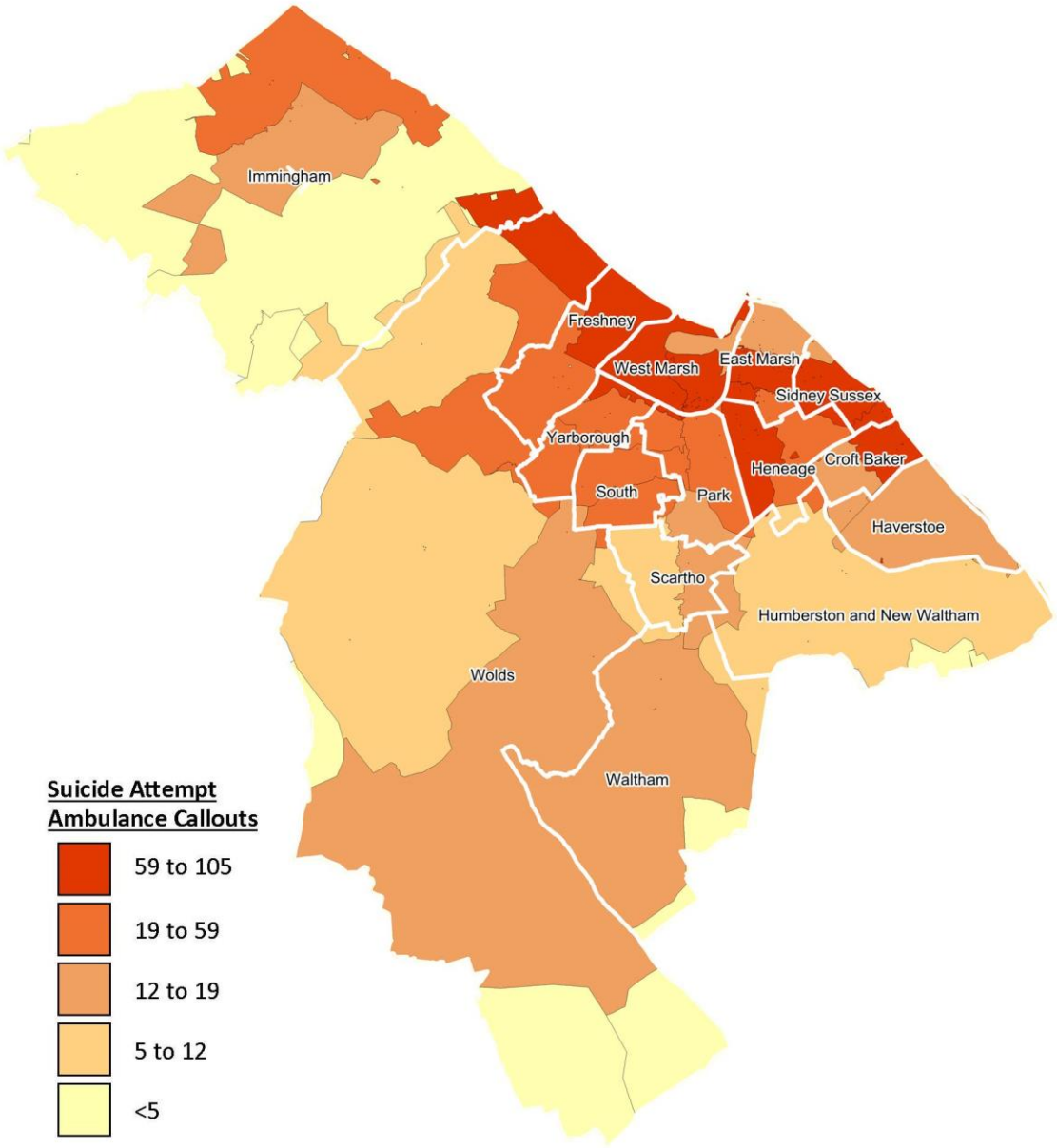


Source: North East Lincolnshire CCG

Suicide related ambulance callout locations were thematically mapped at 5 digit postcode geographies[xvii] within North East Lincolnshire. The highest number of callouts were recorded in West Marsh, Sidney Sussex and East Marsh. Parts of Croft Baker ward also had a higher number of call outs. There were a higher number of call outs in the more urbanised areas of central North East Lincolnshire.

[xvii] 5 digit postcode boundaries cannot be mapped to any of the common or more recognisable geographical boundaries traditionally used for thematic mapping within North East Lincolnshire. Therefore some 5 digit postcode boundaries may transverse multiple ward boundaries.

Figure 45 Suicide related ambulance callouts for North East Lincolnshire postcodes*



Source: North East Lincolnshire CCG

** map vectors calculated from 5 digit postcode areas within North East Lincolnshire*

Suicide Ambulance Call Outs – Key Points

- There were 843 suicide ambulance related call outs in 2016/17 within North East Lincolnshire. Over half of all suicide related ambulance call outs were for people aged 20 to 39 years.
- A higher number of suicide related ambulance call outs were in the spring and summer months.

12. CONSULTATION

12.1. Stakeholder and Community Champion Survey

To understand community mental wellbeing issues in North East Lincolnshire a total of 121 stakeholders and community champions (69), GPs and practice nurses (32), and education professionals (20) were surveyed. Questions were tailored for the relevant professional/stakeholder group.

Overall all the majority of respondents felt that mental wellbeing amongst the general population has got worse over the past 5 years in North East Lincolnshire. GPs and practice nurses felt that the number of patients presenting to them with mental wellbeing issues had increased and teachers also felt that the number children they see with mental wellbeing issues had increased in recent years.

GPs and stakeholders were most likely to say they don't know where to refer someone who they come in to contact with mental wellbeing issues whereas 7 out 10 teachers where confident they always know where to refer to.

Most GPs and stakeholders do not believe the majority people the in community have the capability to manage and improve their own mental wellbeing issues. There was also a majority consensus that there are insufficient community services to support people with low level mental wellbeing issues.

7 out of 10 teachers think there is adequate support for children in school who are suffering with poor mental wellbeing and almost all teachers believed that parents and carers have a significant role in influence mental wellbeing issues amongst children.

Similar responses amongst different professional groups were noted regarding the leading cause of mental wellbeing issues for various age groups. For young people the leading cause of poor mental wellbeing felt to be bullying, family/relationship problems, social media, physical/emotional abuse, sexuality and education. Amongst the working age population, alcohol/substance misuse, family/relationship problems, finances/ debt, work related stress and unemployment were considered to be the leading causes of mental wellbeing issues. For older people loneliness, poor physical health, bereavement, poor housing/living environment, disability and the side effects of medication were felt to the most prevalent causes of poor mental wellbeing.

Mental Health Needs Assessment Survey

GPs & Practice Nurses

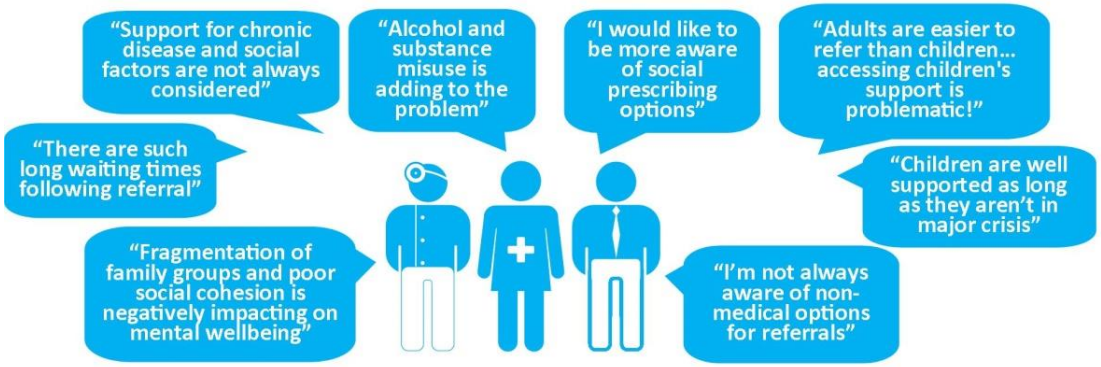
8.5 out of 10 GPs think the number of **patients presenting** with **mental wellbeing issues** has **increased**

8 out of 10 GPs think **mental wellbeing issues** have **worsened** in the **general population**

7.5 out of 10 GPs don't always know where to **refer patients** with **mental wellbeing issues**

6 out of 10 GPs don't believe **people** have the **capability** to **manage/ improve** their own **mental wellbeing**

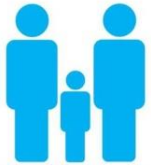
8 out of 10 GPs don't think there are adequate **community services** to **support** people with **mental wellbeing**



Top 5 causes of poor mental wellbeing according to GPs

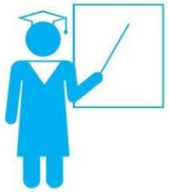
Children & Young People

88% Bullying



82% Family/ relationship problems

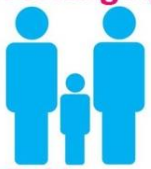
76% Physical/ emotional abuse



71% Education

65% Sexuality

Working Age

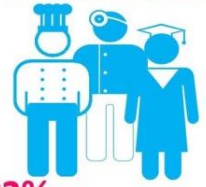


91% Family/ relationship problems

91% Work related stress

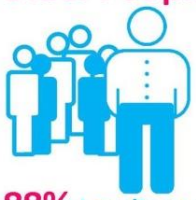
85% Finances, debt

85% Alcohol & substance misuse



82% Unemployment

Older People



88% Loneliness

85% Poor physical health

79% Bereavement, significant loss

71% Poor housing, living environment, fuel poverty

65% Side effects of medication

Mental Health Needs Assessment Survey

Stakeholders & Community Champions

4.5 out of 10 stakeholders think the number of **people** with **mental wellbeing issues** they **engage** with has **increased**

6 out of 10 stakeholders think **mental wellbeing issues** have **worsened** in the **general population**

4 out of 10 stakeholders say they **don't always know** where to **refer someone** with **mental wellbeing issues**

6.5 out of 10 stakeholders don't believe **people** have the **capability** to **manage/ improve** their own **mental wellbeing**

8.5 out of 10 stakeholders don't think there are adequate **community services** to **support** people with **mental wellbeing**

Top 5 causes of poor mental wellbeing according to stakeholders

Children & Young People

73% Family/ relationship problems

73% Bullying

71% Sexuality

65% Physical/ emotional abuse

64% Education

Working Age

84% Alcohol & substance misuse

83% Finances, debt

81% Work related stress

75% Poverty

75% Unemployment

Older People

80% Loneliness

70% Poor physical health

68% Bereavement, significant loss

67% Poor housing, living environment, fuel poverty

64% Disability

Mental Health Needs Assessment Survey

Teachers & Education Providers

9 out of 10 teachers think the number of **children** with **mental wellbeing issues** has **increased** in the last **5 years**

8.5 out of 10 teachers think **mental wellbeing issues** have **worsened** in the **general population** in the last **5 years**

7 out of 10 teachers say they **always know** where to **refer children** suffering with **mental wellbeing issues**

7 out of 10 teachers believe there is enough **support** within their **school** for **children** with **mental wellbeing issues**

9 out of 10 teachers believe **parents** and **carers** have **a lot** of **influence** on the **mental wellbeing** of their **children**

Top 5 causes of poor mental wellbeing amongst children and young people according to teachers

90% Family/ relationship problems

80% Social media

65% Physical/ emotional abuse

65% Life changes

60% Bullying

12.2. Stakeholder and Community Champion Interviews

Semi-structured interviews were undertaken with stakeholders and community champions regarding the mental wellbeing issues of service users and people in the community. In total 6 interviews were conducted with a range of professionals and community champions. The discussions were analysed and grouped into themes:

1. Increasing community mental wellbeing issues

Professionals discussed that they were aware of a big increase in the number of people presenting to their services with mental health issues in recent years. In particular more complex cases of mental health, particularly those involving historical abuse and trauma, seemed to have increased disproportionality to the general trend in recent years.

Changes in mental health service provision are considered to be partly responsible for identifying large cohorts of those suffering with mental wellbeing issues. Services are expected to see more people and whereas low level mental wellbeing in the population would have previously gone unnoticed 10 years ago, these people are now expected to be seen in services. A large proportion of clients seen by mental health services are self-referrals, suggesting that people are more likely to acknowledge and seek support if they are struggling with poor mental wellbeing.

Services and community champions felt that mental health stigma is, in general, dissipating and people are more likely to seek support if they are suffering from mild mental wellbeing issues. National media campaigns and a celebrity culture being more likely to talk and acknowledge mental wellbeing being were also credited with more people being willing to seek support. However, generational issues associated with a “stiff upper lip” attitude were thought to contribute towards older people being less likely to seek help when they need it.

Social factors, such as economic activity, cultural issues and deprivation, were thought to have changed considerably in the last 5 years which were believed to be a contributory factor towards a decline in community mental wellbeing and resilience.

2. Complex mental health

It was stated that mental wellbeing issues appear to be much more complex in North East Lincolnshire compared to other areas and stakeholders felt that issues including chaotic lifestyles, sexual and physical abuse, PTSD, childhood trauma were all significant problems in North East Lincolnshire. These were felt to not just be mild to moderate issues but significant problems that have been left undealt with in a whole generation of the population.

Professionals discussed a local cultural issue relating to people just tend to get on with their life without acknowledging or seeking help for mild mental health issues which can then manifest into more severe problems over a longer period of time.

An emerging issue that has been noted is people developing complex mental health issues as a result of living with or being diagnosed with long term health conditions.

3. Service access and availability

On the whole it is agreed that the mental health services available in North East Lincolnshire are good as long as people are able to get access and the relevant services they need are available. However, where people with mental wellbeing issues did not meet the clinical criteria for treatment or don’t fit a particularly pathway they don’t always get the service they need, these were seen to be gaps in service; particularly in the way of community support. This inability to be treated suggests a gap for more informal out in the community support for mild mental wellbeing issues.

Professionals expressed confusion at knowing which element or branch of mental health services they would be best referring a client on to. Waiting times for some mental wellbeing support services were up to a year following a referral and some services are seen as totally inaccessible. The population mental health needs are generally considered to vastly outweigh the current services provision. There were also concerns around continuity of long term mental health care with little or no following up care following a previous diagnosis/treatment.

It was felt that low level counselling services in the community have the potential to drastically improve the mental wellbeing of people in the community, particularly with coping strategies, promoting what mental health is and coaching people to understand what they can do to help themselves. Social prescribing is also seen as lacking in North East Lincolnshire with most interviewees stating that this would be of benefit at a community level.

Those suffering with both drug and/or alcohol problems as well as mental health issues are often stuck between addiction and mental health services. It is common for local mental health services to require clients to be substance free before mental health treatment can begin but a holistic approach to dealing with addiction and their mental health has been suggested as a more appropriate pathway.

4. Children and young people

Professionals have noticed an increase in the number of children tested for mental health conditions in recent years as a result of parents wanting a 'label' for bad behaviour. However, it is perceived that bad behaviours and poor mental wellbeing in children is a result of a lack of parental accountability, chaotic home lives and other social and cultural 'pressures'. This is seen as more pronounced amongst younger parents who are seen as more likely to raise children with poor mental wellbeing due to the lack of boundaries they set.

Social media, peer pressure, underage gaming (particularly in boys), constant access to the internet through smartphones and tablets and underage access to TV programmes are all seen to be contributory towards poor mental wellbeing in children. Parental legacy issues such as prison, unemployment, domestic violence and other social problems are all seen to have a knock on issue for children's mental wellbeing.

Services for young people are considered to be hard to access despite a consensus that there are many good services available. CAMHS in particular was mentioned as particularly difficult to refer children into.

5. Lack of resilience and community cohesion

Both professionals and community champions discussed the issue of a lack of general resilience amongst the local population in relation to very low level mental wellbeing issues. Coping mechanisms appear to be poor within the community and family relationships/support networks that would previously have been an initial coping means are not what they used to be. A lack of routine and framework coupled with low aspiration and isolation are believed to be some of the principal reasons resulting in poor family support networks locally.

12.3. Community Engagement

The Community Engagement element has involved speaking to people mainly who attend groups with the aim of improving their, or their family's health and wellbeing. A variety of groups were contacted, however a high proportion of the individuals who have engaged with the research were older people or new parents.

One member of the Public Health Team attended each of the groups, informally talking to small clusters of people and taking anonymous notes on the themes of conversation. As well as attending a variety of different groups the facilitator ensured wherever possible, both males and females were engaged with. During the children and young people engagement year groups were collected of those who took part.

Some of the conversations happened either before events started or during break times, these discussions were therefore often short. There were three main questions / areas of focus which are described in the following section. These questions were phrased slightly different depending on the cohort to ensure all individuals understand what is being asked. After starting the research it soon became clear that individuals either did not understand the first question, it was simply not relevant (new participants to a group for example) and therefore tended to answer it in regard to the group they were attending, the question evolved to consider attitudes around mental health in North East Lincolnshire as a whole. The research question was quickly altered to adapt for this and ensuring all groups answered the same question.

- **Question 1: Do you think, or how do you think attitudes around mental health and wellbeing have changed in North East Lincolnshire?**

Most people agreed that attitudes around mental health were more positive including; a reduction in stigma, an increase in empathy and better understanding of the topic, particularly in the last 10-15 years. Many felt that this was because famous people including the Royal family have been talking about it. There was a concern amongst some that this amplified communication could be a reason for the increase in the number of people with illnesses such as anxiety. Most individuals who were spoken to agreed that it was easier to speak about mental health on the whole, although one individual suggested we were being told it's more acceptable to speak about mental health rather than it actually being more acceptable to have a mental illness.

A few people, mainly ones in their early 20s, over the course of the engagement did actually say they did not think about mental health, they were prompted with the explanation, everyone has a mental health as well as a physical health, every-time this then led to a discussion about mental health being about people who have mental ill-health.

As a caveat to the overall attitude change there was concern by some individuals that in parts of the borough, potentially due to a lack of education and understanding, attitudes had not changed. Furthermore it was suggested 'we need to make it acceptable and normal' as individuals do not always pay enough attention towards both their own mental health never mind others and it was even suggested some people were frightened to get help. The media was given as one of the reasons this could be an issue as people with mental illnesses are often portrayed in a negative light and it therefore must make it scary when you get a diagnosis of an illness such as schizophrenia. One individual made an empathetic statement that it can take a lot of bravery to go to a mental health appointment as 'mental ill-health makes you really vulnerable'. It was also mentioned with some sympathy that it can be difficult to understand what mentally ill people are going through.

The only groups of people who seemed almost on the look-out for their own mental ill-health were new mums who said they were continually being asked how they were and to consider post-natal depression (PND) at every health professional appointment. Some were fearful of the prospect of this, however one new mother disclosed she was feeling particularly low during the discussion, she was immediately signposted to a Health Visitor, however this actively highlighted both the need to ask about an individual's mental health and how when asked people will often open up that they really need support. Children's Centre groups also often concentrated on the mental state of the mum as well as the development of the child and many new mums shared that they felt comfortable talking about their difficulties in this supportive environment. Some new parents did mention that they did still feel there was space for improvement, for example support for new dads as well as new mums and especially following a difficult birth, again for both mothers and fathers (who witnessed the birth).

The language around mental health was brought up and thought to have changed, an example of a word given which one of the groups said is no longer used was Doolally, however in the same conversation one participant talked about 'her nerves' as a colloquialism for her anxiety alluding to the idea that we still use words we are familiar and comfortable with to describe our mental health, as opposed to more factual ones. It was mentioned by some, mainly those with the mental illness depression, that the word depression is currently being used very loosely, potentially because now it is ok to talk about mental health. These individuals found this use of the term offensive due to the debilitating nature of the illness. Obsessive Compulsive Disorder (OCD) was mentioned in the same light by one individual as well. A couple of people also wondered if people are using mental ill-health as an excuse (e.g. for not leading productive lives) now it is so public.

There was a small amount of concern over the medical profession (Doctors/NAViGO/Social Care) still showing signs of stigma towards those with mental health issues, although it was remarked that Doctors no longer suggest a cigarette for depression. Those who expressed signs of stigma in other aspects of their lives (Learning disabilities) did however express concern over stigma for their mental health issues too. It was mentioned that support for parents was not always there either. One individual with a Long-term condition (LTC) stated that she had had great support with her anxiety over her life. She has had issues with contradictory advice as she has moved from children's services to adult services, it is unknown whether this is directly mental health services.

People on the whole who had had experience with mental health services agreed that they were good and most said they would go back if they needed to. It was repeatedly brought up that it was very difficult to get a GP appointment and even then you need an understanding GP. High demands on services such as Open Minds and Child and adolescent mental health services (CAMHS) causing long waiting lists worried people that support was not really out there when it was most needed. And a few people alluded to the fact that you needed to know the system to get the support you required – learn as you go. Others said if you didn't fit into the system; you had to argue your case and repeat your story many times to get the help you need or it was also mentioned that there isn't much flexibility with sessions and if you work attendance may be difficult. Staff changes and a lack counsellor continuity was also mentioned as an issue by a number of participants. For these individuals, who had experience with this, it was described as a very stressful situation and had had a negative impact on their mental health; one individual who's mum had Bipolar, had experienced this on a number of occasions which was not only stressful for her mum, but also for the family.

As well, people with, fibromyalgia, substance misuse dual diagnosis, or those individuals who do not want to take medication have found it difficult to access support they feel they need. One individual also did not feel supported in her long-term mental illness (following a course of Dialectical behaviour therapy - DBT) and felt her GP (the first point of call following NAViGO discharge) was not knowledgeable enough in her particular case history. Another group said they did not want to bother their GP with a relapse and suggested light-touch support from professionals could help them deal with more difficult and stressful situations, causing some to go down a dark path, potentially self-medicating.

With regards to dementia, the main issue which came up was a lack of understanding of who can offer help and support, particularly with the amount of people who have the illness. Participants, in particular those who classed themselves as carers, talked about how they had to go out of their way to understand what they were entitled to which included repeating themselves and completing lots of paperwork (some online) – this was mentioned in relation to other mental health illnesses too. Regarding attitudes to dementia, some people thought that organisations such as Friendship At Home and Dementia Friends helped, however some thought society did not respect the elderly and therefore did not help those with dementia. Also the lack of support as a Carer was mentioned, not just with dementia but any illness, particularly when

the individual who needed caring didn't want the support themselves, for example to deal with the stress and isolation of caring.

There was a lot of concern about the younger generation's mental health, as to why there are so many young people who need mental health support. People questioned whether it was because of the change in attitude and how much mental health is talked about? 'It was never like it in my day, we just had to get on with it'. Although blame was put on computers (Cyberbullying was mentioned by a few groups as this type of bullying has no boundaries), lack of fresh air (young people can't just go to the park), school pressures, peer pressure and body image pressures. A group of young people (over 18s) talked about how their negative school experiences (including being bullied / not invited to class parties) has stayed with them into adulthood and affects their self-worth and the choices they make today. A couple of groups again mentioned that they believed more work around grassroots mental health including training in school would help. When young people were spoken to they said they didn't believe mental health was covered enough in school, however they agreed with most adults saying it was more acceptable to talk about and they had noticed more children were getting support in school. Even young children (year 5 and 6) agreed that feelings about mental health were good.

Self-harm was brought up a few times, with concern over the amount of young people who are self-harming alongside family members not understanding it or knowing how to support their children (under and over 18 years olds) through this. A few individuals, who spoke about their experiences of attending A&E following self-harming, said they felt that staff at the hospital were fed up of seeing them so they were less likely to attend in future, another individual who said that when she had previously been a 'terrible drinker' she also perceived this lack of sympathy.

Male mental health was brought up by a few groups. On the one hand it was mentioned by one individual that two of her close male family members were now receiving support with their mental ill-health due to the promotion and attitude changes which had taken place recently. Another individual talked about how it was difficult to support their male friends particularly in the light of their drug and alcohol misuse, especially when they asked for help. He spoke about how neither of them had a diagnosable mental illness, but they demonstrated mentally unhealthy behaviours and he spoke about how both of these individuals unfortunately ended their lives with suicides. Another male individual said he had struggled with his mental health due to a number of stressful events (miscarriage, childhood bereavement, homeless at a young age), he found that, mainly the older generation, were very unsupportive and experienced clichés such as 'man-up' / 'grow-up' / 'just get on with it'. He spoke about how his mental ill-health had led him into a dark place which had caused him to previously offend and misuse medication.

Some of the individuals spoken to had experience working with people who were mentally ill; mental health services, the NHS, Breast Feeding Peer Supporters (BFPS) and the Job Centre Plus. They spoke about their professional experiences as well as personal. They all said that they have noticed people quite like to speak to a stranger especially for those seeking anonymity. The colleague at Job Centre Plus also mentioned that they see many individuals experiencing mental ill-health. The BFPS who were spoken to say they see lots of mums showing signs of anxiety due to how well they perceived their baby was feeding, there was no mention of any prior relationship with these mums.

- **Question 2: What can individuals do for themselves? / What can the NHS /NAViGO do?**

It was agreed by many that talking about mental health helps and keeping it 'hushed up' can make things worse.

Groups for both older people and for parents of young children were mentioned as a great help towards keeping a positive mental health. The reasons which were given were; building new friendships, as well as surrounding yourself with friends, men talking to other men, talking to those with similar backgrounds and

experiences (learn that you are not alone), just getting out the house, building confidence, volunteering, keeping active – mind and body.

Getting out the house was talked about by every new mother who was spoken to. In particular breast feeding mums, some of whom said they had experienced periods of loneliness due to the isolation of cluster feeding a new-born. A couple of new mums actually said that their ability to breast feed their baby greatly affected, and in one case 'rocked', their mental health and a lack of support alongside the push to use formula can make this even more difficult when you are in an emotionally, vulnerable post-birth state. Skin-to-skin was however mentioned as something which can help reduce the chances of developing PND.

Groups also were said to give support to carers - as a widow/er of someone with dementia being around others who had a similar experiences was reported to be a comfort. This was also the case during their time as a carer for their partner. This is different to comments about the carers' system which it was suggested isn't set up to support housebound individual's mental health due to the time restraints.

Counselling was particularly mentioned by people who had had good experiences when they received it in the past and it was agreed there is a lot of support available for those who meet the criteria thresholds. It was suggested that the NHS could advertise what support is available as it is difficult to know what is out there. A general understanding that services are stretched and long waiting times expected, was reluctantly accepted. A few people who were spoken to had not heard of NAViGO and did not know what they did, these tended to be younger parents who did not have any knowledge or experience of mental ill-health. There was a comment by one individual that a family member had had to reach crisis and do something dramatic before they were offered any help, unfortunately then their family member would not accept the support available - 'you have to admit you have a problem first'. Another individual said that she had not come across information about mental health, in the same way she had come across breast feeding support information.

One group had an interesting discussion about how Harrison House turn you away when they do not think you are having a mental health crisis. Their experience involved other non-mental health professionals thinking they are mentally ill and taking them for help, the professionals who were discussed had a lot of experience working with people in a mental health crisis; i.e. YMCA. They talked about how after hours of waiting around, NAViGO did a quick assessment before sending them away. Their concerns were there was no signposting given at this time and that it has often happened again a few days later.

Some other issues with the mental health services which were identified by individuals were, how you have to pluck up the courage to seek help and it can be disheartening when you have to wait for many weeks for the support. Another issue which was identified by a number of individuals who had experiences with mental health services, either for themselves or a family member was the continuity of staff, these changes either affected individuals mental health or in a couple of circumstances when counsellors / support workers had left they had not had any follow-up.

A number of non-mental health services were mentioned as having an impact on your mental health. Two older ladies had found that their over 50s exercise provision had been reduced and bowling greens were being closed. Social services was mentioned as they have a great influence over whether a child is diagnosed with an illness, it was suggested they do not want to label children, however parents stated that this can make life difficult as they do not get the support they need. Midwives were discussed as a profession who readily discussed both mental and physical health, the new parents who discussed this support viewed it in a positive light, especially the phone service which is available post-birth. Anger Management and Mindfulness at Open Door were mentioned by one individual as two things which have helped him deal with his mental ill-health and move on with his life positively.

Taking anti-depressants and anti-anxiety medications were discussed by a few groups who had been prescribed them often without the support of therapy, there was frustration that this happens as they understood the importance of talking therapies alongside medication.

Some people thought education for Grandparents about child development, particularly in regards to supporting their mental health would be useful, supportive and reduce stress.

A number of people who were spoken to said they wouldn't want to live anywhere else; their friends and the support available were brilliant. One lady who had recently moved to Britain said Cleethorpes was a lovely place to bring up a baby.

The research suggested that many people in North East Lincolnshire are, without necessarily being aware, following the five ways to wellbeing to keep themselves mentally well.

Connect

- Talking to people with similar experiences e.g. other foster carers
- Keep in touch and interacting with family and friends
- Trying to socialise
- Having a good support network, for example living in a group dwelling, parents around to help with the children or support in work
- Not isolating yourself
- Time without kids to talk to other adults (about things other than children)

Be active

- Physical activity – tai chi / sports (channel your anger) / Dancing / Gardening (having the patience to see something grow & improves your self-worth) / running / gym / aerobics / Football / Swimming
- Getting out the house into the fresh air and just walking, especially with a pram
- Trips and holidays
- Thrill seeking for example; riding motorbikes

Take notice

- Being responsible for yourself, seeking help when you need it and following any advice given – the same as you would with your physical health
- Having aspirations
- Using safe self-harm techniques
- Plan for the night-time as this is the worst time when you are dealing with mental ill-health
- Thinking about positive aspects of life and what they would miss if they weren't here ('if I killed myself')
- Taking yourself out of a negative situation and making decisions which positively benefit my mental health (to feel empowered)
- Saying yes when you had previously said no because of your mental health
- Trying something new to get out of a rut & out of your comfort zone
- To belong to something bigger

Learn

- Keeping the mind active – Crosswords / cooking / Bingo / quizzes / Puzzles - Sudoku
- Experiencing music – listening / playing / singing
- Reading
- Cooking (for fun)

- Art and crafts - knitting / colouring / drawing
- Playing games – board games i.e. Cluedo / Chess
- Keeping busy – one new mother identified the irony having no time when you have kids and somehow doing more
- Having a job
- Learning construction and decorating

Give

- Attending church – praying and socialising
- Have a pet – unconditional positive regard

Taking care of you

- Having a bath - in peace / 'an hour to myself'
- Taking time for yourself / chill time / 5 minutes out
- Take one thing at a time – one day – one hour – one task
- Think about what you have got – not what you haven't got
- Drinking water
- Attending therapies & accepting support from people who want to help e.g. CBT / EFT / DBT / NAViGO's telephone support / physiotherapy

Young people said to keep mentally well they:

- Attend therapy sessions
- Sudoku
- Art and crafts - Therapy colouring / Knitting
- Physical Activity – running / football / biking / swimming / Playing (tag)
- Being in good environment with friends
- Had a good family

- **Question 3: Where do individuals go for support if they had a mental health need?**

Most people said straight away that they would talk to someone they know well, or they even live with; family (partners, daughters, sons, cousins, mum, mother-in-law, sister), however one person said only after speaking to a GP (the second choice of who to speak to by most) and a couple were very fearful of speaking to family due to a previous relationship breakdown. Trust was very important to most people with whom they would choose to speak to so for a lot of people close friends or even work colleagues were chosen. Another group pointed out that family members often notice changes in you before you do.

For those who attended a church, the Vicar was mentioned as someone who was good to talk to and signpost to other services.

GPs were said with some concern, many people said that it was difficult to get a Doctor appointment, particularly when females wanted to speak to a female doctor. A Practise nurse was mentioned as a good alternative to a GP as it was easier to get an appointment and it didn't feel like you were wasting their time as much.

Open Minds, although only mentioned by people who said they had been before were seen as very good, however, again waiting times were once again brought up. The Crisis Team was also mentioned as being very good when you qualified for their support. One woman said she had paid for a private counsellor so she didn't have to wait – to help her deal with her dark thoughts which she couldn't share with those close to her.

When some third sector services, for example The Alzheimer's Society, were named as being helpful, there was some confusion why the local authority was not doing more to support people.

Carers from organisations, Midwifery services, Health visitor, BFPS, Open Door staff, Longhirst and Havelock support workers, were said by some as services they could speak to. Strong relationships with these groups was however stated as important as individuals said they needed to feel comfortable and needed to have met them before. Others however had a very stoic view of sharing and said they would not speak to anyone, even friends they saw every week.

The Single Point of Access (SPA), Crisis Team and Children's Centres were examples of somewhere you could access information but only by a few individuals, mainly those who had experience using them.

The children and young people who were spoken to (mainly 'looked after children') said they would speak to friends (mainly best friends) / social workers / family (who you trust) / manager of residential home / Mum / School / Responsible adult / foster carers / respit**e** carers.

Most people didn't have a backup if family was not available to talk to.

Summary

Most people agreed that it is easier to talk about mental health nowadays and in particular this was put down to the Royal Family speaking out about their own experiences. It was suggested however that in some areas stigma was still very prominent, the media were particularly identified due to their portrayals of mentally ill people alongside the day-to-day language used to describe mental health. Most people agreed that when accessed, services were good, however it can be difficult to get support in certain circumstances for example, when people also have another health need or do not meet the referral threshold. Many people found it difficult to find the right information and support predominantly in reference to financial situations which occur due to mental ill-health and dementia. There was a suggestion that the NHS and schools could advertise mental health services more so individuals know what is available to help them. Self-harm was also expressed as a particular concern, particularly with young people and when family members did not know how to deal with the situation.

Most people discussed mental ill-health with empathy and talked about the bravery of individuals living with mental ill-health, this was often alongside the fear of becoming mentally ill.

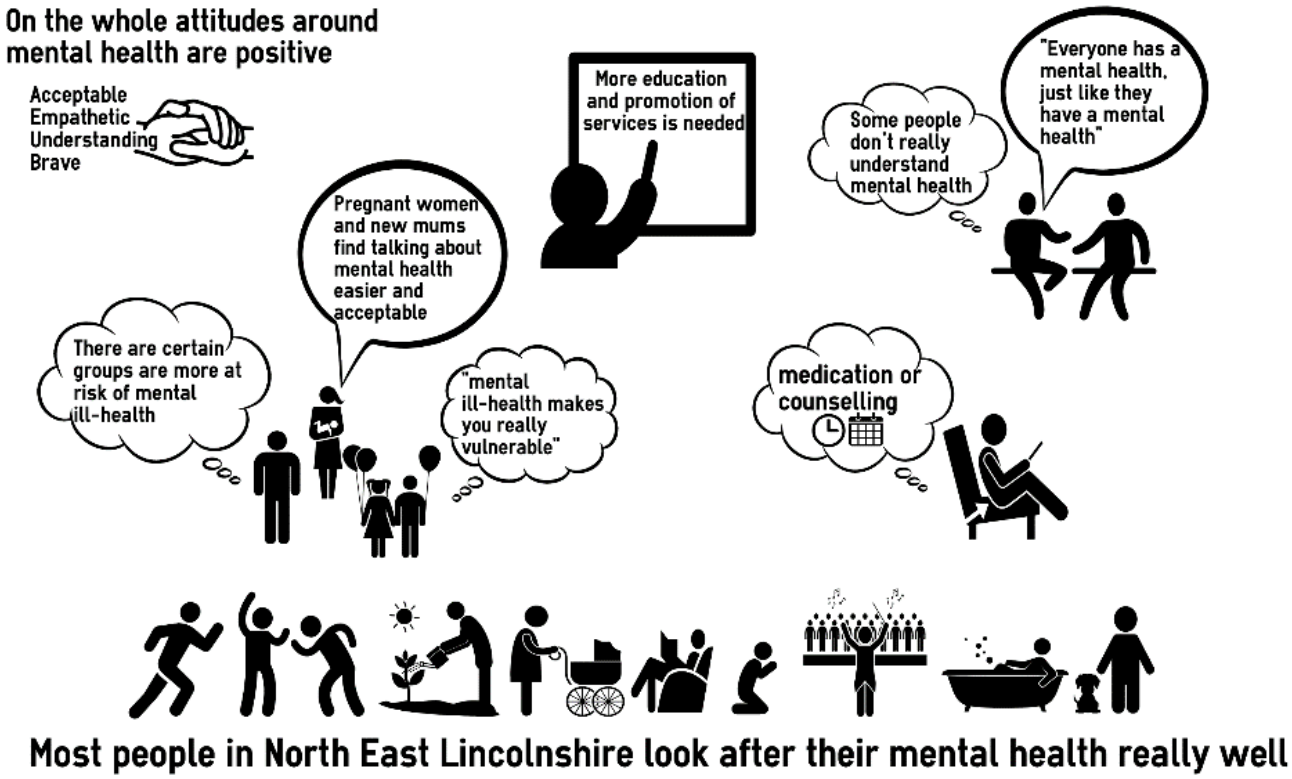
People also seem to understand that there are certain groups who are more at risk of developing a mental illness and then actually getting them to access support, these include; new mothers, young people (especially self-harming) and men.

Most of the people spoken to did something to benefit their mental health, from attending a group, to chatting and taking part in activities, to walking and other physical activity, to keeping their mind active through things like crosswords. Some of the younger adults found this more difficult to answer, however the under 18s talked again about physical activity, crafts and having good family and friends. Accepting and following any mental health advice and guidance was also seen as very important.

Although on the whole people believed mental health services were good and those who had had support from NAViGO generally had a positive and often life changing experience. There was concern about accessing them; getting a GP appointment, meeting the threshold for mental health support, long waiting lists and medication offered without talking therapies.

Most people spoken to said that if they were concerned about their mental health they would speak to their partners or family. Other people who were mentioned were close friends and in a couple of circumstances

a vicar or trusted services such as, midwifery services. Many people said one of the first places they would go to for help is the GP.



13. STATUTORY & SUPPORTING MENTAL HEALTH SERVICES IN NEL

This section provides an overview of current statutory mental health services in NEL for children and young people, adults and older adults. It also provides an overview of perinatal mental health and primary care services. Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. An overview of services that support mental health services in the area are also discussed in this section.

13.1. Perinatal Mental Health Services

Perinatal mental health (PNMH) problems are those which occur during pregnancy or in the first year following the birth of a child. North East Lincolnshire currently has no dedicated perinatal mental health services and therefore, pre and postnatal women with an existing or developing mental health illness currently access adult mental health services (e.g. Open Minds) provided by NAViGO Health and Social Care Community Interest Company (CIC), a social enterprise in North East Lincolnshire).

However, the gap in provision has been recognised nationally and task and finish groups have been established locally and across the Sustainability and Transformation Partnership STP footprint to improve access to specialist perinatal mental health services.

Providers and commissioners recognise the importance of PNMH and are committed to developing the universal offer alongside the development of specialist services. This commitment is shared by allied services that have supported training for their staff - (Institute of Health Visiting (IHV) Perinatal Mental Health Champions Training and IHV PNMH Awareness) - and contributed to pathway development, improving earlier identification and referral through the a PNMH midwife who works across Northern Lincolnshire and Goole NHS Trust, giving advice and support to midwives across the Trust on how to support pregnant and post-natal women with mental health illness. A bereavement midwife also works alongside the PNMH midwife for those women who have experienced a loss or a stillbirth.

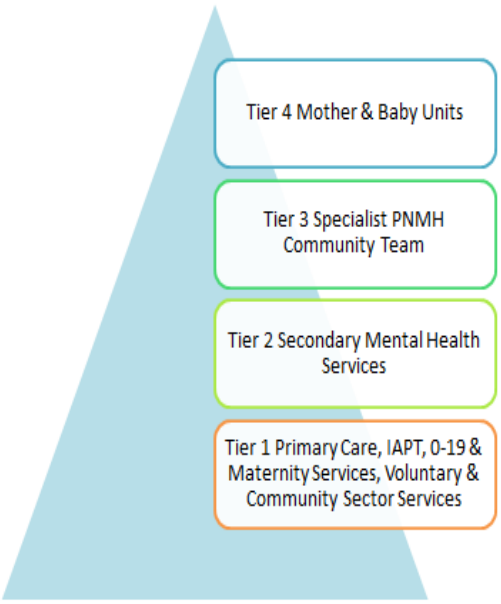
The local model:
If a woman experiences a complex or severe perinatal mental health problem, she will usually receive care from specialist perinatal mental health services. These services include:

Inpatient Mother and Baby Units – These units are commissioned by NHS England (NHSE). They provide inpatient care for women with complex or severe mental health problems during the last trimester of pregnancy and the first 12 months after childbirth. A primary function of the inpatient Mother and Baby Units **(**MBUs) is to enable women to receive inpatient care while remaining with their baby. NEL women with complex or severe mental health problems will access the MBUs in Leeds NHS WebBeds, an online bed occupancy tool to helps practitioners to identify where beds are available. The MBU in Leeds also provides an outreach service for any women in our area who are planning a family who have had previous episode of severe perinatal illness or who has current mental illness which could result in an admission, to carefully plan the woman care. The outreach service also offers support to professionals caring for women who have or are suspected to have perinatal mental illness.

Specialist community perinatal mental health teams, offer specialist psychiatric and psychological assessments and care for women with complex or severe mental health problems during the perinatal period. The team also provides preconception advice for women with a complex or severe mental health problem (current or past) who are planning a pregnancy. The Humber, Coast and Vale area through the Sustainability and Transformation Partnership (STP) has been awarded a grant from NHSE to extend the reach of the Specialist Community Perinatal Mental Health Teams to ensure equality of access across the STP area. The Humber Foundation Trust will act as the conduit for the Humber area and will work

alongside North and North East Lincolnshire's providers to embed a local specialist community perinatal mental health service.

Working with the wider system



Stepped Care Model – Perinatal Mental Health Services

Specialist perinatal mental health services form part of a wider system of care working with women and families as shown in the Stepped Care Model. As an STP and locally, the pathways for this service are currently being developed in line with national guidance and ensuring women and their families are involved in the co-production of new services, so support can be accessed at the approprate threshold of need. Service partners are also crucial, both in the care and interventions that they offer as part of supporting good mental health, and for identifying potential issues requiring specialist support and referring people on to the appropriate specialist perinatal mental health service.
As the Specialist community perinatal mental health teams embed themselves locally across the sytem, the stepped care model for Perinatal Mental Health Services will be implemented. This will be further supported by developing the appriorate workforce training programme to support specilaist and community services across the workforces.

Gaps in service provision

- The main gap identified for this service is the lack of specialist service for women with complex or severe mental health problems during the perinatal period. This is being addressed by the funding obtained from NHSE funding to set up a local service.
- Tier 1 services are limited and there are no specific services for women in NEL who are at risk of developing perinatal mental illness.
- There is no link between fathers' mental health and their babies as fathers' mental health histories are not known or recorded in most cases. Also, some of the women do not stay with the father of their babies and this makes it difficult to obtain the mental health history of the fathers.

13.2. Children and Young People Emotional, Wellbeing and Mental Health Services: Young Minds Matter Service

North East Lincolnshire Council (NELC) has delegated responsibility for the commissioning of children's and young people's mental health and emotional wellbeing services from North East Lincolnshire Clinical Commissioning Group (NELCCG), and have been supported by CCG laying the foundations for an all-age approach to mental health commissioning. The partnership continues to develop as we work towards new 'Union' arrangements whereby both organisations share a Chief Executive.

Over the last few years, partners in NEL have come together in different ways to improve children' and young people's mental health and emotional wellbeing. The local transformation plan developed in September 2015 and reviewed annually has been pivotal in guiding transformation for CYP mental health and emotional wellbeing services in NEL.

As a result, there is a strong commitment across the local future in mind project board to develop new and innovative ways to achieve outcomes whilst building up resilience in children, young people and their families within their schools and wider communities to improve outcomes.

In 2016, NELC commissioned ‘Unique Improvements’ as part of our local transformation plan to undertake a child and adolescent emotional wellbeing and mental health needs assessment. The needs assessment was used to influence the Children and Adolescent Mental Health Services (CAMHS) re-procurement and shape the future of the emotional wellbeing and mental health local offer.

A recommendation of the needs assessment was for NEL to move away from the four-tiered approach , which is now over 20 years old, and consider moving towards implementing the THRIVE framework. This shift in service provision ensures that mental health and emotional wellbeing services are arranged around the needs of children and young people (CYP). This new model will encourage LPFT to be the champion across the system and support CYP with mental health and emotional wellbeing concerns to ensure that they get the right support, at the right time. There will be a gradual shift of resources and a greater focus on the ‘getting advice (coping)’ and ‘getting help’ quadrants as the new model embeds within the system.

There have been significant focus in government policies and strategies with regards to mental health and emotional wellbeing issues in the last few years. The recommendations coupled with the findings from the needs assessment, led NELC to review the mental health and emotional wellbeing services available for CYP and to move to a new service delivery model (THRIVE model) to align with the ambitions set out in Future in Mind and the Five Year Forward View for Mental Health.

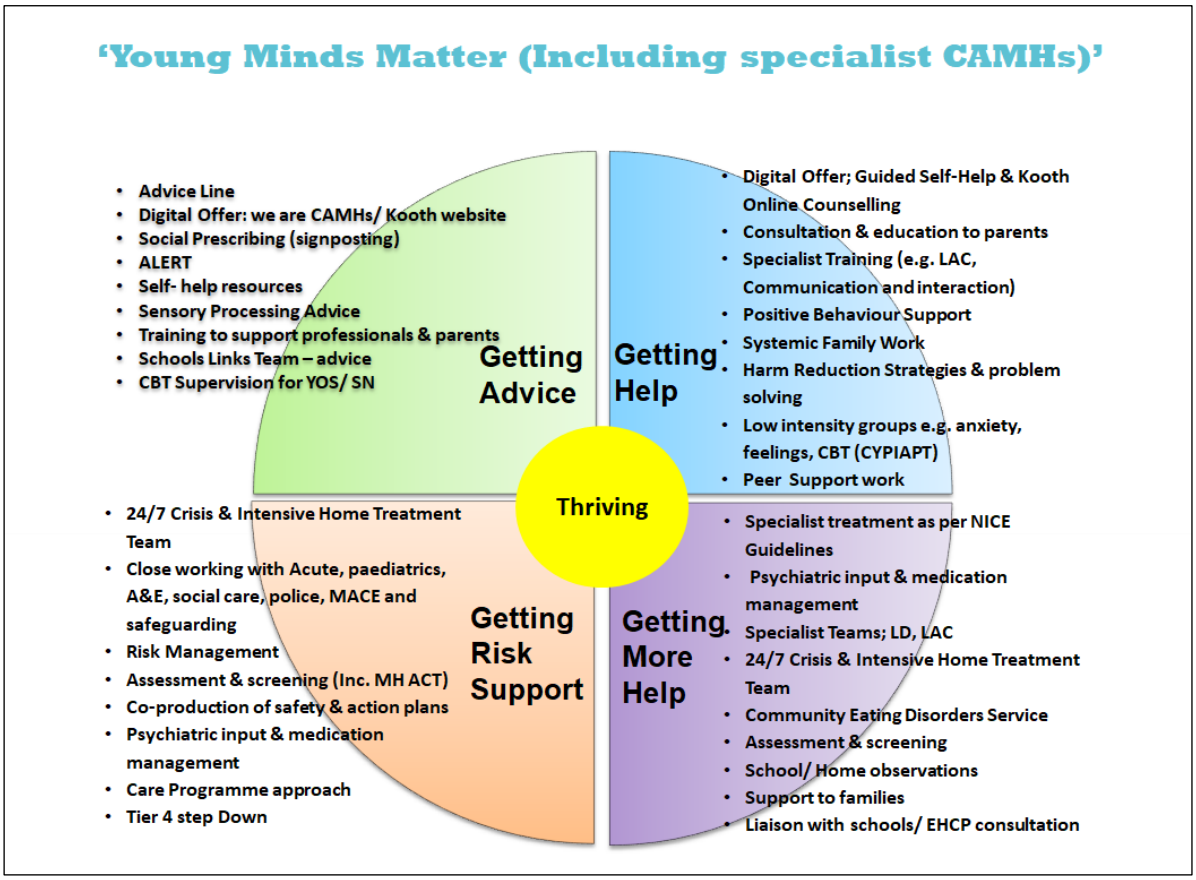
The re-commissioning of the children and young people’s mental health and emotional wellbeing service has been officially awarded to the incumbent Provider Lincolnshire Partnership Foundation Trust in April 2018 In 2018, the quality of service provided by LPFT across the trust was rated ‘Good’ overall and ‘outstanding’ in NELCAMHs.

13.2.1. Young Minds Matter Service

The THRIVE approach has been adopted in NEL and rebranded following on with engagement with children and young people locally, to “Young Minds Matter service (YMMs)”. The service is a goal focussed patient-centred, emotional wellbeing and mental health service, which utilises a whole systems approach to support CYP. It supports CYP with a wide range of needs which includes anxiety, mood related disorders such as depression, bipolar, self-harm, trauma, eating disorders and mental health difficulties associated with a physical health problem. It also focusses on prevention, early intervention and building a resilient community. The new service which still includes specialist CAMHs provision is provided by LPFT. The service has extended support to CYP up to the age of 19 years to assist with the transition process to adult mental health services (19.5 years if a care leaver and up to 25 if receiving support for special educational needs and disability - SEND).

The YMM service model has 4 quadrants (Figure 46); children and young people can enter any one of the four quadrants at any time and receive the appropriate care pathway and can also be accessing more than one quadrant at any point.

Figure 46 Quadrants within the Young Minds Matter Service Model



The two top quadrants of the YMM service model in Figure 46 **(Getting Advice and Getting Help Services)** show a range of newly commissioned services to support with low and medium level emotional and mental wellbeing issues. These new services have been commissioned to encourage prevention and early intervention in order to reduce the number of CYP reaching crisis point or escalating to needing a clinical response. For example, Kooth service is a new online support service and is part of the digital offer to CYP. The digital offers are: **getting advice** (ChatHealth Text Service/Kooth online resources/chat forums /peer support/Directory of services/information (professionals)) and **getting help** through online counselling.

The **Getting Advice (Coping**) quadrant focuses on building and promoting resilience within children, young people, families, schools and the wider community. This is appropriate for CYP who are adjusting to life circumstances with mild or temporary difficulties who are choosing to manage their own health.

The **Getting Help** quadrant shows services for CYP who have clinical presentations that would benefit from focussed short evidence based treatments in line with NICE guidance for example online counselling and school nursing/youth offending team CBT principles.
The bottom quadrants **- Getting More Help and Getting Risk Support Services** (Figure 46) - show the specialist services offered by CAMHs prior to April 2018 and which are still offered in the new service model.

The **Getting More Help** quadrant shows services for CYP that require extensive and long-term interventions into inpatient care or with extensive out-patient provision from healthcare professionals for example CYP with Learning disabilities and Looked After Children.

The **Getting Risk Support** quadrant shows services for CYP who are unable to benefit from evidence based treatments but remain a significant risk or concern and are supported by a multi-agency team for example CYP being supported by the 24/7 Crisis and Intensive Home Treatment Team.

In the 2 bottom quadrants, YMM service provides client support through the services for CYP with additional vulnerabilities; these include those with learning disabilities, looked after children, those in the criminal justice system, those who misuse substances and those in alternative provision (e.g. pupil referral units). It also provides a range of interventions and support which is appropriate to the needs of CYP. Assessment and diagnosis of autism autistic spectrum conditions for CYP is undertaken by a multidisciplinary panel. Post-diagnosis support is provided through accredited targeted parenting programmes, inclusion support workers linked to school localities and a small number of specialist units within mainstream schools.

The new service consists of a multi-disciplinary team that can help with a range of mental health and emotional wellbeing problems for CYP. These are nurses, allied health professionals (AHPs), social workers, clinical psychologists, psychology assistants, counsellors, group workers, consultant psychiatrists and an administrative team. The service also has close links with and specific workers in the following services: School Nursing, Looked After Children Team, Youth Offending Service, North East Substance Team, Paediatrics and A&E, Pupil Referral Units, Early Intervention in Psychosis Team, Schools and Families First Access Point (FFAP) and the voluntary sector.

In the new service, there is an increased focus on the service provider, LPFT, to engage and consult with CYP, their families and carers to ensure that the services provided meet their needs. LPFT is expected to use non-traditional approaches to improve outcomes for CYP, for example using a range of technologies, apps and social media platforms. It is also expected that a range of methods will be used to capture the voice of the child and joint co-production for future planning of services.

YMM service has a 24/7 team which offers both quick response to emergency mental health presentations, as well as short term intensive home treatment which is designed to avoid young people being placed in out of area hospitals. Only Young Minds Matter staff can refer for intensive home treatment.

Children and young people with a learning disability who may be experiencing a mental health problem have equal access to the service, and there is a specialist learning disability team for those whose needs cannot be met by the mainstream service.

13.2.2. School Links Team

Within the new service model there is a new School Links Team that will be a school/educational settings point of contact for social, emotional and mental health champions to have a link between school, specialist mental health support workers and wider mental health and emotional wellbeing services. The team will work with the identified school staff with a focus on early intervention and prevention and building resilience within children and young people.

The team will also provide:

- Consultation and advice to educational professionals
- Opportunity to receive support and advice about a broad range of mental health and emotional wellbeing concerns
- The team also offer training courses which include
    - Awareness of emotional health
    - Dealing with stress
    - Anxiety and depression

- Self-harm awareness
- Maintaining positive mental health
- Coping mechanisms
- Healthy relationships
- Managing behaviours and feelings
- Importance of individuality
- Eating disorders

- The training that can be offered can be flexible and meet the needs of the educational setting, dependent upon the needs of the CYP and educational settings can request specific training on an ad-hoc basis.

Referrals
Referrals can be made by any professional to the Young Minds Matter service by post or email. Parents and carers cannot directly refer to the service but any professional such as a GP or teacher can refer on their behalf. The service offers an advice line to discuss possible referrals before completing the service referral form.

Routine referrals have a target to be seen within eight weeks, urgent referrals which relates to a possibility of risk to life and/or presentations such as serious eating disorders have a target to be seen within 5 days. For emergencies (which relates to definite risk to life and presentations such as psychosis), a target has been set for contact to be made within an hour and an appointment to be arranged within 24 hours.

13.2.3. Getting the right support, at the right time (Early Help)

The YMM service utilises some early help services (supporting services) in NEL to form part of the wider local mental health offer in the getting help quadrant. This is so CYP can access the support and treatment they need in a timely and integrated manner. The early help services are to encourage prevention and early intervention and to stop people developing mental ill health in the first instance. These services are discussed below.

13.2.4. Kooth Online counselling

The Kooth service has been in operation since December 2016. Kooth online counselling is a free, safe, confidential and non-stigmatising way for young people aged 11-25 years to receive counselling online up to 10:00pm 365 days a year; and receive advice and support through online leaflets and threads on chatrooms on the website 24 hours a day, 365 days a year. This digital approach is an extended provision for CYP to access support and tackle the stigma associated with physically accessing a mental health and emotional wellbeing service. The service is linked into existing care pathways to ensure that if a child or young person is in crisis or needs a specialist service that they are directed to the most appropriate service.

Kooth counselling service is being promoted through the popular social media channels such as Instagram and Facebook to target more CYP and increase the number of registrations. The service is also being displayed on the screens within local GP surgeries locally to promote it and encourage registration with the service.

13.2.5. School Nursing Text Service

A school nursing text service has also been implemented in NEL since 2016 through ‘ChatHealth’ to provide early help to CYP. CYP in the area access the school nursing text service from the school nursing team regardless of what educational setting they attend. This secure messaging service is available for all pupils aged between 11-19 years attending a school (including home schooling) within NEL. The service is

manned 9:00am–5:00pm Monday to Friday and can be an anonymous service or children can share their personal data if they so wish. This service has recently been extended to young people aged up to 19 years to align with the 0-19 transformation programme. NEL school nurses are in the process of advertising the text service within colleges and further/higher educational settings in NEL.

13.2.6. Stepping Stones (Positive Parenting Programme)

Stepping Stones is a service based on the Positive Parenting Programme's (Triple P's) positive parenting strategies. Stepping Stones offers strategies to help parents manage problem behaviour and developmental issues common in children with disability. It helps parents encourage behaviour they like, cope with stress, develop a close relationship with their children and teach their children new skills.

13.2.7. Workforce Development

Underpinning the Young Minds Matter service model of care is the identification of workforce training and development requirements needed to ensure the delivery model can embed itself across the whole system. The YMM service has therefore identified the relevant training needed and developed a comprehensive training and development programme in partnership with Public Health wellbeing services, educational psychology and other agencies. The training programme developed has raised awareness of mental health and emotional wellbeing, given professionals the tools and skills to support CYP, promoted local pathways and services, updated the workforce on relevant information, policies and guidance. It has also aligned the Future in Mind training portfolio to the "Children's Workforce: Professional Capabilities Framework" for North East Lincolnshire and to wider NHS England professional competency framework for professionals working with CYP.

The identified training is being provided free to professionals and volunteers that work with CYP and support them with emotional health and wellbeing issues, in order to implement the YMM service successfully and ensure that the needs of CYP are met. In total, 869 people were trained in 2017/18 to identify, support and signpost CYP when concerns first arise. The targeted and specialist mental health training provided include:

- **Perinatal Mental Health Champions Training** – Train the trainer course for professionals to deliver the perinatal mental health awareness training to other professionals to ensure that the workforce working with women and their families have a greater understanding of the signs and symptoms of PNMH
- **Perinatal Mental Health Awareness Training** – PNMH cascade training is available across the children's workforce for professionals who work with women and children in the perinatal period. The training aims to recognise the signs and symptoms of PNMH for early identification.
- **New-born Behavioural Observations (NBO) and Neonatal Behavioural Assessment Scale (NBAS**) – This training is offered to health visitors to allow them to link into early attachment, parenting pathways and perinatal mental health (PNMH).
- **Wellbeing Service provides a range of training courses, including:**
    - **Mental Health First Aid/Youth Mental Health First Aid and Lite versions-** This is a national program to give an in-depth understanding of mental health and emotional wellbeing issues and factors that affect wellbeing, practical skills to spot the triggers and signs of mental health and emotional wellbeing and the confidence to reassure and support an individual in distress. This training is offered out freely to professionals working with women, children and families across the system.
    - **Emotional Resilience**
    - **Managers Stress Awareness**

- **Cognitive Behaviour Therapy (CBT)** - School nurses and youth offending professionals and other professionals have undertaken basic skills training to be able to better support CYP with low mood, depression, anxiety and self-harm. This support programme ensures that CYP have the opportunity to discuss and receive structured, evidence based support. CYP present with some of the following problems; relationships, self-esteem, body image, self-harm behaviour and bereavement problems.
- **Self-Harm and Suicide Prevention** – training for self-harm/suicide to up skill the wider children's workforce to recognise signs and symptoms accordingly to inform, advise, or to refer to the appropriate services.
- **Youth Mental Health First Aid Peer Supporters** – Young people have been trained to be peer supporters through the youth mental health first aid course. These young people are supporting their peers within their educational settings to support CYP and are being supervised by trained professionals from their schools to assist them whilst supporting their peers. This is a programme which has been initially piloted in one secondary school and there are plans to roll this out across the remainder of the secondary schools and colleges.
- **B-EAT Beating Eating Disorders** – This training was commissioned to increase the knowledge and awareness of eating disorders to ensure the workforce is equipped with the skills, training and experience to best support children and young people. In 17/18 160 employees were trained.
- **School Links Team -** The team also offer training courses which includes, but is not exclusive to:
    - Awareness of emotional health
    - Dealing with stress
    - Anxiety and depression
    - Self-harm awareness
    - Maintaining positive mental health
    - Coping mechanisms
    - Healthy relationships
    - Managing behaviours and feelings
    - Importance of individuality
    - Eating disorders

13.2.8. Gaps in Service Provision

The Young Minds Matter service was commissioned in April 2018 to address the gaps identified in mental health service provision for children and young people in the area. Any new gap in service provision would be identified as time goes on and will be explored as part of the contract management meetings.

13.3. Adult Mental Health Services

People in North East Lincolnshire with mental health problems have access to a wide range of primary, specialist, community and secondary care services to address their health needs.

13.3.1. Specialist adult mental health services

NAViGO provides a wide range of health and social care services including primary care and specialist services across North East Lincolnshire and in 2018, based on the quality of service provision, CQC report for Navigo was 'overall good with outstanding in some areas'. Services provided by NAViGO are for adult residents in NEL with mental health problems, including people with a dual diagnosis of learning disability and a mental health condition. NAViGO's specialist services provide a range of assessment, treatment and rehabilitation interventions on an inpatient, outpatient and community basis to patients who have mental health needs and or physical health needs (Table 1). It also provides a dementia and older people's/adult mental health service for people of any age experiencing needs associated with suspected or diagnosed dementia and for older adults presenting with complex mental health problems (Table 1.).

Acute inpatient facilities for adults who require intensive treatment and support are provided by NAViGO at Harrison House (an ageless needs led service for functional mental health), Konar suite (older adult mental illness including Dementia) and Rehabilitation (Hope Court). These services are commissioned by NEL CCG. NAViGO also holds two contracts with NHS England, one for Eating Disorder inpatients (Rharian Fields) and one for Liaison and Diversion services.

An overview of the range of mental health services provided by NAViGO in NEL and supporting services (Table 19) is discussed in this section.

Table 19Adult and Older Adult Mental Health Services and supporting services in North East Lincolnshire

Adult and Older Adult Mental Health Services			
Adult Mental Health Services			**Older Adult Mental Health Services**
Specialist Services	**Community Services**	**Acute, Crisis & Home Support**	
• Early Intervention in Psychosis & Transitions Service • Assertive Outreach • Adult Psychology • Pharmacy Service • Rehabilitation and Recovery • Tukes Employment and Training Scheme • Transcranial Magnetic Stimulation (TMS) • Rharian Fields: Eating Disorder Service (NHSE) • Liaison and Diversion Service (NHSE)	• Open Minds: Improving Access To Psychological Therapies (IAPT) • Community Mental Health Service ○ Wellbeing Health Improvement Service (WHISe)	• Acute Inpatient Services • Access Team (Adults 18+ and Older Adults) • Forensic Service • The Sequoia Personality Disorder Service	• Acute Mental Health and Memory Service • Community Mental Health and Memory Service
Other services supporting Adult & Older Adult Mental Health Services			
Single Point of Access (SPA)	Primary Care Mental Health Wellbeing Service MIND	Rethink – NEL Crisis (Field View)	Primary Care Mental Health

13.3.2. Early Intervention in Psychosis & Transitions Service

Early Intervention in Psychosis Service

The Early Intervention in Psychosis (EIP) service is a multidisciplinary community mental health service that offers early support and assessment to young people and adults between the ages of 14 and 35 years who are experiencing a range of emotional and psychological difficulties including psychosis. The main functions of the EIP service are to identify psychosis and also identify and treat those at risk of developing a mental illness (ARMS). The aim of the service is to reduce the stigma and the duration of untreated psychosis through early detection, and have meaningful engagement with evidence based interventions.

The service actively promotes positive mental health by raising awareness of mental health issues, challenging stigma and acting as a resource to the local community. It works closely with schools, colleges, Young Minds Matter service and also works in collaboration with the Mental Health Crisis/Home Treatment Team to support service users who are in crisis. People referred into the EIP service are seen within 2 weeks of referral and can be supported for up to 3 years by the team.

Transition Service

The Transition service supports young people who are leaving the Young Minds Matter service and potentially needing a service from adult mental health. This service aims to avoid disruption to the young person's care and the potential for deterioration in their mental health. The team provides planned, orderly and a purposeful process of change from child orientated to adult models of care.

Referrals to the EIP and Transitions service can be self-referral or from many different areas of the community such as other health agencies, schools and colleges, young people's services and GPs. Urgent referrals are through the Single Point of Access (SPA).

13.3.3. Open Minds: Improving Access to Psychological Therapies Service

NAViGO provides a range of primary care psychological therapies through the Open Minds Improving Access to Psychological Therapies (IAPT) service. There are two components to the IAPT service and these are core IAPT service and long term conditions IAPT service.

The Open Minds: core IAPT service is a community service which offers a range of primary care psychological therapies and support to people aged 16 years and over who are experiencing mild to moderate mental health issues such as stress, anxiety disorders and depression. Open Minds: long term conditions IAPT service focusses more specifically on individuals with long term conditions such as COPD, diabetes and cardiovascular diseases, whose depression and anxiety is directly linked with their condition. Open Minds also works with people with chronic fatigue and fibromyalgia.

Open Minds provides support to maintain positive mental health and well-being using a range of National Institute for Health and Care Excellence (NICE) approved evidence based treatments known as talking therapies. The service currently has two branches in NEL, one in Grimsby and the other in Cleethorpes but aims to move the branches together in the next few months. Open Minds staff also work out in GP practices across the area.

Open Minds offers a range of therapies and support options which are aimed at identifying causes of stress, anxiety and depression, different ways of coping and helping individuals to move forward. The therapies and support options offered by Open Minds include guided self-help, Cognitive Behavioural Therapy (CBT), mindfulness and counselling. The service also provides talking therapies to help with a range of difficulties such as relationships when these are specifically linked to people's depression or anxiety. It also supports people who are employed to stay in work or help people return to work if they are signed off and signposts service users to other local or national services that can offer them additional support and help them achieve their goals.

Referral into Open Minds is through self-referral which can be by simply calling the team, walking into any of the branches or registering online. Referrals can also come from GPs or any health professional.

13.3.4. Community Mental Health Services

NAViGO's Community Mental Health services support people with severe and/or enduring mental illness (SMI), a wide variety of mental health conditions and social care needs. These are mainly people recovering from an on-going mental illness who as a result may be in need of a complex range of services.

The aim of the Community Mental Health Teams (CMHTs) is to provide high quality care incorporating three key principles "Right Care, Right Time, Right Place". The service provides recovery focused support and packages of care which are devised and delivered via the Care Programme Approach/Care management processes in line with NICE guidance.

The CMHT is a multi-professional team which is recovery focussed and provides a variety of interventions and support including medication initiation, monitoring and review, physical health screening and health promotion, individual placement and support, social inclusion, packages of social care support, occupational therapy and evidence-based psychological interventions. The team also provides on-going crisis intervention and risk management.

The CMHTs provide a holistic mental health and wellbeing service through the Wellbeing Health Improvement Service (WHISe). WHISe is a multi-award winning service offered by NAViGO to service users under Care Programme Approach. In this service, service users receive a full holistic health check including blood pathology, urinalysis, general physical health checks, and full body analysis and monitoring. Lifestyle choices are also explored and discussed and healthier alternatives offered.

Referrals to the Community Mental Health Service are via the Single Point of Access (SPA) or by any healthcare professional including GPs, care managers, community matrons or district nurses.

13.3.5. Assertive Outreach Service

The Assertive Outreach service provides care for people aged 18 years and over who have a diagnosis of severe and enduring mental health problems and who currently do not effectively engage with mental health services. The people supported are mainly people with schizophrenia and those with psychoses often with dual diagnosis. Support is provided for service users in their own homes or place of choice in the community including police stations, social security offices, parks, and cafés, in the street and inpatient units or wherever the service is most needed and most effective. The support provided is not time limited but has a strong focus on reaching and maintaining stability for the service user.

The Assertive Outreach team is a multi-disciplinary team comprising a range of professional disciplines such as nurses, social workers, assistant practitioners and a psychiatrist. To work effectively, the team has established links and working relationships with a wide variety of community resources. The team also provides on-going crisis intervention and risk management.

Referrals into the service are mainly through the CMHTs, other mental health services, the Single Point of Access, GPs or other healthcare professionals.

13.3.6. Adult Psychology Service

The Adult Clinical Psychology service is a secondary mental health care service that works alongside the CMHTs and also provides psychology interventions to all other NAViGO services. The psychology service offers evidence-based therapeutic treatments as appropriate to all adult service users (18+) with severe and enduring mental health problems, at step 4 of the stepped model of care. The treatments offered are underpinned by high-quality assessment and formulation and target the emotional, behavioural and environmental factors that are directly related or responsible for the psychological difficulties of the service user. Service provision is within a timely and respectful manner and focusses on the reduction of the

distress experienced by clients and liaising with colleagues and relatives/carers in maximising the potential for attaining this.

The community psychology service provides where appropriate, psychometric investigations of neuropsychological difficulties in intellect, memory or learning that are impacting upon functioning, and where the likely cause of the onset of these cognitive difficulties is a primary mental health Axis I[xviii] or II[xix] diagnosis. It monitors clinical risk, vulnerability and responds appropriately as per NAViGO clinical risk policy, safeguarding adults' policy and safeguarding children's policy. The service also offers psychological, clinical risk and management, and diagnostic consultancy, support and guidance to colleagues within the adult community mental health teams and wider NAViGO community and its partners. All intervention provision is embedded in NICE approved and evidenced-based models, including ensuring the appropriate requirements for clinical supervision are met.

The service team consists of Consultant Clinical Psychologist, Principal and Senior Clinical or Counselling Psychologists, Cognitive Behaviour Therapists, Eye Movement Desensitisation and Reprocessing (EMDR) therapists, Dialectical behaviour Therapy accredited practitioners, Behaviour Family Therapists, Health Psychologist, Trainee Clinical Psychologists, Research Associates and Assistant Psychologists. The team is supported by an administrative team.

Referrals to adult community mental health psychology service are through the community mental health teams for all service users meeting Care Programme Approach (CPA). For non-CPA service users, referrals are through the Cluster 4 Pathway that provides an appropriate referral pathway.

Dialectical Behaviour Therapy (DBT) service

The Dialectical Behaviour Therapy (DBT) service is part of the Psychology service and based at the Eleanor Centre. The service offers intensive psychological treatment for community-based individuals with high risk of suicide and/or self-harming behaviour with a primary diagnosis or traits of Emotionally Unstable Personality Disorder. The service comprises 6 accredited practitioners from Psychological, Nursing and Social Work backgrounds, and a further 5 practitioners are undertaking accredited DBT training in 2018.

Referrals to the DBT service are made by clinicians across all Navigo services including acute, CMHT and specialist teams.

13.3.7. Forensic Mental Health Service

The Forensic mental health service is based at Harrison House. The service offers support and treatment to people who have offended or are inclined to offend as a result of their mental health illness or their disability, and who pose a risk to the public. It offers a CPA, care coordination and case management of individuals who are detained under Part Three of the Mental Health Act (1983).

The Forensic team is made up of two practitioners who hold a caseload of service users (some out of area in secure services and some in the community). The team also consists of nurses and social workers who work with people in special (low, medium or high) security hospitals, secure units or prison setting to assess their mental health needs and provide necessary advice to the authorities. The service supports people within the community and puts appropriate safety measures in place.

[xviii] Major depressive disorder or post-traumatic stress disorder are diagnosed on Axis I

[xix] Axis II is for long-standing conditions of clinical significance, like personality disorders and mental retardation. These disorders typically last for years, are present before adulthood and have a significant impact on functioning.

Referrals to the Forensic service are through local services or criminal justice agencies.

13.3.8. Access Team

The Access Team works directly with adults and older people experiencing a severe mental health crisis and who need immediate, urgent or emergency care and treatment in their home. The team focuses on mental health assessment in the individual's own home, community, or hospital settings and supports people and their families during the acute phase of their mental illness. The team has direct access to inpatient beds and other community services, as well as medical, nursing and social care input and advice.
The Access Team provides an open referral system where people can self-refer via the team's Single Point of Access.

13.3.9. Pharmacy Service

The NAViGO Pharmacy supports service users, carers and their staff in achieving safe and effective medication management. The Pharmacy service provides support and advice in the choice and use of medication used for mental health problems and crosses all of NAViGO.
The service has one specialist pharmacist and a team of technicians based at Lloyds Pharmacy in the area. The specialist pharmacist works with hospital wards and community teams to help service users and healthcare staff achieve the best use of medication. They also undertake medication audit, provide education, meets with service users, give advice and attends mental health reviews with patients. The technicians visit mental health services that dispense medication such as the acute inpatient, older people's and eating disorders services to check stock levels of all medications and order more stock if required.

Access to the Pharmacy service is through a member of staff who arranges an appointment for the service user to see the NAViGO Pharmacist.

13.3.10. Targeted Transcranial Magnetic Stimulation

Transcranial Magnetic Stimulation (TMS) is a revolutionary technological treatment for depression and an alternative to Electric Convulsive Therapy (ECT). TMS is a painless, non-invasive stimulation of the brain recommended by NICE guidance as an effective and safe treatment in the UK for treating depression. NAViGO has been at the forefront of the application of TMS, focusing on the treatment of mood disorders. The alternative treatment, ECT, is based in Hull and is recommended occasionally and as a last resort in cases where no other treatment works (ECT can cause memory loss).

13.4. Rehabilitation and Recovery Services

NAViGO provides rehabilitation interventions on an inpatient (acute) and community basis to patients with mental health illness and or physical health needs.

13.4.1. Acute Specialist Rehabilitation Service

The Acute Specialist Rehabilitation service is an inpatient service based at Harrison House. Harrison House is a purpose-built, state-of-the-art facility designed to support the needs of privacy and dignity of those who use this service. It has two 11-bed lodges, Meridian and Pelham Lodges, which provide mixed sex accommodation. The third lodge, Brocklesby Lodge, is a 5-bed specialist rehabilitation service and is a stepdown service from low/medium secure to community. The lodges have direct access to nursing, occupational therapy, medical, psychological, social care and healthcare support.

13.4.2. Community Rehabilitation Service

NAViGO's Community Rehabilitation service for adults in NEL is based at Hope Court and is known as Springboard rehabilitation and recovery services. This service is for adults who are no longer in the acute phase of their illness but who require a period of support to progress towards socially inclusive independent living and recovery.

Springboard is a mixed gender, 13-bed rehabilitation unit which offers intensive rehabilitation and recovery to individual residents in a safe environment. The service is staffed 24 hours a day. Interventions provided include; occupational therapy, social work interventions, creative therapies including music, reminiscence, art therapy, pet therapy and horticulture, social inclusion, collaborative involvement work with the person, their family and friends, dietetics, physiotherapy and physical health care. The community rehabilitation service also provides specialist supported living schemes based within the community (e.g. Reavesby Bungalow) that allows people to have their own tenancy and staff support people to become more independent. Referrals to the Springboard team are made through NAViGO's community mental health teams.

13.4.3. The Sequoia Personality Disorder Service

The Sequoia Personality Disorder service is a four day a week service also based at Harrison House. The service supports people with long-term borderline personality disorders, people who experience Emotionally Unstable Personality Disorder (EUPD) and people with needs that cannot be met by other mental health services. Support is provided by uncovering the triggers responsible for service users' behaviour and options are offered to individuals on how they might act to cope in a more self-affirming way.

Referral to the Sequoia Personality Disorder service is through the service user's care co-ordinator or key worker.

13.4.4. Tukes Employment and Training Scheme

The Tukes Employment and Training scheme provided by NAViGO also supports rehabilitation and recovery. Tukes provides support, education, training, skill development and work experience in real working environments for individuals with mental health problems or dual needs aged 16 years and over, who historically have had negative experiences within education and limited employment opportunities. The aim of this service is to improve the quality of life of these individuals by enabling them to gain new skills, help increase their confidence, self-esteem and motivation and reduce social exclusion within the labour market.

Tukes works very closely with the employment specialist within the CMHT who concentrates on resolving non-mental health issues that service users might have before they are offered employment or training. Issues could relate to accommodation, benefits/finances, etc. Tukes runs job clubs where service users are supported with searching for work, completing application forms, interview techniques and confidence building.

The Tukes Employment and Training scheme offers three main areas of opportunity to people with mental health problems. These are education/employment and training, in-house contractual works and external contractual works,

The education aspect of Tukes gives service users the opportunity to gain qualifications in subjects relevant to occupational sectors. Teaching techniques are adapted to ensure individual learning requirements are met and bespoke services are offered to individuals. To identify potential training needs, service users' literacy and numeracy skills are initially assessed and also screened for visual stress and dyslexia. Upon assessment, service users are placed within relevant training areas to learn their practical work skills.

Training is delivered on-site at Tukes educational facility which has been designed to be a relaxed and welcoming environment to aid individuals learning experiences.

NAViGO has recently purchased a local garden centre which operates as a commercially viable business, directly engaging and trading with the general public 7 days per week. On average, 12 Tukes service users per day attend onsite training at the garden centre, gaining transferable skills in areas such as horticulture, catering, domestics, customer service, ground and building maintenance with the aim of moving into paid employment. To date, three Tukes service users have gained full time employment at the garden centre as a result of receiving training there. Tukes also has a number of commercially run internal contracts and external businesses that act as training areas to on average of 100 service users per week. Individuals work alongside experienced and qualified staff in a number of occupational sectors, gaining valuable skills, qualifications and knowledge.

Referrals to Tukes are through GPs, care co-ordinators, employment agencies or by self-referral.

13.4.5. Liaison and Diversion Service

The Liaison and Diversion service is an NHS England commissioned service based at Hope Court. This is a seven day service. This service was set up to address health inequalities for vulnerable people who enter the criminal justice system and operates on a Northern Lincolnshire footprint i.e. North East Lincolnshire and North Lincolnshire. The service is for adults and young people who are over the age of criminal responsibility (10 years).

The Liaison and Diversion service identifies people who have mental health problems, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects or offenders. It then identifies their needs and supports them through the early stages of the criminal justice system pathway, refers them for appropriate health or social care services, signposts and supports them to access treatment or enable them to be diverted within or away from the criminal justice system into a more appropriate setting, if required.

The Liaison and Diversion service works alongside other services such as Probation and Addaction and the Youth Offending service that have service users who are currently involved with the police or court. It has a mixture of staff that all have identified skills in one of many vulnerabilities it works to support.

Referrals to the Liaison and Diversion service are from the criminal justice system via a screening process at the point of access or people can self-refer.

13.4.6. Eating Disorder Service: Rharian Fields

NAViGO's specialist Eating Disorder service is a Tier 4 service and is also commissioned by NHS England. This service is provided at Rharian Fields and offers inpatient, day patient and outpatient care to adults (17 years and over) and young adolescents 17 to 18 years old, who have been diagnosed with an eating disorder. These are people requiring specialist treatment for weight restoration, stabilisation, management of abnormal weight control mechanisms and psychological interventions. The aim of the eating disorder service is to get service users to a healthy body weight and then work on their psychological needs. In all cases, an assessment is made as to whether the service user will be able to be safely managed within the environment of Rharian Fields.

Rharian Fields' team dietitian offers support to service users alongside the multidisciplinary team. The dietitian is consulted on all potential admissions and all service users have a dietetic review on admission. The dietitian holds 1:1 therapeutic sessions with all service users at least once a week, provides a

therapeutic group once weekly, and also attends clinical reviews weekly. Rharian Fields provides a bespoke care package with service users to suit their stage of recovery. Interventions offered include CBT for eating disorder, cognitive analytical therapy, dialectic behaviour therapy, supportive counselling and physical health monitoring, weight restoration, and body image.

The outpatient service is based at NAViGO House and this service offers a similar package to the inpatient service in the community. The service is very successful with local clients as evidenced by the local clients rarely needing to go onto inpatient care. The service also offers places to out of area clients from areas where there is no specialist provision.

Rharian Fields has the ability to offer day patient services, where a client is struggling in the community and needs more support than that provided by the outpatient service or as a step down from inpatient admission. This service is offered as a bespoke package and can include any element of the inpatient pathway as needed.

The inpatient unit/service is based at The Gardens, Diana Princess of Wales Hospital, Grimsby and has nine individually designed bedrooms that allow privacy and space for service users. The same therapeutic programme are offered for both inpatient and day patients.

Referrals into the eating disorder service are through the Single Point of Access, health or social care professionals including GPs or direct to Rharian Fields.

13.4.7. ACCESS POINT- Single Point of Access (SPA)

The Single Point of Access (SPA) service is a multi-disciplinary triage, assessment and signposting system. It is largely telephone based and operates 24/7/365 days, for members of the public and professionals within the North East Lincolnshire area. The SPA provides access to health (for all ages), adult social care (including adult safeguarding), physio and occupational therapy (for all ages) and adult mental health. The service is delivered by Focus independent social work CIC, Care Plus Group, Navigo, Northern Lincolnshire and Goole Hospital and Rethink. The SPA has one overarching general manager, the organisations delivering work under an alliance agreement facilitated by NEL CCG.

The SPA operates differently dependent on the primary reason for the call. Health calls are answered and triaged/assessed by professionally qualified health professionals, supported by GP's within primary care and out-of-hours services. All other functions are delivered using a tiered triage system, where calls are taken initially by trained call advisors supported by professionally qualified professionals where required.

Calls into the service are initially directed by an automated telephony selection process, (press 1 for health, 2 for social care and 3 for mental health) however calls can be re-directed between professionals dependent upon presenting need. Most of the professionals are co-located with the exception of in hours (9am to 5pm) mental health which is delivered by Navigo from Harrison House. An integrated client data base (SystmOne) is utilised for recording and to support decision making and information sharing. (Navigo is expected to commence using SystmOne 1 in September 2018).

Access to mental health is delivered by 2 organisations, using a tiered triage system, trained call handlers from Navigo and Rethink take calls initially; they will attempt to resolve concerns using a combination of signposting and emotional support. Calls requiring professional input will be transferred to the Navigo Crisis team both in and out of hours.

13.5. Older Adult Services

Older adult mental health services in North East Lincolnshire are provided by NAViGO. These consist of the Community Mental Health and Memory Service (CMHMS) and an Acute Inpatient Service (Konar Suite). NAViGO provides an ageless service, rather than the service user being required to transfer to Older Adult Services at the age of 65. An adult with a severe and enduring mental health problem (bipolar disorder, depression, psychosis) will typically have frailty and/or co morbidities associated with older age, if they are to be placed within Older Adult Services.

13.5.1. Community Mental Health and Memory Service

CMHMS offers specialist support to adults who are experiencing memory loss or dementia and their carers and also to people who have severe and enduring mental health needs and their carers. There are a number of teams within this service that provide the interventions required to meet the needs of service users and their carers; and service users may be receiving interventions from more than one team at any given time, depending on their individual need.

The service focuses on keeping older people with mental health and/or memory problems independent in their own homes. It also works to improve their quality of life by working on general health and wellbeing, encouraging engagement in hobbies and activities, and offering help and support to carers in a number of ways – including training. Interventions provided by the different teams are as follows:

- Functional Team: primarily focus on illnesses of a functional nature (depression, schizophrenia). Care coordination is provided.
- Memory Service (**accredited with the Royal College of Psychiatrists):** supports the pathway of dementia diagnosis (including care coordination). Post diagnostic support and treatment is also provided.
- Admiral Nurses: support the carers of people experiencing dementia, offering guidance, education and advice.
- Therapy Team: help and support with building confidence and achieving personal goals.
- Support to Care Homes Team: support people with dementia living in care homes on a permanent basis and offer advice and support to the care home staff.

Referrals into CMHMS are made via the Single Point of Access (SPA) which forms part of the Access team, based at Harrison House and are primarily received from GPs and other health and social care agencies.

13.5.2. Konar Suite (rated for Outstanding Service - CQC 2018)

Konar Suite is a purpose built, 12 bedded inpatient facility for people who require intensive assessment and treatment and meets the needs of primarily older adults who are experiencing acute mental health problems, which may be of a functional or organic nature. Services are provided using evidence based high quality approaches, which promote rehabilitation and independence.

Admission to Konar Suite is usually via the Crisis Home Treatment Team (who form part of NAViGO's Access Team) and may also be further to a Mental Health Act Assessment completed by an Approved Mental Health Professional (AMHP). Konar Suite is supported by nurses, doctors, nursing assistants, psychologists, occupational therapists, speech therapists, dieticians, physiotherapists and other professionals.

Crisis Home Treatment can be provided to individuals prior to admission and upon discharge from Konar Suite if intensive intervention is required within the home environment. Crisis Home Treatment Team staff and community care coordinators (CMHMS) work closely with Konar Suite to aid smooth transition between home and inpatient stay.

A complex dementia unit for individuals experiencing symptoms that pose challenges to therapeutic engagement or care provision such as Behavioural and Psychological Symptoms of Dementia (BPSD) is currently being developed.

13.6. Services supporting adult mental health services

13.6.1. Wellbeing Service

The NEL Wellbeing service provides a range of services that contribute towards improving people's mental health. This service provides non-clinical support to people struggling with stress, those in a low mood or with low level mental and emotional issues who do not meet the level of criteria for treatment at NAViGO. This includes people with non-diagnosed mental health illness who are signposted and supported to access the appropriate service.

The Wellbeing service takes a holistic approach to addressing mental health issues. The service uses the wellbeing wheel assessment tool for assessment. The tool is used to assess service users' daily routine, finances, housing, relationships, learning, physical health and emotional health and lifestyle and then signposts and refer them if necessary. The Wellbeing service works in partnership with NAViGO who refers their service users needing support with lifestyle issues to the wellbeing service.

13.6.2. Primary Care Mental Health Services

Primary care mental health (PCMH) refers to mental health services and support which are embedded into primary care such as within GP practices, community pharmacists, and others, as well as Improving Access to Psychological Therapy (IAPT) services. IAPT services provide evidence-based psychological therapies to people with anxiety disorders and depression. The IAPT service in NEL is through Open Minds, a NAViGO service, and is available to all practices in the area (and also within many practices). Some practices within the three newly formed practice federations in NELCCG (Freshney Green Pelham, Meridian and Panacea) deliver PCMH services directly.

Currently, **Meridian and Panacea Federations** PCMH service is a partial service that covers only the practices within the former 360 practice group which are now spread across the two Federations. The service has in-house mental health therapists, who are employed by the former 360 Care Ltd as part of the healthcare team.

The mental health therapists is a team of four practice counsellors (one volunteer and three part-time practice counsellors) who provide counselling for mental health at different levels and provide support for people who do not meet caseness criteria for IAPT. The therapists also link with Open Minds IAPT model (Step 3 level of intervention) to deliver additional Step 3 care across the group of practices. They provide six to eight counselling sessions per client within the step 3 model, but on occasions if there is a clinical requirement, would offer more sessions, usually up to 12. On assessment, people needing Stepped care interventions (e.g. people with severe PST or OCD who require CBT interventions) are referred to Open Minds while those needing a higher level of intervention are referred to the Single Point of Access to be signposted to the most appropriate service.

Referrals into the service are from GPs and people are seen within six weeks of referral.

The **Freshney Green Pelham Federation** PCMH service is also a partial service and operates only in Freshney Green practices but not Pelham practices. This is because the formation of the Freshney Green Pelham Federation has added about 12,000 patients from Pelham practices to those of Freshney Green; the contract currently maintains the legacy position.

The Freshney Green PCMH service offers support across the life course and has a team of two mental health nurses employed by the Federation. They support children who do not meet secondary care criteria and those in transition as historically, several children have been referred back to their GPs at transition. The service provides counselling services and support, medication review, monitors progress and has a new contract to provide IAPT Step 3 and dementia services. To fulfil this contract, dementia staff are needed to support people at home. The service works closely with NAViGO Older Adults service. And referrals into the service are from GPs within the Federation.

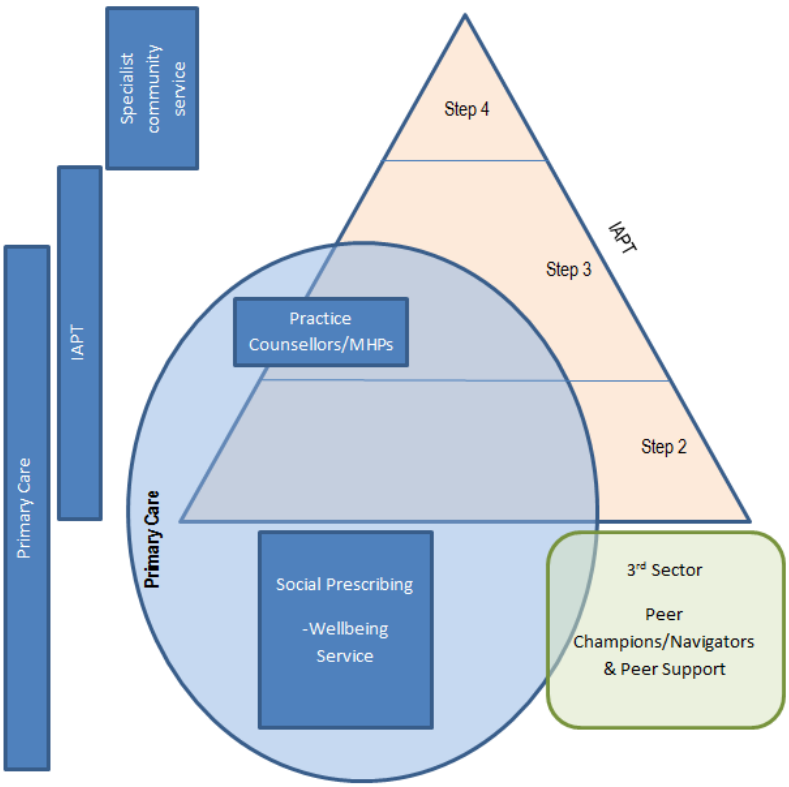
13.6.3. Integrated IAPT

As part of the 5 Year Forward View developments there has been a local move towards implementing an Integrated IAPT service (i.e. IAPT provision within General Practices). Where space to accommodate the workers is available, this is used to ensure as wide availability as possible across Primary Care. More IAPT presence in Primary Care settings is required. Locally, developments include:

- IAPT practitioners working more closely with general practice within primary care centres
- Primary Care services to be re-specified to ensure capture of IAPT data (where applicable) and defined IAPT working practices
- Developing smoother, more integrated pathways with primary care practitioners, hospital services and wellbeing services.

In order to have an integrated IAPT, NEL CCG, NAViGO and Primary Care have been working together collaboratively and have jointly come up with/developed a future model of primary care mental health (Integrated IAPT) for NEL. This proposed model is shown in Figure 47.

Figure 47 Common MH difficulties and Primary Care[xx]



[xx] The shapes are not indicative of size of population served

Figure 47 illustrates the proposed relationships and options available for adults in NEL with common mental health issues (such as anxiety or depression).

The vertical axis shows and goes up in level of complexity or need, with the most intensive and most specialised care at the top.

The IAPT triangle shows the various steps within the stepped care model. IAPT (Step 2 and above) is only available for those with a PHQ of 9 or more, or a GAD of 7 or more. Those scoring less than that these will benefit more from lower level interventions such as those provided in Primary Care, or other provision such as the Wellbeing service which is establishing itself within practices. The Social prescribing agenda, soon to be implemented in the area, aims at tackling the underlying issues behind the presentation – for example confidence to improve chances of employment or lifestyle changes.

It has been identified that locally, there are some small and informal groups of people with mental health related issues who meet to support each other and share advice and coping strategies. For common mental health issues these are presently not well coordinated, are ad hoc and access to these groups is by word of mouth. Figure 47 shows that there are ambitions to devise ways to support such groups to develop, and to develop Peer Champions or Navigators to offer the level of advice and guidance needed – in the local communities, and linked to Primary Care.

13.6.4. Rethink

The national charity Rethink Mental Illness is commissioned by NEL CCG to provide three functions: a MH Crisis House (Field View), A Crisis Telephone Helpline (Lincsline), and to support MH SPA function out of hours. All 3 services support people aged 16 years and over with mental health problems such as depression, anxiety spectrum, bipolar disorder or schizophrenia, to achieve a better quality of life.

Field View provides short-term community based residential and personal care for up to five adults who may be experiencing mental health illness. This is a 24 hours a day, 7 days a week service that provides three beds for crisis care support for a maximum of seven days and two beds for people needing respite support with no specific length of stay attached.
Whilst in Field View, residents receive emotional and practical support. Residents are supported to address the causes of their mental health crisis and coping strategies are explored with them to avoid relapse. Residents are also supported to become an active part of their community by being encouraged to join a social group and find paid or voluntary work. Referrals into the Field View are only through NAViGo's mental health teams.

Rethink runs an out-of-hours helpline "Lincsline" from 5pm to 9am on weekdays, weekends and bank holidays. Lincsline is a support line which provides empathy and advice to users. The service also runs another telephone helpline from Monday to Friday, 9am to 5pm through the Single Point of Access (Option 3). This service provides a listening ear, distraction for people attempting to commit suicide or those self-harming and needing support. Rethink promotes positive mental health and is part of the reducing suicide strategy.

Rethink also undertakes community outreach service at Tukes Café by bringing ex-service users to come together to support one another. The outreach service is not commissioned by the CCG.

13.6.5. North East Lincolnshire Mind

NEL MIND is a not-for-profit organisation and is currently a non-commissioned service providing support and advice to older adults aged 65 years over with a mental health problem and anyone of any age with a mental health problem in NEL. The aim of the service is to combat loneliness and enhance people's quality of life by helping service users increase their independence and achieve the goals they set for themselves. NEL MIND no longer has funded contract and has had its Cleethorpes service closed.

NEL MIND currently runs a "welcome arms group" 1 day a week (day service) to help older adults with mental health problems meet other people, develop social skills and build supportive friendships. This is a peer support group where members engage in meaningful activities (arts and craft, chair based exercise, curling, bingo, etc) within a community setting with social and emotional support. Due to lack of funding and after consultation with the group, members now fund this group by making a contribution of £7.50 a week to attend the group.

NEL MIND also runs a "ways to wellbeing workshop" for 12 weeks for the group where they are taught low level self-help such as coping strategies, challenging negative thinking, talking about mental health. People are also supported to have peer to peer conversations in order to build up a network of relationship.

The service runs an information line through Hull where people ring for information, advice and guidance and are signposted to mental health services for people living in North East Lincolnshire.

13.6.6. FOCUS

FOCUS is the provider of statutory adult social work for older people and individuals with a disability in NEL. This includes use of The Care Act 2014 to assess need, working in partnership with the individual to develop a support plan as to how any unmet eligible need can be met and if necessary micro commissioning services.

When a social care need is identified for an individual known to NAViGO's Older Adult Services, staff within the service liaises with FOCUS who work with them to complete a Care Act assessment. NAViGO is seen as the specialist mental health provider and their views play a large part in the overall assessment. Once an assessment is completed and any unmet eligible needs identified, FOCUS will then work with the individual as to how the unmet need can be met and a personal budget will be determined. It may be that the need can be met via voluntary services or sometimes services need to be micro commissioned from a home care agency or from 'NAViGO Extra' a more bespoke service for individuals with mental health difficulties.

13.6.7. Gaps in Adult Mental Health Services

- There is currently no early intervention provision for people aged 35 years and over. NAViGO is currently not commissioned by NEL CCG to provide this service to people aged 35 years and over.
- There is currently no safe space or night time service to support people who are in crisis out of hours (night time). These are people whose crises are not mental health related and who turn up at Harrison House for support.
    - It was reported that funding has been made available for this but the service is yet to be set up.
- Also, there is a gap in service for people who misuse drug and alcohol and are unwell and **do not have a dual diagnosis** but turn up at Harrison House for support.
- There is currently a gap of five psychological therapists' trainees in the service according to the requirement of the Five Year Forward View (5YFV) for mental health expansion programme for psychological therapists i.e. training more staff. If these posts are not in place by 2020, the service

will not be able to meet the increase in targets from 2021 to 2025 stipulated in the 5YFV for mental health.
    - NAViGO now has an agreement with the CCG (dependent on them getting the funding) to recruit to the necessary number of trainees
- There is an absence of social prescribing[xxi] for low level mental health support and intervention in the community. If in place, it would support clinical intervention and enable clinical staff to focus on treating the mental health more effectively while social prescribing provides the necessary input for social issues.
- There is a lack of formal peer support groups where people with common mental health issues could meet to support each other and share advice and coping strategies.
- Psychology provision: more resources are needed to expand the psychology service in the area to enable psychology input in areas lacking psychology provision. The services/areas of need identified are the Forensic, Liaison and Diversionary, crisis/acute services, anger management (a massive local issue), complex psychological assessment, and psychology input targeting self-harm/suicide.
- Universal Credit is having an impact on people receiving this in NEL and has created massive issues within services including mental health services in the area. People are in distress because of financial difficulties and this impact on their wellbeing.
- Greater resource is required to increase robustness of the Rethink provisions as service resilience is low due to the quantity and intensity of the work outstripping the staffing resource available.
    - Rethink is a lone working service which has a robust lone working policy but needs more staff for better management of service and for making the administrative work a lot easier. Rethink currently has only 20hours of management a week for the 7 day a week, 24 hours a day service.
- Currently pathways are unclear where a person has mental health issues on top of pre-existing vulnerabilities (for example Learning Disability or Autism).
- There is a gap in equity of access in the provision of PCMH in the three newly formed primary care Federations, as NEL resident could have different options of support depending on which practice they are registered with.
- PCMH services have low service capacity. Guidelines recommend that patients are seen within 6 weeks but this sometimes goes up to 10 weeks.
- There is a gap in service provision for people who are too complex for PCMH service and who when referred to SPA are considered not severe enough to meet secondary care input or not to meet IAPT criteria. There is therefore a need to bridge this gap to ensure that people get referred to the right service.
- Funding is required by NEL Mind to reconfigure the service and develop a new service.
- NEL Mind is not well promoted in the area and as a result the service lacks relationship with key people in various organisations. NEL Mind has opportunities to flourish with the relationship with Hull and East Yorkshire Mind. Transferable skills from Hull can be brought to the area.

[xxi] Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.

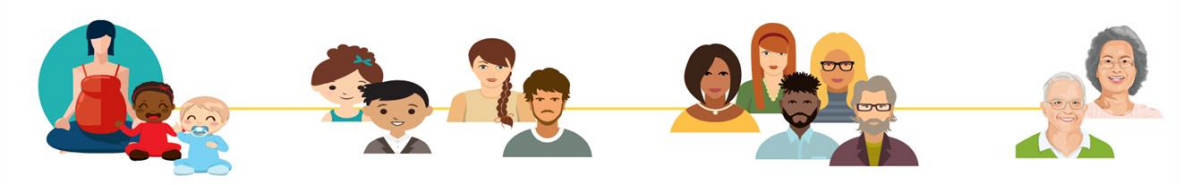
14. AREAS OF FOCUS FOR NORTH EAST LINCOLNSHIRE STRATEGIC PREVENTION FRAMEWORK FOR MENTAL HEALTH

It is clear from the literature and from our local research that mental health and wellbeing problems do not always present in obvious ways and early manifestations of mental wellbeing problems can provide opportunities for early intervention that will prevent more serious issues arising in the future. Such manifestations can be many and varied and will not always be mental health related but consideration should be given as to whether mental health is a factor. Some of the manifestations which have been associated with mental health problems across the lifecourse are illustrated below.

Common Manifestations of Mental Health Problems Across the Lifecourse

Interventions for mental health are traditionally associated with primary care or with providers of specifically mental health services such as NAViGO in North East Lincolnshire. However if we are to shift to a truly preventative model we need to ensure that mental health is genuinely everyone's business. There are certain 'touchpoints' across the lifecourse where people come into contact with organisations or services that may have the ability to make some sort of intervention for mental wellbeing before issues become clinical. Illustrated below are the potential touchpoints that exist in North East Lincolnshire across the lifecourse.

Potential Touchpoints Across the Lifecourse



Midwives	School Nurse	GP	GP
GP	School / College	Workplace	Church / religious organisations
Health visitor	Libraries / Leisure Centres	Job Centre Plus	Community Centres
Family Hubs	Sport Clubs	Gyms / Leisure Centres	Libraries
Church / religious organisations	Youth Clubs	Social / Sport Clubs	Voluntary Sector e.g. Age Concern
Voluntary Sector e.g. Play Group	Voluntary Sector e.g. Scouts		

In order to promote positive mental health and prevent the development or exacerbation of mental illness we need to take a lifecourse approach and recognise the different risks and triggers for mental health problems at different stages of the lifecourse.

The tables below identify four key life stages and segment the population at these stages into the main groups where evidence suggests a focus on positive mental wellbeing can make a difference. Within those groups we can also look to stratify the populations to identify those at higher risk of mental health difficulties and where specific efforts should be put into specially tailored interventions to address the need. In many cases it will be possible to identify the numbers of people who will into each category. This approach will form the basis of the prevention framework that will be developed following this needs assessment.

Areas of Focus: Perinatal Mental Health

Population	Main Touchpoints	Potential Areas of Focus
Parents to be	Midwives, GPs, social media	Parenting programmes
All mums	Midwives, GPs, health visitors, social media, family centres, community and voluntary	Community mothers programme, parent and child activities
Mums (women) already experiencing perinatal mental health problems	Midwives, GPs, health visitors	Peer to peer support programmes, parent and child activities, CBT
Mums (women) at high risk of experiencing perinatal mental health problems, e.g., - Mums with previous history of mental health problems -Mums experiencing a traumatic childbirth -Mums who have suffered bereavement by miscarriage, stillbirth or neonatal death -Mums exposed to domestic violence -Mums or a partner who is misusing drugs or alcohol -Mums with limited social support or relationship difficulties -Mums with previous history of abuse in childhood -Mums who are classified as obese -Teenage mothers	Midwives, GPs, health visitors, family centres	Interventions that promote early identification of at risk group

Areas of Focus: Children and Young People

Population	Main Touchpoints	Potential Interventions
All children and young people	GPs, health visitors, pre-school settings, schools, community organisations, churches, sport clubs, social media	Five ways to wellbeing, resilience programmes, relationship programmes, anti-bullying programmes
Pre-school children	Health visitor, GP, Children's centres, nurseries/ pre-school settings	Home to school transition practices/programmes; 2½ year early help offer
Primary school children	Primary schools	Transition programmes aimed at Year 6 children going onto Year 7
Secondary school children	Secondary schools, Social media	Programmes to support resilience and address specific issues identified as causes of stress in this age group, e.g. exam pressures, bullying, social media etc.
SEN Children	Schools	Specific programmes or set of steps to help these children improve in their specific area of educational need
Specific populations at high risk of mental health problems, e.g. -Looked after children -Children with disabilities -Young carers -Children in need -Children affected by domestic violence -Pupil referral unit and home educated -Youth offenders -Children in transition LGBT children	Children's social care, safeguarding, voluntary sector organisations, GPs, local authority	Interventions that promote early identification of at risk group Targeted interventions to address specific needs of the different populations

Areas of Focus: Working Age People

Population	Main Touchpoints	Potential Interventions
General Population	Workplaces, colleges, GPs, community organisations, local authority, social media	Five ways to wellbeing, mental health first aid
People with low level mental health disorders	Workplaces, GPs, social media, wellbeing service	Five ways to wellbeing, mental health first aid, social prescribing, wellbeing service
Long-term unemployed	Job Centre Plus, training providers, employers, GPs, Lincs Inspire	Five ways to wellbeing, mental health first aid, programmes that increase employment opportunities, exercise and leisure activities
People experiencing debt or financial problems	Finance providers, CAB, community and voluntary organisations	Information, Advice and Guidance
Drug and alcohol misusers	GPs, Addaction, Navigo	Targeted interventions to address substance use and mental health comorbidity

People with long term conditions or disabilities	GPs, Care Plus, local authority, community and voluntary organisations	Targeted interventions to address specific needs
Specific populations at high risk of mental health problems, e.g. -LGBT adults -Veterans -Ex offenders -Homeless -People affected by family/ relationship breakdown	GPs, Care Plus, local authority, Navigo community and voluntary sector, Probation service etc.	Interventions that promote early identification of at risk group Targeted interventions to address specific needs

Areas of Focus: Older People

Population	**Main Touchpoints**	**Potential Interventions**
Active Independent	Community and voluntary organisations, Lincs Inspire, social media	Five ways to wellbeing, community education, leisure activities
Socially isolated	Community and voluntary organisations, churches, GPs, libraries	Wellbeing service, social prescribing, community education, leisure activities
Frailty	Care homes, GPs, Care Plus, community and voluntary organisations	Social activities, light physical activity, community transport
Dementia	Care homes, GPs, Care Plus, community and voluntary organisations	Maintain physical activity and mental stimulation, e.g. crosswords, Social activities, community transport
Specific populations at high risk of mental health problems, e.g. -Terminally ill -Multiple long term conditions -Chronic pain	GPs, hospital, Care Plus, Hospice, community and voluntary organisations	Interventions that promote early identification of at risk group Targeted interventions to address specific needs

15. RECOMMENDATIONS

15.1. Perinatal Mental Health

It is recommended that:

- The Clinical Commissioning Group **(CCG) leads the Specialist Perinatal Mental Health Service** implementation in order to obtain optimal support for people with perinatal mental health issues.
- **All services** need to consider identifying those women at risk of poor mental health before, during and after pregnancy to ensure equity of access to provision, preventing the escalation of problems to support early access to treatment.
- During routine antenatal and postnatal appointments, **all health professionals** should discuss emotional wellbeing with women and identify potential mental health problems.
- The **CCG and NAViGO** should ensure that partners of women with perinatal mental health issues are also offered support at times of extreme stress and anxiety; as caring for a partner suffering mental ill health when a new baby arrives is a difficult and often lonely experience.
- **All healthcare professionals** referring a woman to a maternity service should ensure that information on any past and present mental health problem is shared. Also, the mental health of father's should be recorded where possible.
- Improved data collection across **key services** needs to identify the local incidence rate of perinatal mental health during and after pregnancy, rather than basing local need and service design on national estimated prevalence.
- All practitioners are familiar with case law and how this impacts on care delivery such as: NHS Trust 1 v G Practice Note [2014] EWCOP 30 http://www.bailii.org/ew/cases/EWCOP/2014/30.html

15.2. Children and Young People

It is recommended that:

- North East Lincolnshire Council continue to implement the Future in Mind Strategy to address the lack of support available for lower level emotional wellbeing through the commissioning of the Young Minds Matter Service and implementing the iThrive approach for C&YP in the area. Note**:** The Young Minds Matter service was commissioned in April 2018 (8 months ago).
- The **CCG & Council** and wider partners continue to work together to consider how the application of the Mental Capacity Act (MCA) impacts those in transition.
-

15.3. Adults and Older Adults

It is recommended that:

- The **CCG** commissions early intervention in psychosis service for people aged 35 years and over to the national model and standard as part of the implementation of the 5YFV.
- **NAViGO** implements and evaluates the mental health hub project (Safe Space) to help people who are in crisis but not mental health crisis who turn up at night at the acute specialist rehabilitation service based at Harrison House.
- The **CCG and the Council** take a joint commissioning approach to address the issue of people misusing drugs and alcohol who present in acute crisis at Harrison House (the acute specialist rehabilitation service) and in the community.
- The **CCG and NAViGO** address the gap in psychological therapists' trainees in the Open Minds: IAPT service by implementing further expansion of the IAPT programme in line with the 5YFV.
- The **CCG, NAViGO, Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Addaction** undertake work to understand relapse of those who have mental health problems and attend the variety of services (including Accident and Emergency (A&E) / IAPT / Addaction) for example those with alcohol and drug dual diagnoses and those who self-harm.

- **NAViGO** considers the need of 'light touch' support to prevent a relapse at times when those with mental health problems are faced with extreme stress such as; trauma / bereavement.
- The **CCG** undertakes a comprehensive review of the Adult Clinical Psychology services to ensure it best meets provision across the wide range of mental health support.
- The **CCG** undertakes a commissioning review of the mental health crisis house (Field View) and the crisis telephone helpline (Lincsline) managed by Rethink.
- The **CCG, NAViGO and Care Plus** should agree clear pathways for people who have a mental health problem in addition to pre-existing vulnerabilities (e.g. people with learning disability or autism)
- The **CCG and NAViGO** implement integrated IAPT in Primary Care setting across all federations to reduce the gap in equity and access to service provision and ensure that all practices are providing the same standard of service as stated in the 5YFV.
- The **CCG** ensures that IAPT waiting time standard are maintained in GP Practices (Primary Care MH services) where therapist provision is commissioned in line with recommended guidelines.
- **All providers** should review processes to establish the degree to which they comply with the Local Mental Capacity Act Policy and where necessary create an action plan to address any gaps.
- The **CCG and NAViGO** to implement and audit against the Memorandum of Understanding (MOU) Deprivation of Liberty in Hospitals: Agreed Principles.
- All **health and care partners** to work with the CCG to ensure that support and advice is offered to service users to proactively plan for their future including the potential of a time where they may lack the capacity to make decisions about their care and treatment.
- The **CCG** should explore options for more local provision of services for older people with complex long-term mental health conditions rather than sending them out-of-area.
- The **council and the CCG** should recognise the increased demands being placed on NAViGO and other providers and include this in the action plan going forward.

15.4. Public Health and Community

It is recommended that:

- Before the end of 2019 **Public health** will produce a new prevention framework for mental health in North East Lincolnshire, taking a population health management approach closely aligned to the new prevention framework for North East Lincolnshire.
- The **CCG** completes the implementation of social prescribing to address various underlying issues that lead to poor mental wellbeing/low level mental health issues. Social prescribing can address loneliness, help to build aspirations and build peer support network. It can also support perinatal women with low level mental health problems.
- The **CCG** understands more about why mental health medication is given without referrals to IAPT for talking therapies.
- The **CCG, Public Health and NAViGO** should run a primary care Protected Time for Learning (PTL) event on mental health and wellbeing during 2019.
- **Public Health/ CSSU** undertakes the follow on study on Financial Resilience Needs Assessment as recommended in the first study to assess the impact of Universal Credit on the mental and physical health of people receiving this in NEL.
- The **CCG and the Council** should ensure that the right support is in place to address the mental health needs of carers. The Director of Public Health report for 2018 focused on vulnerable groups and included a chapter on carers. Recommendations can be found in the report https://www.nelincs.gov.uk/wp-content/uploads/2018/05/6.-Director-of-Public-Health-Annual-Report-2018.pdf Actions from these recommendations should be implemented by the identified organisation/s.

- The **CCG and the Council** should ensure that the right support is in place to address the mental health needs of older people. The Director of Public Health report in 2016 focussed on older people and social isolation and various recommendations on how to tackle this issue are contained in this report http://www.nelincsdata.net/resource/view?resourceId=380
  Recommendations made in this report should be implemented by the identified organisation/s.
- **All local health and community services** should encourage people to follow the five ways to wellbeing, in particular to talk about their mental health.
- **Public Health** should include a focus on social isolation in the new over 75 health check which is being piloted next year.
- The weakness of community and voluntary sectors on mental health support and mental illness prevention was a common theme throughout the needs assessment. The **council, the CCG and NAViGO** should work in partnership with the voluntary sector, in particular those organisations that have a particular interest in mental health such as MIND, to better understand the issues that they face and identify how this sector can be strengthened.
- The **council's Wellbeing service** should identify community and voluntary sector groups where Mental Health First Aid training could be delivered.
- Absence associated with mental health problems is having a major impact on workplaces across North East Lincolnshire. The **council's Wellbeing service in partnership with local employers, employment organisations and Job Centre Plus** should explore how best to deliver programmes to improve the mental wellbeing of employees and those seeking to return to work.

15.5. Intelligence and Future Needs Assessments

It is recommended that:

- It proved extremely difficult to access some key intelligence sources in this needs assessment. **CSSU** should work with sectors such as primary care and schools to ensure that effective intelligence is collected and shared on mental health and wellbeing in North East Lincolnshire and data sharing agreements should be established where appropriate.
- **NELC Public Health/ CSSU** should organise an event that brings together intelligence analysts and leads across key local organisations and undertake a piece of work to establish a minimum dataset for mental health and wellbeing intelligence in North East Lincolnshire.
- Vulnerable children have been identified as being at particularly high risk of mental health problems in this needs assessment and these vulnerabilities often persist into adult life. However we were not able to explore some of the detail around the sort of adverse childhood experiences impacting on these children. It is important therefore that **NELC Public Health/ CSSU** undertake a needs assessment focused on these children immediately.
- A number of other groups have been identified where it is believed that there are particularly acute mental health issues, examples include homeless people, military veterans, carers, older people living alone and people with dementia living in the community. **NELC Public Health/ CSSU** should prioritise these groups for future needs assessment programmes.

16. APPENDICES

16.1. Consultation Surveys

North East Lincolnshire
Mental Health & Wellbeing Needs Assessment 2018
EDUCATION PROVIDER SURVEY

There has been growing interest in mental wellbeing in recent years and a widespread realisation that mental health impacts on a wide range of factors in our lives across all stages of the life course. Similarly there are many things in young people's lives which can contribute to poor mental health including life changes, poverty, personal image, social status as well as family and relationships. In order to provide a broad understanding of mental health and wellbeing, our 2018 needs assessment will aim to establish the underlying causes of poor mental wellbeing in our area.

For the purposes of this survey mental wellbeing describes an individual's mental state. This means how they are generally feeling and their ability to cope with day to day life.

We would be grateful if you would complete the following short survey to help us understand how you, within your capacity working within education provision, believe mental wellbeing issues are manifesting in young people.

1. How do you think mental wellbeing amongst young people in your school/college has changed in the last 5 years?
- ◯ Improved
- ◯ Not changed
- ◯ Worsened

2. How do you think mental wellbeing amongst the general population (across all ages) has changed in the past 5 years?
- ◯ Improved
- ◯ Not changed
- ◯ Worsened

3. What do you think are the most common factors which contribute towards poor mental wellbeing amongst children and young people? *(please tick all that apply)*

	✓
Family, relationship problems	☐
Physical/ emotional abuse	☐
Bullying	☐
Disability	☐
Bereavement, significant loss	☐
Caring responsibilities	☐
Life changes	☐
Alcohol and/or substance misuse	☐
Poverty	☐
Poor housing, living environment	☐
Unsafe neighbourhood	☐
Crime	☐
School work/exams	☐
Special education needs	☐
Sexuality, sexual identity	☐
Social Media	☐
Personal image	☐
Their future/job prospects	☐
Social status	☐

Other *(please detail below)*

4. Do you know where to refer/signpost a young person who you have identified or who has told you they are suffering with poor mental wellbeing as a result of factors listed in the previous question?
- ◯ Yes, always
- ◯ Sometimes
- ◯ No, never

Please explain your response

5. Do you think there is adequate provision within your school/college to help support young people with their mental wellbeing?
- ◯ Yes
- ◯ No

Please explain your response

6. To what extend do you think parents/carers can influence the mental wellbeing of their children?
- ◯ No influence
- ◯ A little influence
- ◯ Some influence
- ◯ A lot of influence

Please explain your response

7. Please tell us any other comments you may have in relation to mental wellbeing amongst young people below.

Thank you for taking the time to complete this survey. Your responses will be analysed and form part of the local mental health and wellbeing needs assessment consultation.

NORTH EAST LINCOLNSHIRE COUNCIL

NHS North East Lincolnshire Clinical Commissioning Group

North East Lincolnshire
Mental Health & Wellbeing Needs Assessment 2018
GP & NURSE SURVEY

There has been growing interest in mental wellbeing in recent years and a widespread realisation that mental health impacts on a wide range of factors in our lives across all stages of the life course. Similarly there are many things in our lives which can contribute to poor mental health including our financial and employment circumstances, housing and community issues and family and relationship positions. In order to provide a broad understanding of mental health and wellbeing, our 2018 needs assessment will aim to establish the underlying causes of poor mental wellbeing in our area.

For the purposes of this survey mental wellbeing describes an individual's mental state. This means how they are generally feeling and their ability to cope with day to day life.

We would be grateful if you would complete the following short survey to help us understand how you, within your capacity as a GP or nurse, believe mental wellbeing issues are manifesting in the community and presenting to your services.

1. In the past 5 years, do you think the number of patients presenting to your practice with mental wellbeing issues has...
- ◯ Increased
- ◯ Decreased
- ◯ Not changed

2. How do you think mental wellbeing amongst the general population (across all ages) has changed in the past 5 years?
- ◯ Improved
- ◯ No change
- ◯ Worsened

3. What do you think are the most common factors which contribute towards poor mental wellbeing amongst children, working age adults and older people? *(please tick all that apply)*

	Children & young people	Working age adults	Older people
Family, relationship problems	☐	☐	☐
Physical/ emotional abuse	☐	☐	☐
Bullying	☐	☐	☐
Loneliness, social isolation	☐	☐	☐
Disability	☐	☐	☐
Poor physical health, long term condition	☐	☐	☐
Bereavement, significant loss	☐	☐	☐
Caring responsibilities	☐	☐	☐
Life changes	☐	☐	☐
Alcohol and/or substance misuse	☐	☐	☐
Side effects of medication	☐	☐	☐
Finances, debt	☐	☐	☐
Poverty	☐	☐	☐
Poor housing, living environment, fuel poverty	☐	☐	☐
Unsafe neighbourhood	☐	☐	☐
Crime	☐	☐	☐
Education	☐	☐	☐
Special education needs	☐	☐	☐
Unemployment	☐	☐	☐
Work related stress	☐	☐	☐
Sexuality, sexual identity	☐	☐	☐

Other *(please detail below)*

4. Do you know where to refer/signpost a patient who presents with poor mental wellbeing as a result of factors listed in the previous question?
- ◯ Yes, always
- ◯ Sometimes *(please explain below)*
- ◯ No, never *(please explain below)*

5. In general, do you think your patients who present with poor mental wellbeing have the capability to manage and improve their own mental wellbeing?
- ◯ Yes
- ◯ No

6. Do you think there are adequate community services/groups/provision to help prevent and support individuals in the community with their mental wellbeing?
- ◯ Yes
- ◯ No

Please explain your response

7. Please tell us any other comments you may have in relation to mental wellbeing in the community and/or your patients below.

Thank you for taking the time to complete this survey. Your responses will be analysed and form part of the local mental health and wellbeing needs assessment consultation.

NORTH EAST LINCOLNSHIRE COUNCIL

NHS North East Lincolnshire Clinical Commissioning Group

North East Lincolnshire
Mental Health & Wellbeing Needs Assessment 2018
PROVIDER SURVEY

There has been growing interest in mental wellbeing in recent years and a widespread realisation that mental health impacts on a wide range of factors in our lives across all stages of the life course. Similarly there are many things in our lives which can contribute to poor mental health including our financial and employment circumstances, housing and community issues and family and relationship positions. In order to provide a broad understanding of mental health and wellbeing, our 2018 needs assessment will aim to establish the underlying causes of poor mental wellbeing in our area.

For the purposes of this survey mental wellbeing describes an individual's mental state. This means how they are generally feeling and their ability to cope with day to day life.

We would be grateful if you would complete the following short survey to help us understand how you, within your capacity as a service provider, believe mental wellbeing issues are manifesting in the community and presenting to your services. Even if your service does not provide mental health services specifically we would still like to hear your views.

1. In the past 5 years, do you think the number of people presenting to your service with mental wellbeing issues has...

- ◯ Increased
- ◯ Decreased
- ◯ Not changed

2. How do you think mental wellbeing amongst the general population (across all ages) has changed in the past 5 years?

- ◯ Improved
- ◯ No change
- ◯ Worsened

3. For the population group(s) relevant to your service area, what do you think are the most common factors which contribute towards poor mental wellbeing amongst children, working age adults and older people? *(please tick all that apply)*

	Children & young people	Working age adults	Older people
Family, relationship problems	☐	☐	☐
Physical/ emotional abuse	☐	☐	☐
Bullying	☐	☐	☐
Loneliness, social isolation	☐	☐	☐
Disability	☐	☐	☐
Poor physical health, long term condition	☐	☐	☐
Bereavement, significant loss	☐	☐	☐
Caring responsibilities	☐	☐	☐
Life changes	☐	☐	☐
Alcohol and/or substance misuse	☐	☐	☐
Finances, debt	☐	☐	☐
Poverty	☐	☐	☐
Poor housing, living environment, fuel poverty	☐	☐	☐
Unsafe neighbourhood	☐	☐	☐
Crime	☐	☐	☐
Education	☐	☐	☐
Special education needs	☐	☐	☐
Unemployment	☐	☐	☐
Work related stress	☐	☐	☐
Sexuality, sexual identity	☐	☐	☐
Other *(please detail below)*			

4. Do you know where to refer/signpost a person who presents with poor mental wellbeing as a result of factors listed in the previous question?

- ◯ Yes, always
- ◯ Sometimes
- ◯ No, never

5. In general, do you think the people you encounter with poor mental wellbeing have the capability to manage and improve their own mental wellbeing?

- ◯ Yes
- ◯ No

6. Do you think there are adequate community services/groups/provision to help prevent and support communities with their mental wellbeing?

- ◯ Yes
- ◯ No

Please explain your response

7. Please tell us any other comments you may have in relation to mental wellbeing in the community and/or your patients below.

Thank you for taking the time to complete this survey. Your responses will be analysed and form part of the local mental health and wellbeing needs assessment consultation.

NORTH EAST LINCOLNSHIRE COUNCIL

NHS North East Lincolnshire Clinical Commissioning Group

16.2. Stakeholder/Provider Interview questions

INTRO

There has been growing interest in mental wellbeing in recent years and a widespread realisation that mental health impacts on a wide range of factors in our lives across all stages of the life course. Similarly there are many things in our lives which can contribute to poor mental health including our financial and employment circumstances, housing and community issues and family and relationship positions. In order to provide a broad understanding of mental health and wellbeing, our 2018 needs assessment will aim to establish the underlying causes of poor mental wellbeing in our area.

For the purposes of this survey mental wellbeing describes an individual's mental state. This means how they are generally feeling and their ability to cope with day to day life.

QUESTIONS

1. Who are your client group?

2. What is their age range?

3. How do you think mental wellbeing amongst the general population (across all ages) has changed in the past 5 years?

4. Have you seen a change in the number clients presenting to your service in the past 5 years?

   PROMPT – *why do you think there has been a change? More/ less recognition of MH illness, more people want to acknowledge MH problems, cuts to other support services, an increase in mental health illness or an increase in recognition of MH illness by professionals/ the person themselves. Criminal justice system, domestic violence, children's services*

5. Amongst your clients who are suffering with poor mental wellbeing, what do you think are the most common factors which are contributing towards poor mental wellbeing?

   PROMPT – are they lifestyle issues? Factors outside their control? *See info sheet on age specific issues*

   - Family, relationship problems
   - Physical/ emotional abuse, bullying
   - Loneliness, social isolation
   - Self-care
   - Disability
   - Poor physical health, long term condition
   - Bereavement, significant loss
   - Caring responsibilities
   - Life changes
   - Alcohol and/or substance misuse
   - Excess use of social media/ smart phones etc
   - Finances, debt
   - Poverty
   - Poor housing, living environment, fuel poverty
   - Unsafe neighbourhood
   - Crime
   - Education
   - Special education needs
   - Unemployment
   - Work related stress
   - Sexual identity

6. Of the issues that you have identified above, are they issues which affect the one or two people or many people?

7. Do you think there are the right services available to signpost a client who is showing signs of poor mental wellbeing for reasons previously discussed? Is the referral process easy? Where do you refer people on to?

8. Where do they refer/ signpost people when MH is not severe enough for acute care? – Community groups, other people, friends, family?

9. What do you do if there isn't the right service available for their needs?

   PROMPT – *Are there any other services/groups/activities which are not specifically connected with mental health that you would refer to?*

10. Do you think your clients have the capability to manage and improve their own mental wellbeing?

    PROMPT – *support required? What would this look like?*

11. Do you think there are adequate community services/groups/provision to help prevent and support communities with their mental wellbeing?

    PROMPT – *suggestions for improving services provision?*

12. Is there anything else you would like to tell us that we haven't covered?

16.3. Service Mapping Interview Questions

1) Questions for statutory mental health service providers

First, explain what the project is about.

- What does your service provide?
- Who are your client group and what is their age range?
- Where do you get referrals from? Who refers into your service?
- Where do you refer to?
- What obstacles / bottlenecks or gaps do you have in providing this service?
- Any suggestions for improving service provision?
- Is there any other thing you'll like to talk about that we haven't covered?

THANK YOU VERY MUCH

2) Questions for commissioners of mental health services

Commissioners of mental health services were interviewed to gain insight into:

i) the services they intend to put in place to address perinatal mental health issues as there are currently no dedicated perinatal mental health services in North East Lincolnshire

ii) the services to be provided by the newly commissioned Young Minds Matter service for children and young people with mental health, emotional and wellbeing issues. The Young Minds Matter service was commissioned two months to the start of this project.

First, explain what the project is about.

- What dedicated local services are currently commissioned for women with perinatal mental health issues/ children and young people with mental health, emotional and wellbeing issues?
    - Discuss in further details any gaps in service provision
- If new services are to be developed, what services will these be and how will they be funded?
    - Who are these services for and what will be the age range of service users?
    - Who will provide these services?

THANK YOU VERY MUCH

3) Questions for other services supporting statutory mental health services

- What services do you provide?
- Who are your client group and what is their age range?
- How does your service support statutory mental health services in the area?
- What obstacles / bottlenecks or gaps do you have in providing this service?
- Any suggestions for improving service provision?
- Is there any other thing you'll like to talk about that we haven't covered?

THANK YOU VERY MUCH

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