Mental Health Joint Strategic Needs Assessment (JSNA) Topic Report

1 Introduction

1.1 Scope

This Joint Strategic Needs Assessment (JSNA) topic report focuses on mental health. Its primary aim is to consider the factors that affect mental health and wellbeing and to identify some of the key data, information and knowledge that build a picture of need within the context of the impact the COVID-19 pandemic has had on the local population. It provides an overview of the response provided by services to address changing needs, outlining where gaps may still exist. The scope will cover the full life course, from maternity, to children, young people, and adults.

1.2 Overview

Mental health is important for everyone, at every stage of life - from birth, through childhood and adolescence and into adulthood. It goes beyond the mere absence of a mental health condition. Good mental health enables people to realise their full potential, be productive in work and education, form meaningful relationships, remain resilient in times of adversity and contribute to their communities[1]. It is a valuable resource for individuals, families and communities to protect against the impact of stressors and traumatic events[2].

Everyone has mental health, and at any given point it is on a spectrum from 'good' or 'healthy' through 'coping' to 'struggling' and then 'unwell'.[3] Although the terms are often used interchangeably, poor mental health and mental illness are not the same. A person can experience poor mental health and not be diagnosed with a mental illness. Likewise, a person diagnosed with a mental illness can experience periods of physical, mental and social well-being[4]. There is a considerable burden of sub-optimal mental health that does not reach the threshold for diagnosis as a mental disorder but that influences how we function day to day and how our body functions[5].

Mental and physical health are equally important components of overall health and are often connected. For example, depression increases the risk for many types of physical health problems, particularly long-term conditions like diabetes and heart disease.[6] Similarly, the presence of chronic conditions can increase the risk for mental illness[4]. Mental health is also important in a wide range of social and economic outcomes such as: better educational achievement, increased skills, healthy lifestyles, employment, productivity at work, reduced anti-social behaviour and reduced criminality.

The social, physical and economic environments in which people are born, grow, live and age[2] impact mental health, for example: living in poverty, unemployment, poor housing, childhood experiences, domestic abuse, living with a long-term condition, caring responsibilities, social isolation and loneliness. As a result, a person's mental health can change over time as their environment changes and as the demands based on them exceed their resources and coping abilities.

Some groups of people have a greater risk of poorer mental health than others. In certain cases, those same groups of people have less access to effective and relevant support for their mental health, and when they do get support, their experiences and outcomes are often poorer[7].

The COVID-19 pandemic had a wide-reaching impact on mental health. It has been suggested that as many as 8.5 million adults and 1.5 million children and young people in the UK will require mental health support as a direct impact of the pandemic during the next three to five years. If this scenario plays out, predicted levels of demand are two to three times that of current NHS mental health capacity within a 3–5-year window[8].

The cost-of-living crisis is expected to have a significant impact on mental health. Research shows that unemployment, debt, financial difficulties, and loss of a home increase an individual's risk of depression, suicide attempt and suicide. The people most likely to be affected are those who are already vulnerable due to pre-existing mental health ill-health or other risk factors for poor mental health. In addition, people experiencing mental health ill-health because of their financial and employment difficulties often lack the motivation and support to navigate the benefits and advice systems[9].

Mental health problems currently cost the UK at least £117.9 billion a year (£100.8 billion year in England). Most of these costs are due to people living with mental health conditions that are unable to work or working less and the costs associated with support from informal carers. Specialist mental health care costs were estimated to be £13 billion in the UK, a further £2.3 billion was spent in primary care and £1.2 billion on Social Care. Special educational needs provision accounted for more than £2.5 billion[10].

2 Who's at highest risk and why?

This section maps risk and protective factors for mental health at individual, family, community, and structural levels. The section broadly follows a framework created by The National Institute of Health Research to map out the factors affecting mental health across all stages of a person's life[11].

2.1 Individual Level Risk and Protective Factors

2.1.1 Socio-demographic Factors

- **Education** settings can support mental health via good relationships; feeling safe; belonging; space to play and to access support; developing cultural, artistic and life skills. They can have negative impacts via poor relationships; bullying; exam pressure; and transition from primary to secondary school. Some groups of children, such as young carers and looked after children, may have negative experiences of school, and others, including those from Gypsy, Roma and Traveller communities, black Caribbean boys and white working-class boys, experience negative stereotypes [12].
- **Employment and working conditions** can be protective for mental health particularly when employees have autonomy, fair pay, work life balance, opportunities for

progression and there is no bullying and harassment [13]. Conversely people with jobs that give them less autonomy and control or lower or unequal pay are at higher risk of poor mental health.

- **Unemployment** is a key risk factor for poor mental health. In January 2021, 43% of unemployed people in the UK had poor mental health compared to 27% in employment[14]. In Buckinghamshire 2.8% of adult residents claimed unemployment benefits (April 2022). This proportion is lower than both the South East (3.1%) and England (4.0%) averages[15].
- **Financial insecurity** and poor mental health are often intricately linked. A Buckinghamshire resident survey in 2020 found a fifth of respondents (21.6%) were concerned about their finances and being in debt. This was highest among those aged under 50 years of age, ethnic minority groups, and people living in more deprived areas[16].
- **Housing difficulties and homelessness** such as finding a suitable home, poor property conditions, problems paying, or threat of eviction contribute to poor mental health. A survey by Shelter showed 21% of respondents in England said a housing issue had negatively impacted their mental health in the last five years[17]. Mental health problems among people experiencing homelessness are more prevalent than in the general population, particularly among people caught in the 'revolving door', between hostels, prison, hospitals and the streets[18].

2.1.2 Life Experiences and Opportunities

- **Life transitions**, such as job change, retirement, and becoming a parent can positively affect mental health or be a source of stress**Error! Bookmark not defined.**.
- **Hobbies** have been seen to decrease depressive symptoms and reduce the chance of experiencing depression by 30%[19].
- **Migration** can provide positive opportunities to work or study, but for some, such as asylum seekers and refugees, their experiences before, during and after migration are risk factors for mental health[20].

2.1.3 Trauma and Adversity

- **Traumatic experiences in childhood or adulthood** such as assault, domestic violence, and bereavement, are key risk factors for mental health. An estimated one in three women who attempt suicide in the UK have experienced domestic abuse[21].
- **Bullying** (including cyber bullying) experienced in childhood or adolescence increases the risk of depression, anxiety, a range of serious mental health issues, self-harm and suicide attempts. People frequently bullied in childhood are more likely to use mental health

services throughout their life[22]. Bullying was ranked in the top five causes of ill-health and death in five- to 14-year-olds in Buckinghamshire in 2019[23].

2.1.4 Physical and Psychological Health

- **Healthy lifestyles, such as being physically active,** protect against poor mental health and can help protect against the genetic links to some mental health conditions[24]. Conversely unhealthy behaviours such as using alcohol and drugs, and smoking are known risk factors[22].
- **Physical health** problems significantly increase the risk of poor mental health and vice versa. Around 30 per cent of all people in England in 2012 with a long-term physical health condition also had a mental health problem, most commonly depression/anxiety[25].
- **Perinatal** mental health problems affect 10 to 20% of women[26] and mental ill-health is one of the leading causes of maternal death in pregnancy and the first year after birth.[27] Although numbers are small, there was a statistically significant increase in the rate of suicide during pregnancy and up to six weeks after the baby was born in the UK between 2017-19 and 2020.

2.1.5 Personality Traits

Certain personality traits are associated with better mental health and well-being:

- **Resilience and self-efficacy** help an individual cope with stressors and grow from challenges, trauma and adversity[28].
- **Personal aspirations and ambitions** which are intrinsic - such as community, moral purpose and social connection – are linked to happiness[29].
- **Autonomy** to make decisions and act according to one's own choices is protective for mental health.

2.1.6 Identity

- **Ethnic minorities** are more likely to experience societal risk factors for poor mental health, including poverty, worse employment, housing conditions and healthcare.[30]
- **Gender** influences mental health risk. In England young women are three times more likely than men to experience common mental health problems, post-traumatic stress disorder and eating disorders[31] and men are three times more likely than women to end their own lives, particularly those in the lowest social class, in their mid-years.[32]

- **LGBT+** people are at substantial risk of poor mental health outcomes, especially suicide attempts, substance use and difficulties attending school.[33]
- **Religion, spirituality and faith** are largely protective for wellbeing, particularly through personal belief, service attendance, volunteering, and a way of coping with poor health.[34]

2.2 Family Level Risk and Protective Factors

2.2.1 Family Structure

- **Households** with two parents have been associated with a lower risk for depression in young adult children than growing up in stepparent or single-parent families[35]. Parental separation and bereavement of a close family member are risk factors for mental health[36].
- **Caring responsibilities** are a risk factor for mental health. In 2021 30% of carers stated that their mental health was 'bad' or 'very bad'. This increased from 27% in 2019 and worsened for those caring for more than 35 hours (34%)[37].
- **Growing up in poverty** impacts mental health. Children living around debt are five times more likely to be unhappy than children from wealthier families[38].

2.2.2 Family Dynamics

- **Attachment** by an infant with their primary care giver promotes better coping and faster recovery from distress, as well as resilience in youth. Poor attachment increases the risk of depression, anxiety and long term poor emotional regulation.
- **Parenting** styles which are warm, responsive and sensitive to needs are linked to increased resilience in young people[39]
- **Relationship** problems are a known risk factor for suicide, particularly among men,[40] and poor family relationships increase the risk of depression[41]. Close families provide social support, and feelings of belonging which promote wellbeing, reduce depression, and lower suicide ideation[42].

2.3 Community Level Risk and Protective Factors

2.3.1 Social and Physical Environment

- **Neighbourhood deprivation** is associated with poorer mental health, suicide and longer treatment for mental health; perception of high **community safety** is associated with lower psychological distress and depression.

- **Social support and social networks** foster effective coping strategies, resilience and counteract loneliness. Perceived and actual lack of social support increases the risk of suicide[43].
- **Cohesive communities and volunteering** improve mental health and reduce the negative effect of neighbourhood deprivation on mental health. Research shows community hubs, for example, sports clubs and activity groups, and acts of neighbourliness, fostered feelings of togetherness and were informal sources of support.[44]
- **Nature** is protective for mental health, whereas urban environments, especially those with decay and pollution, are a risk factor. In April 2021 12% of UK adults spent an hour or less around nature each week; people in affluent areas have five times more access to green space than those in deprived areas; spending time in nature dips aged 10-12 and does not recover until one's 30s; ethnic minority children spend less time in nature than white children[45] [46].

2.3.2 Access to Services

- **Access to high quality health, social care, public and community services** is protective for mental health. Transport allows access to formal and informal support; community spaces foster social networks; social care provides support for those with mental and physical conditions; culturally competent services reduce stigma and language barriers.
- **People in contact with prisons, probation and the courts** are at high-risk for mental health conditions, such as depression, anxiety, and for suicide. Risk is at its highest at transition points as people move into, within and out of the criminal justice system[47].

2.4 Structural Risk and Protective Factors

2.4.1 Broad Factors

- **Inequalities** including income, being part of a disadvantaged group, having a long-term condition or experiences such as discrimination, abuse and homelessness, lead to higher risk of poor mental health. The negative effects of social disadvantage and its associated stress accumulate throughout the lifespan. These factors will affect individuals differently, depending on how they are buffered by things like social support, financial resources and emotional resilience[48].
- **Social norms** which promote protective factors such as family connectedness are protective for mental health, but others are risk factors, for example such social norms linked to masculinity have been associated with lower appropriate help-seeking. Negative beliefs can contribute to **stigma and discrimination** towards certain groups which can be barriers to seeking help.
- **Climate change** such as extreme heat, cold, flood, fire, storms, exacerbates many social and environmental risk factors for mental health such as loss of livelihood and property,

forced migration, loss of autonomy. This can lead to stress, strained social relationships, financial hardship, grief, trauma, and substance misuse.[49] Research shows extreme heat is associated with higher rates of emergency department visits for mental health conditions, including anxiety, stress-related, and mood disorders[50].

2.4.2 Global and Political

- **Economic instability** is associated with higher unemployment, financial difficulties, debt, loss of homes and relationship stresses, all of which significantly impact mental health. People most at risk are those with pre-existing risk factors for poor mental health, and people with existing mental illness who may find it difficult to navigate support systems. In England following the financial crisis of 2008– 2010 there were 846 more suicides among men than would have been expected from historical trends and 155 more suicides among women, and English regions with the largest increase in suicides among men also had the largest rise in unemployment[51].
- **Welfare systems** (education, transport, social care, benefits and financial hardship support) are protective for mental health**.**
- **Global politics and events** can contribute to feelings of uncertainty, stress and anxiety, as well as impacting economic instability such as the war in Ukraine and international terrorism.

3 Level of Need

3.1 Children and Young People Mental Health

3.1.1 Mental Well-being – The Local Picture

Good mental health is particularly important in the first five years of life - these years have a lasting impact -and in adolescence, where social and environmental influences may change[52]

The OxWell Children's Buckinghamshire Health and Wellbeing Survey 2021 took place during May to July 2021. Around 4,200 children and young people from 31 schools responded - 15 primary schools (~1000 pupils), nine secondary schools (~3000 pupils) and seven covering sixth form (~200 pupils). The results are not necessarily representative of all children and young people within Buckinghamshire, particularly for secondary and sixth form children and young people, with more grammar schools in the sample than other schools.

Of the primary school age children that responded, around two in 10 (18.3%) had a low wellbeing score[i], a higher proportion than the children that completed the survey in 2020 (16%). Around four in 10 (39.1%) of the secondary school age children that responded had a low wellbeing score, compared with 31% in 2020. And five in 10 of the respondents in sixth form (51.3%) had a low wellbeing score, compared with 46.3% in 2020.

[i] Score defined by use of the Warwick Edinburgh Mental Wellbeing Scale

For children with a low wellbeing score, more than half (56.1%) stated that reasons included that they were worried about what others think and/or about their appearance. Around a third said the climate (33.2%) and feeling sad (30.9%) were reasons. These factors had also increased since the 2020 survey. Sixth form pupils were most concerned about their appearance (61.6%), the climate (56.9%) and what others think (58.6%). The children with a low wellbeing score were more likely to worry at night compared to those with high wellbeing scores.

Feeling tired during the day where they considered it a problem affected more than one in ten children (12.5%) in primary school, three in ten (30.9%) in secondary school and more than four in ten of sixth formers (44.3%). One in ten (10.9%) primary school children and nearly a third (30%) of secondary school children said they were too worried to sleep.

One in ten (10.4%) primary school children who were surveyed reported being bullied at least weekly in the last year, this was lower in secondary school and sixth form age children (6.8%) who were surveyed. In the majority of cases (68.6% for primary, 77.8% for secondary and sixth form) bullying was verbal, followed by physical (24.9% for primary, 21.3% in secondary and sixth form) and there were clear differences by age when it came to cyberbullying (13.8% in primary, 28.3% secondary and sixth form).[ii] Primary school children with a low wellbeing score were more likely to have reported being bullied compared to those with a high wellbeing score (16.6% compared to 10.9%).

More than one in ten (11.8%) primary school age pupils said they would do nothing if they needed mental health support and more than three quarters (77.7%) would speak with parent/carers. In secondary school and sixth form settings more than six out of ten young people (62.9% and 64.5%) surveyed knew who provided mental health support in their school, however there was still more than one in five (22.4%; 21.7%) who found it difficult to find someone if upset and needing help.

3.1.2 Mental Ill-health – The Local Picture

It is estimated 1 in 10 children will have a clinically diagnosed mental disorder in childhood, that half of all mental disorders will emerge before the age of 14, and three quarters will emerge before the age of 25[53].

Childhood mental health problems have been rising during recent years, particularly during the COVID-19 pandemic. A national survey suggested that the proportion of 6- to 16-year-olds in England with a probable mental disorder increased from 11.6% in 2017 to 17.4% in 2021[54]. Applying this to the Buckinghamshire population gives an estimated 16,546 children locally.

Mental ill health is not distributed equally across the population. In England in 2015, children from the most deprived 20% of households were four times more likely to have serious

[ii] Students could select multiple responses

mental health difficulties by age 11 compared to those from the least deprived 20% of households[55].

3.1.3 Self-harm - The Local Picture

The reasons for self-harm are varied and often the product of a complicated interplay between biological, psychiatric, psychological, social and cultural factors, and negative life events. They are not always linked with mental health problems[56]. This highlights the complexities in delivering services to young people for self-harm and the important role of working with families and schools to build resilience and help-seeking behaviours.[57] Self-harm is a very private behaviour and there is a shortage of reliable information unless people present to services.

Responses to the OxWell Buckinghamshire Health and Wellbeing Survey 2021 showed:

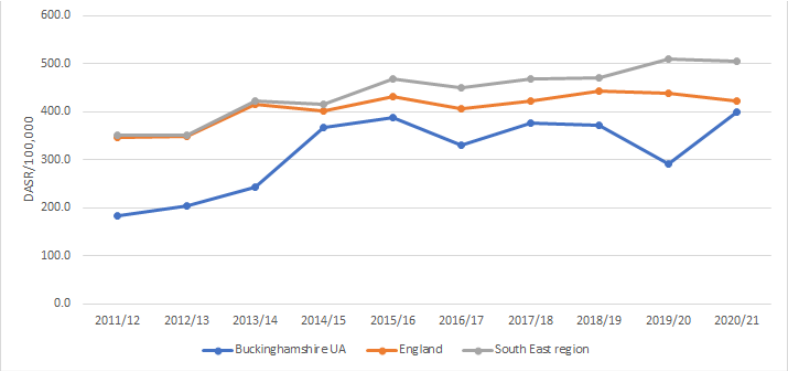
- Nearly one in four (23.9%) secondary and sixth form students reported they had self-harmed.
- Girls (23.3%) were more likely than boys (15.9%) to report they had self-harmed.
- More than half secondary school respondents (54.4%) who reported they had self-harmed[iii] had done so in the last week/month. One in ten (12.4%) of these had needed medical treatment and nearly 9 out of 10 (87.5%) stated they never or rarely told anyone.

Self-harm is more common in adolescence than other age groups and is strongly linked to emotional distress and mental health issues[58]. Our primary source of data is hospital admissions, but it is likely that many more episodes of self-harm occur in the community and do not come to medical attention[59].

The rate of hospital admissions for self-harm in Buckinghamshire in children and young people aged 10 to 24 years in 2020/21 (399.9 per 100,000 population) was similar to the national average (421.9 per 100,000) and statistically significantly below the South East rate (505.6 per 100,000). Between 2016/17 and 2020/21, the admission rate increased but the change between these dates was not statistically different. There was a significant increase in the admission rate in Buckinghamshire in most recent year, from 2019/20 to 2020/21, with an increase (from 265 to 360 admissions) which is not seen in either England or the South East. However, this increase between 2019/20 and 2020/21 in Buckinghamshire is magnified by drop in the admission rate between 2018/19 and 2019/20 (Figure 1).

[iii] Out of 320 respondents

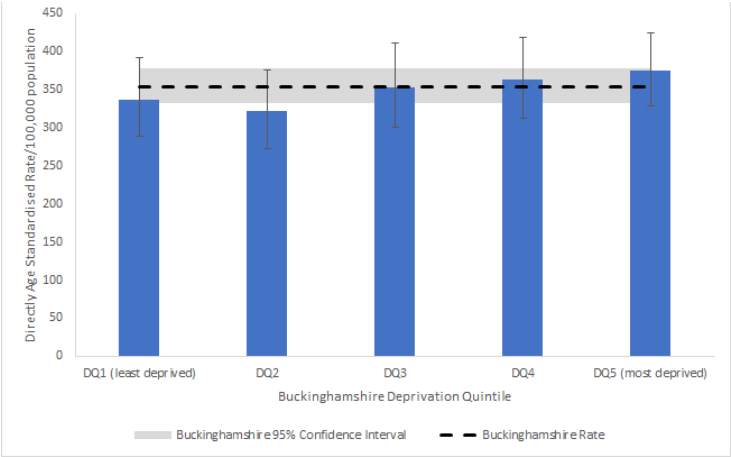
Figure 1. Buckinghamshire Hospital admission rate per 100,000 population as a result of self harm (aged 10-24 years), compared with the South East region and England average, 2011/12 to 2020/21



Source: Hospital Episode Statistics (HES) Copyright © 2020. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

Figure 2 shows that the rate of hospital admissions for self-harm (aged 10-24 years) for 2018/19 to 2020/21 was higher in the more deprived quintiles in Buckinghamshire, but there was no statistically significant difference between the deprivation quintiles.

Figure 2. Buckinghamshire Hospital admission rate per 100,000 population as a result of self-harm (aged 10-24 years) by deprivation quintile, 2018/19 to 2020/21



Source: Hospital Episode Statistics, Buckinghamshire Public Health Intelligence Team.

In the period 2018/19 to 2020/21, admission rates for self-harm in children and young people in most Community Board areas were similar to the Buckinghamshire average (354.4 per 100,000 population aged 10 to 24 years). The numbers by Community Board are small and so differences should be interpreted with caution. Amersham (678.3 per 100,000; 74 admissions) and Beeches (580.6 per 100,000 population; 64 admissions) Community Board areas had statistically significantly higher rates compared to the Buckinghamshire average. No Community Board area saw a statistically significant increase in admissions for self-harm between 2015/16-2017/18 to 2018/19-2020/21.

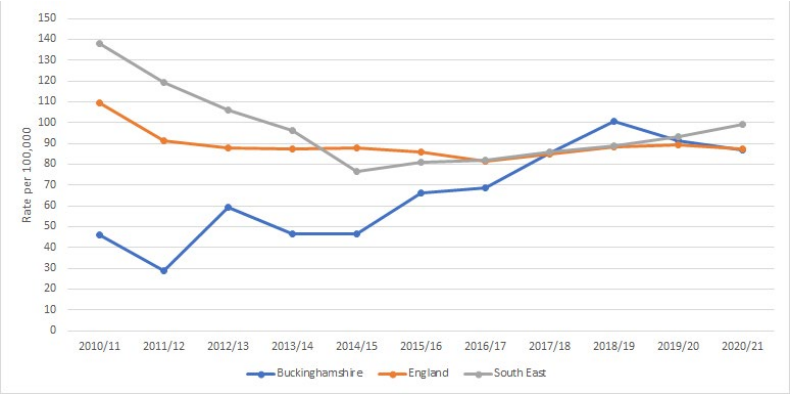
3.1.4 Hospital Admissions - The Local Picture

Admissions for Mental Health Disorders

Treating mental health disorders in childhood is important to give children and young people the best start in life, to prevent what can be a devastating impact on their future, and to prevent long term mental health problems in adulthood.

In 2020/21 the hospital admission rate for mental health disorders in 0- to 17-year-olds in Buckinghamshire was 86.8 per 100,000 population (110 admissions). This was similar to the average for England (87.5 per 100,000), and the South East (99.4 per 100,000) average (Figure 3). However, whilst hospital admission rates have declined and plateaued for England and the South East region, rate of hospital admissions in Buckinghamshire increased between 2010/11 and 2018/19, with a plateau or decline only seen in recent years (2019/20 and 2020/21).

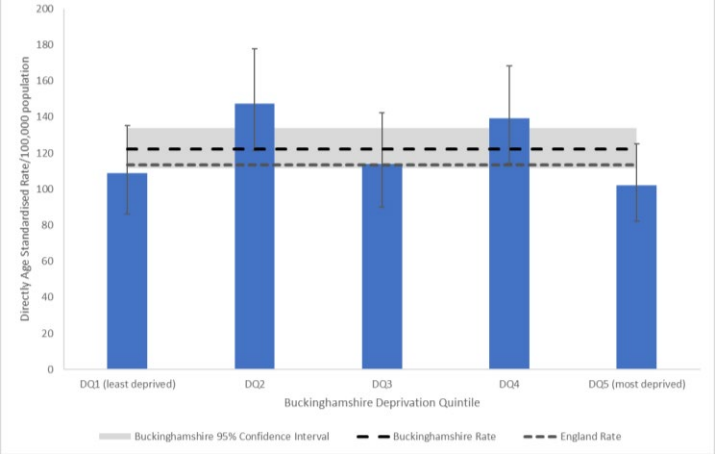
Figure 3. Buckinghamshire admission rate for mental health disorders in 0- to 17-year-olds per 100,000 population, compared with the South East region and England average, 2010/11 to 2020/21



Source: Hospital Episode Statistics (HES). 2022 https://fingertips.phe.org.uk

Figure 4 shows that during the three years 2018/19 to 2020/21, there was no statistically significant difference in the rate of mental health hospital admissions in those aged 0 to 19 years between the Buckinghamshire deprivation quintiles.

Figure 4. Buckinghamshire inpatient mental health admission rate in those aged 0-19 per 100,000 population by deprivation quintile (DQ), 2018/19 to 2020/21



Source: Hospital Episode Statistics, Buckinghamshire Public Health Intelligence Team.

During 2018/19 to 2020/21, most Community Boards had similar rates of mental health admissions for children and young people compared to the Buckinghamshire average (145.3 per 100,000 population aged under 25 years). The numbers by Community Board are small and so differences should be interpreted with caution. Wing and Ivinghoe was the only Community Board area with a statistically higher rate (219 per 100,000 population; 45 admissions). Before the COVID-19 pandemic (2017/18 to 2019/20) Wing and Ivinghoe also had the highest rate (249 per 100,000 population).

Admissions for Eating Disorders

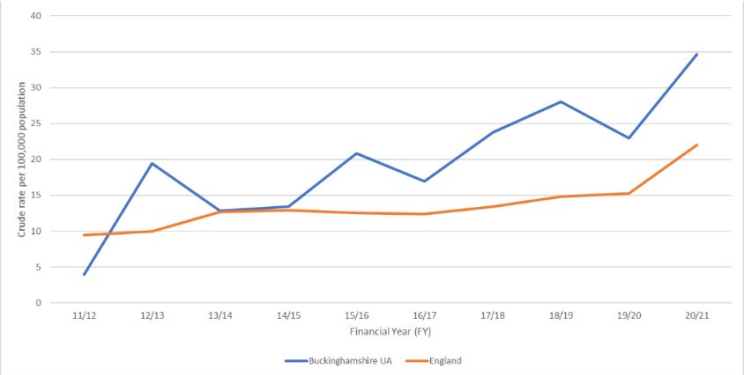
Eating disorders are a group of illnesses that cause someone to have issues with their body shape and weight, disturbing their weight and relationship with food. They include anorexia nervosa, bulimia nervosa and binge eating. There is no single cause, and risk factors can include:

- **Biological factors** – such as a family history or changes in brain or hormone levels.
- **Psychological factors** – such as a low confidence or self-esteem.
- **Social factors** including bullying, difficulties with school or work, or abuse.

Figure 5 shows how hospital admission rates in children and young people aged under 25 years for eating disorders have changed over time in Buckinghamshire, compared to England. Because the numbers for Buckinghamshire are small, increases or decreases at any time point may occur due to random variation so should be treated with caution and it is recommended to look at the trend over several years. Overall, hospital admission rates have generally increased in Buckinghamshire, as in England, since 2011/12. The hospital admission rates in Buckinghamshire have been higher than England since 2014/15. In 2020/21 the rate of eating

disorders[11] in Buckinghamshire children and young people aged under 25 years was 34.6 per 100,000 population, statistically significantly above the rate in England (22.0 per 100,000).

Figure 5. Buckinghamshire hospital admission rate per 100,000 population for eating disorders (aged 0 to 24 years), compared with the and England average, 2011/12 to 2020/21



Source: Hospital Episode Statistics, Buckinghamshire Public Health Intelligence Team.

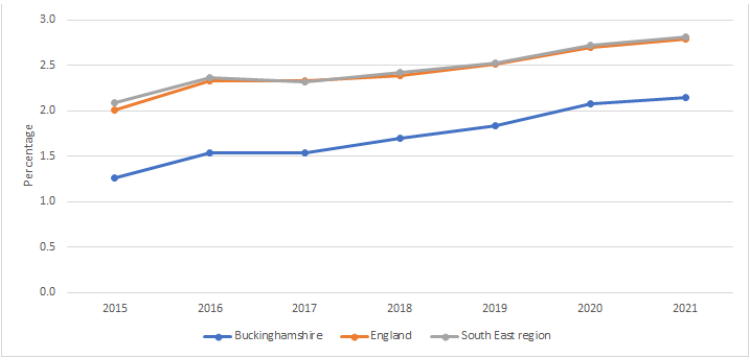
3.1.5 Vulnerable Groups

Special Educational Needs

The term "special educational needs" (SEN) is used to describe learning difficulties or disabilities that make it harder for children and young people to learn compared to others of their age. These children are likely to need extra or different help from that given to others of their age which is known as special educational provision.

The number of primary, secondary and special school pupils with SEN where the primary need is social, emotional and mental health in Buckinghamshire in 2021 was 1,864 (or 2.1% of the total number of pupils), compared with 2.8% in both England and the South East region. This proportion has increased in Buckinghamshire from 1.3% in 2015 (Figure 6).

Figure 6. Proportion of all school pupils with social, emotional and mental health needs in Buckinghamshire, compared to England and the South East region, 2015 to 2021



Source: Department for Education special educational needs statistics: https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

Where SEN are present, but are unknown, it is found to adversely affect the child, particularly if from a disadvantaged area, not geographically mobile and with interrupted attendance at school and known to Social Care. The COVID-19 pandemic has exacerbated this, particularly in relation to reduced attendance at school. During the first year of the COVID-19 pandemic (March 2020 to March 2021) there was increase in children with SEN in Buckinghamshire experiencing higher anxiety, feeling unhappy and being more isolated.

Child Protection Plans

Mental health is the most prevalent issue identified on assessments for children starting Child Protection Plans, particularly for school ages 10 to 15 years. Three quarters (74%) of children starting plans had poor mental health identified as a concern on their assessment in 2021/22. Two thirds (65%) had emotional abuse identified as a risk and 60% had domestic abuse or violence identified. The latter is the most common risk identified for children aged 1 to 4 years. Children exposed to violence have higher rates of anxiety, depression and other mental health problems and suicide[60].

Children in Care and Care Leavers

The number of care leavers in Buckinghamshire as of March 2022 was 257. For many children in care, leaving the care system can be a time of extra challenge, anxiety and fear. National research[61] shows more than a third of care leavers surveyed in July and September 2021 felt they left care too early without the right skills. Many felt isolated and didn't know where to get help for their mental health and wellbeing. A quarter did not feel they were involved with plans about their future which had an impact on their education and emotional well-being.

Young Carers

Young carers have an increased risk of poor mental health, social isolation, missing key appointments and checks, and lower educational attainment due to missing more school when compared to non-carers, all of which were exacerbated by the COVID-19 pandemic [62]. In addition, many young carers are not known to services and therefore not receiving support.

Research has shown as many as one in five children and young people are young carers[63]. In the 2011 census, 1,019 children aged 0 to 15 years (1%) and 2,085 young people aged 16 to 24 years (4.1%) in Buckinghamshire were identified as carers. The 2021 census data will be able to update this picture for Buckinghamshire once published.

Domestic Violence and Abuse

Domestic violence and abuse have a profound impact on victims and survivors, their family and wider society. Witnessing abuse or being harmed by a perpetrator impacts the mental and physical health, safety, and educational attainment of children, contributes significantly to homelessness and increases the risk of poverty[64]. An estimated one in five children are exposed to domestic abuse in the UK[65]. Around two in three (62%) children living with domestic abuse are thought to be directly harmed by the perpetrator[66].

The 2021 Director of Public Health Annual Report in Buckinghamshire for the financial year 2020/2021 identified the following:

- More than 2,400 referrals for a social care assessment were made to Children's Social Care where domestic violence was listed as the primary concern. This represents a 31% increase on the previous year (2019/20) and accounts for 23% of all Children's Social Care referrals.

These figures will underestimate domestic abuse suffered and witnessed by children in Buckinghamshire as not all cases will be referred to Children's Social Care.

Of the 116 children accommodated in Women's Aid Buckinghamshire refuges from 2019 to 2020, more than half (66%) had directly witnessed domestic abuse and 17 of the families were subject to a Child Protection Plan.

The COVID-19 pandemic saw a significant increase in reported domestic abuse. The national and local lockdowns resulted in victims being confined at home with perpetrators. School closures during these periods may have also increased exposure of children to domestic violence in the home. In-person contact with health and social services reduced and home visits, which may have identified and intervened in risky situations, were reduced. Victims reported that the abuse worsened during the COVID-19 pandemic, especially if they lived with their abuser.

Youth Justice

In England, rates of poor mental health are at least three times as high for those within the criminal justice system as within the general population[67]. Children and young people at risk of offending, or within the youth justice system, often have more unmet health needs and greater mental health needs than other children and young people. This is due to stressors on families, as well as aspects of offending and risky behaviours, including the interaction with the justice system. Early detection of mental health concerns may reduce the likelihood young offenders will persist offending into adulthood[68].

In 2021, there were 71 first time entrants to the youth justice system in Buckinghamshire (122.0 per 100,000 population), a similar rate of entry to England (146.9) and the South East region (133.5). The rate of entry in Buckinghamshire has significantly declined over the past 5 years, from 257.6 in 2017 to 122 in 2021.

More than two thirds (69%) of young people assessed by the Buckinghamshire Youth Offending Service in 2021/22 had contact with mental health services and 21% had a formally diagnosed mental health condition. This has increased from 58.5% and 15.4% respectively in 2019/20.[69]

3.2 Maternal (Perinatal) Mental Health

NHS England describes perinatal mental health conditions as those that occur 'during pregnancy or in the first year following the birth of a child'[70].

It is estimated nationally that up to 27% of new and expectant mums are affected by poor perinatal mental health[71] covering a range of conditions including anxiety, depression, post-traumatic stress disorder and postpartum psychosis. If left untreated, these mental ill-health conditions can have significant and long-lasting effects on women, children, and the wider family. In addition, it is estimated only half of these cases nationally are currently diagnosed.

Many factors are linked to increased risk of poor perinatal mental health such as domestic violence and abuse, low social support, substance misuse, emergency situations (including pandemics) and trauma. Bereavement by miscarriage, stillbirth or neonatal death are also more likely to lead to poor mental health in both parents[72].

The right support at the right time can have an enormous impact on the psychological wellbeing and mental health of women (and their partners). Stigma may prevent people from speaking up and seeking help.

During the COVID-19 pandemic the UK experienced an increase in perinatal mental health related deaths, principally suicide. Deaths from mental health-related causes as a whole (suicide and substance abuse) accounted for nearly 40% of perinatal deaths in 2020 with maternal suicide remaining the leading cause of direct deaths in the perinatal period. The UK perinatal suicide rate in 2017-19 was 0.46 per 100,000 compared with 1.48 per 100,000 in 2020. There was no significant increase in female suicides in the general population in 2020 compared with 2019[73]. More insight is needed to understand the causes of these increases and locally to see if the same patterns are reflected in the Buckinghamshire population.

In 2017/18 it was estimated in Buckinghamshire that 137 women suffered with severe depressive illness in the perinatal period[iv].

3.3 Adults Mental Health

3.3.1 Mental Well-being - The Local Picture

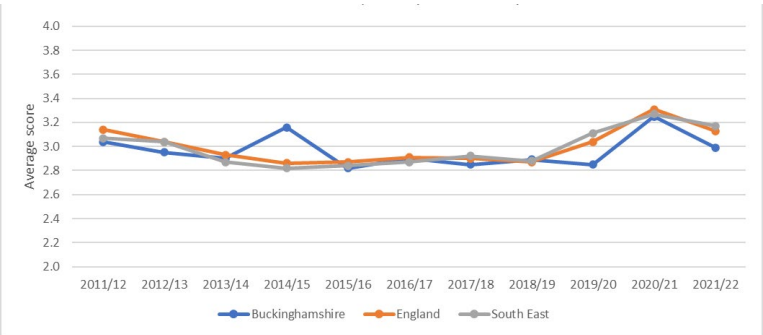
People with good mental health (often referred to as mental well-being) have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

The Office for National Statistics (ONS) conducts an annual population survey with measures of personal well-being across four domains: anxiety, happiness, life satisfaction and feeling that things done in life are worthwhile. Across all four domains, Buckinghamshire residents average scores are better than, or similar to, the England and South East region averages.

[iv] These numbers are based on national prevalence estimates and do not take into account socio-economic or demographic differences between areas.

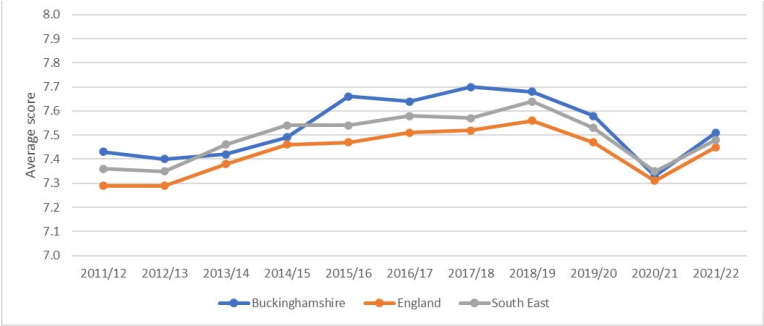
Figures 7, 8, 9 and 10 show the the average scores for each domain since 2011/12. They give an indication of the population impact of the COVID-19 pandemic on personal well-being. On all measures, average ratings got worse over the course of the pandemic years (between 2018/19 and 2020/21) in Buckinghamshire, the South East and England. Average scores across all domains improved in 2021/22 but had not recovered to pre-COVID-19 pandemic levels.

Figure 7. Measure of personal well-being (Anxiety) in Buckinghamshire, compared to the South East region and England average, 2011/12 to 2021/22



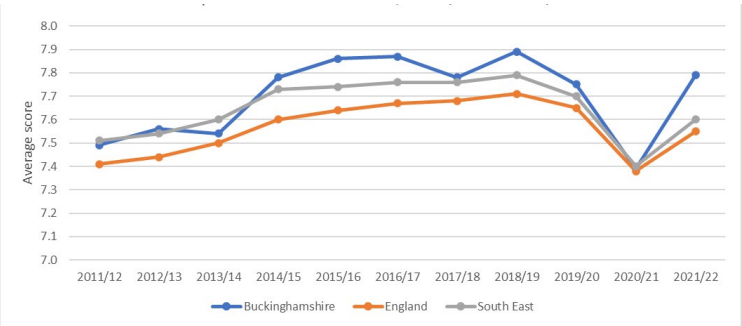
Source: Annual Population Survey (APS); Office for National Statistics (ONS). © Crown copyright 2022

Figure 8. Measure of personal well-being (Happiness) in Buckinghamshire, compared to the South East region and England average, 2011/12 to 2021/22



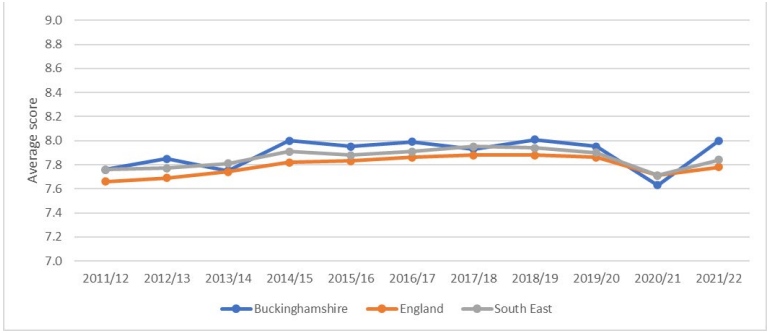
Source: Annual Population Survey (APS); Office for National Statistics (ONS). © Crown copyright 2022

Figure 9. Measure of personal well-being (Life Satisfaction) in Buckinghamshire, compared to the South East region and England average, 2011/12 to 2021/22



Source: Annual Population Survey (APS); Office for National Statistics (ONS). © Crown copyright 2022

Figure 10: Measure of personal well-being (Worthwhile) in Buckinghamshire, compared to the South East region and England average, 2011/12 to 2021/22



Source: Annual Population Survey (APS); Office for National Statistics (ONS). © Crown copyright 2022

During the summer of 2020, a local resident survey of just over 5,000 respondents was conducted. Two fifths (37%) of respondents were concerned about their mental wellbeing. They were significantly more likely to be females, younger age groups (aged under 30 years), White British and those living in the more deprived areas of Buckinghamshire.

3.3.2 Mental Ill-health - The Local Picture

Depression

Depression is one of the world's most disabling diseases and is also responsible for 109 million lost working days every year in England, at a cost of £9 billion[74]. It affects people in different ways and can include feelings of sadness and hopelessness, losing interest in things, feeling tearful, feeling constantly tired, sleeping badly and having no appetite. It can result in significantly reduced quality of life for the patient, their family and carers.

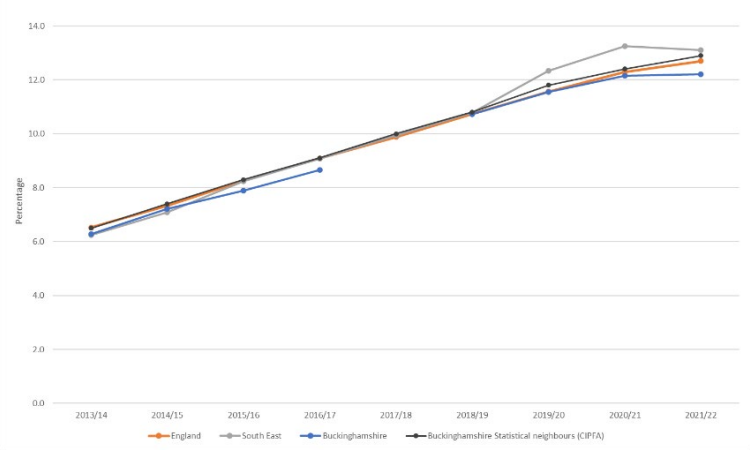
In Buckinghamshire in 2019, depressive disorders were the second highest cause of all years lived in ill-health (behind low back pain).

Recorded Depression Prevalence

Figure 11 shows the percentage of patients aged 18 and over with depression, as recorded on GP practice disease registers, was 12.2% (55,342 patients) in Buckinghamshire in 2021/22. This was significantly lower compared to the England average (12.7%), Buckinghamshire statistical neighbours (12.9%) and the South East region (13.1%).

In Buckinghamshire, the percentage of patients with recorded depression has steadily and significantly increased since 2013/14 (6.3%). The latest year between 2020/21 (12.1%) and 2021/22 (12.2%) reflects an increase of just over 800 patients. The year before there was an increase of just over 3000 patients. The numbers are confounded by recording within GP practices as well as population prevalence.

Figure 11. Percentage of patients (aged 18+) on Buckinghamshire GP Practices recorded with depression, compared to the South East region and England average, 2013/14 to 2021/22



Source: Quality and Outcomes Framework (QOF), NHS Digital. Office for Health Improvement & Disparities. Public Health Profiles. 2022
https://fingertips.phe.org.uk © Crown copyright 2022
Data not available for 2017/18

Looking at a snapshot in time on the 15th of September 2022, shows the highest prevalence of adult patients recorded with depression by Buckinghamshire GP practices was in the 45-64 age group (14.8% registered population). The 18-44 age group (13.6%) was similar to the Buckinghamshire average, with those aged 65 and over lowest.

Table 1. Prevalence of recorded depression from Buckinghamshire GP Practice registers by age group, September 2022

Age Group	Depression Count	Depression %
18-44	25,758	13.6%
45-64	23,344	14.8%
65 and over	10,702	9.9%
Buckinghamshire	59,804	13.1%*

Source: Graphnet Enhanced Case Finder, accessed on 15th September 2022. NHS Digital Patients Registered at a GP Practice, September 2022. * Total prevalence will differ to those quoted above as looking at a different period.

Recorded Depression Incidence (new diagnosis)

In the former NHS Buckinghamshire Clinical Commissioning Group (CCG) area, the incidence (new diagnosis) of patients recorded with depression on GP practice disease registers was 1.2% in 2021/22. This equated to 5,661 patients and was significantly lower than 2018/19 (1.9%). The latest data was also significantly below the England average of 1.5% and the (Buckinghamshire, Oxfordshire and Berkshire West *(BOB) Integrated Care System (ICS) average of 1.5%.

Improving Access to Psychological Therapies (IAPT)

Improving Access to Psychological Therapies (IAPT) is an NHS programme in England that offers interventions to treat people with depression or anxiety.

Age

Table 2 shows the referrals and treatment numbers for IAPT broken down by age group. The majority of referrals were in those aged under 65 years with a significantly higher rate in those aged 18 to 25 years (65.1 per 1,000 population) compared to the other age groups.

Table 2. Referrals received by IAPT across NHS Buckinghamshire CCG broken down by age group, 2021/22

Age - NHS Buckinghamshire CCG	Referrals Received	Rate per 1,000	Entered Treatment	Finished Treatment	Population (March 2022)
18 to 25	2,960	65.1	2,185	1,675	45,461
26 to 64	10,010	33.4	7,845	5,830	299,580
65 to 74	810	14.8	665	420	54,631
75 to 89	560	11.9	410	235	47,025
90 and over	15	2.6	10	10	5,716

Source: NHS Digital and ONS 2021 census

Ethnicity

Table 3 shows the referrals and treatment numbers for IAPT broken down by ethnic group. Of those with an ethnicity recorded, 83.4% of referrals were recorded as White. This compares to 79.9% in the population for Buckinghamshire. Asian ethnic groups were under-represented with 8.6% of referrals received recorded against a population of 12.4%. However, just under 1 in 10 referrals (8.6%) have an unknown ethnicity.

Table 3. Referrals received by IAPT across NHS Buckinghamshire CCG broken down by ethnic group, 2021/22

Ethnic Group	Referrals Received	% of known recorded ethnicity	Population (2021)	Entered Treatment	Finished Treatment
Asian or Asian British	1125	8.6%	12.4%	905	615
Black or Black British	355	2.7%	2.6%	275	205
Mixed	505	3.8%	3.5%	375	290
Other Ethnic Groups	195	1.5%	1.6%	160	100
White	10965	83.4%	79.9%	8830	6750
Not stated/Not known/Invalid	1235			575	215
Total	14,380			11,120	8,175

Source: NHS Digital and ONS 2021 census

Recorded Prevalence of those with schizophrenia, bipolar affective disorder and other psychoses

The percentage of patients recorded with schizophrenia, bipolar affective disorder and other psychoses in Buckinghamshire in 2021/22 was 0.77% (4,461 patients). This was significantly below the England average (0.95%) and the South East region average (0.87%). The prevalence hasn't changed significantly over time, in 2018/19 the prevalence was 0.79% in 2018/19 in Buckinghamshire and 0.96% in England.

Looking at a snapshot in time on the 15th September 2022Table 4 shows the highest prevalence of adult patients recorded with schizophrenia, bipolar affective disorder and other psychoses were those aged 45 to 64 years.

Table 5. Prevalence of patients recorded with schizophrenia, bipolar affective disorder and other psychoses from Buckinghamshire GP Practice registers by age group, September 2022

Age Group	Count	Prevalence
18-44	1,677	0.9%
45-64	1,846	1.2%
65 and over	1,012	0.9%
Buckinghamshire	4,535	1.0%*

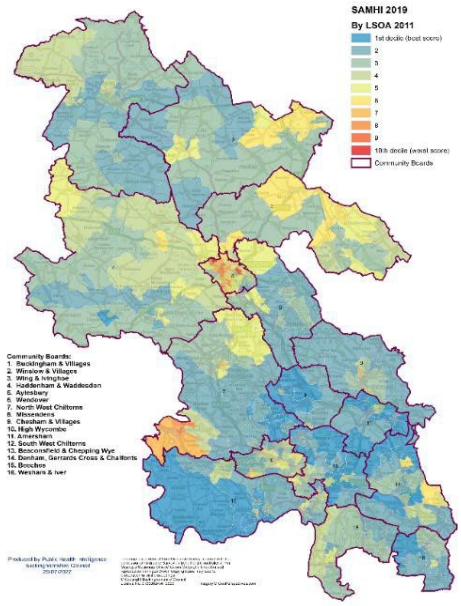
Source: Graphnet Enhanced Case Finder, accessed on 15th September 2022. NHS Digital Patients Registered at a GP Practice, September 2022. * Total prevalence will differ to those quoted above as looking at a different period.

Small Area Mental Health Index (SAMHI)

The Small Area Mental Health Index (SAMH) is a composite annual measure of population mental health for each Lower Super Output Area (LSOA) in England. The SAMHI combines data on mental health from multiple sources into a single index. These sources are NHS mental health related hospital attendances, prescribing of antidepressants, QOF depression data and Incapacity benefit and Employment support allowance for mental illness from the Department of Work and Pensions.

Figure 12 shows that in 2019, the majority (281 out of 319) of LSOAs in Buckinghamshire are in the "better" scoring deciles 1 to 5 with the "lower" scoring areas primarily clustered in the Aylesbury Community Board area.

Figure 12. Buckinghamshire Small Area Mental Health Index (SAMHI) for each Lower Super Output Area and Community Board, 2019



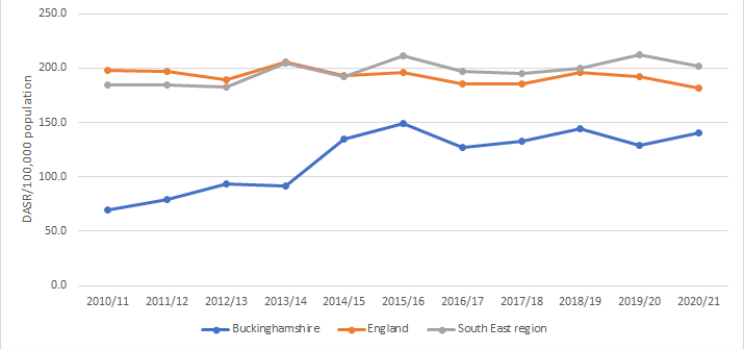
Source: Daras K, Barr B (2021), Small Area Mental Health Index (SAMHI) Version 4.0 [Open Dataset], Place-based Longitudinal Data Resource, DOI: 10.17638/datacat.liverpool.ac.uk/1188

3.3.3 **Self Harm – The Local Picture**

Self-harm results in approximately 110,000 inpatient admissions to hospital each year in England, 99% are emergency admissions[75]. Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves. There is a significant and persistent risk of future suicide following an episode of self-harm, around 50% of people who die by suicide had a history of self-harm and around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death[40].

In Buckinghamshire in 2020/21, the rate of emergency hospital admissions for intentional self-harm (All ages) was 140.6 per 100,000 population (740 people). This was significantly lower than England at 181.2 per 100,000, and the South East region at 201.9 per 100,000. The rate has significantly increased between 2010/11 and 2020/21. Between 2016/17 and 2020/21 the rate has been increasing (from 127 per 100,000; 657 people), although the difference is not statistically significant (Figure 13).

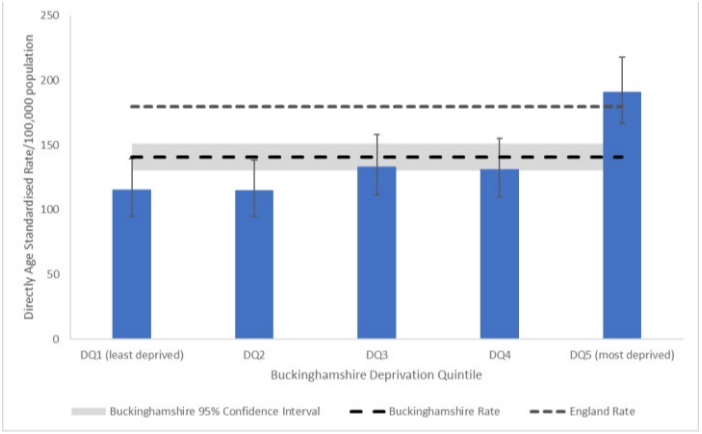
Figure 13: Buckinghamshire Hospital admission rate per 100,000 population as a result of self-harm (all ages), compared with the South East region and England average, 2011/12 to 2020/212011/12 to 2020/21



Source: Hospital Episode Statistics (HES), NHS Digital, England. Copyright © 2019. Office for National Statistics (ONS). Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

The rate of admissions for self-harm in all ages for 2020/21 for most Buckinghamshire deprivation quintiles were similar to the Buckinghamshire average, with the exception of the most deprived quintile which was more similar to the England average and significantly higher than all other quintiles (Figure 14).

Figure 14. Buckinghamshire hospital admission rate per 100,000 population as a result of self-harm (all ages) by deprivation quintile, compared to the England average, 2020/21



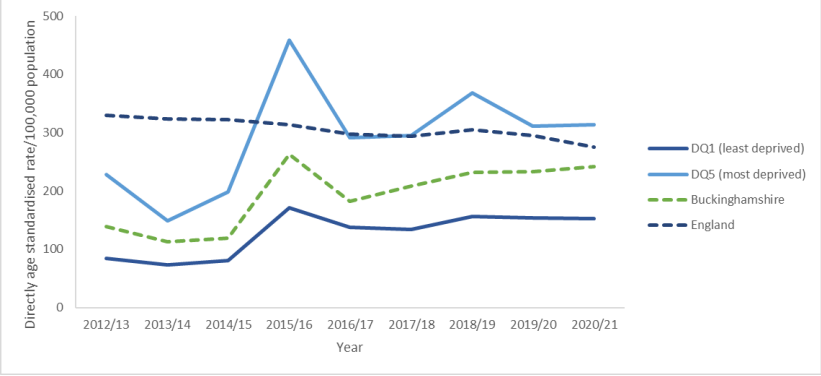
Source: Hospital Episode Statistics, Buckinghamshire Public Health Intelligence Team.

3.3.4 Hospital Admissions - The Local Picture

Mental Health Hospital Admissions (All Ages)

The rate of mental health hospital admissions[19] across all ages in Buckinghamshire has increased from 139.0 per 100,000 population in 2012/13 to 241.9 per 100,000 in 2020/21. Over the same period, the rate of hospital admissions decreased for England overall, from 329.6 in 2012/13 to 275.3 in 2020/21. However, the Buckinghamshire rate in 2020/21 was significantly below the England average. Since 2015/16 the rate of hospital admissions for the most deprived quintile in Buckinghamshire has been at or above the England average, whilst the least deprived quintile in Buckinghamshire has remained below the Buckinghamshire average (Figure 15). The gap between the two quintiles has also increased since the earlier years of the analysis and from 2012/13 to 2020/21 the most deprived quintile (DQ5) has remained significantly higher than the least deprived quintile (DQ1).

Figure 15. Buckinghamshire mental health hospital admissions in all ages by least and most deprived quintiles, compared to the England average, 2012/13 to 2020/21



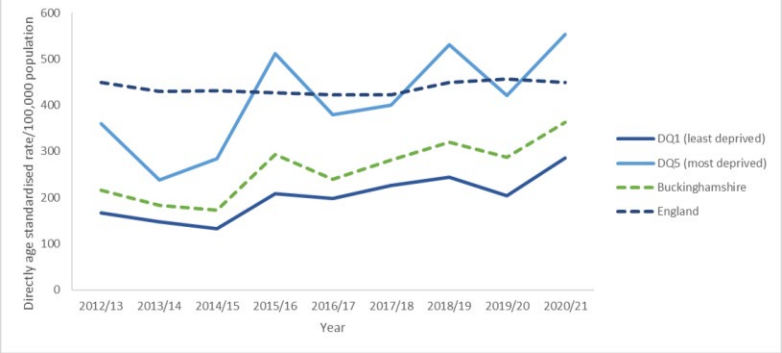
Source: Hospital Episode Statistics, Buckinghamshire Public Health Intelligence Team.

Mental Health Admissions (Aged 65+)

The rate of all mental health admissions among those aged 65 and over between 2018/19 and 2020/21 in Buckinghamshire (3-year pooled rate of 323.5 per 100,000 population) was significantly higher than the rate for all ages (236.0 per 100,000 population). Dementia accounts for 21% of all the admissions for the 65+ mental health hospital admissions. The rate for mental health hospital admissions (excluding dementia) was 258 per 100,000 65+ population.

Figure 16 shows single year mental health hospital admissions (all) in people aged 65 in Buckinghamshire increasing from 172.1 per 100,000 population in 2014/15 to 363.6 per 100,000 population in 2020/21. This is evident in both the most and least deprived areas, however the most deprived areas have significantly higher rates (553.1 per 100,000 population) than the least deprived areas (285.6 per 100,000 population) and are closer to the England rate.

Figure 16: Buckinghamshire mental health hospital admissions in those aged 65+ by least and most deprived quintiles, compared to the England average, 2012/13 to 2020/21



Source: Hospital Episode Statistics, Buckinghamshire Public Health Intelligence Team.

Mental Health Admissions by Ethnic Group

The ethnic minority group, with the highest proportion of mental health admissions in Buckinghamshire between 2018/19 and 2020/21 was Asian, followed by Other, Mixed and Black. Caution needs to be taken with the figures in the Table 6 due to the high number of 'not stated/known'.

Table 6: Buckinghamshire mental health hospital admissions in all ages broken down by ethnic group, 2018/19 to 2020/21

Broad ethnic groups	Count	%	Overall Buckinghamshire population %*
White	2,727	72.1	79.9
Mixed	78	2.1	3.5
Asian	183	4.8	12.4
Black	68	1.8	2.6
Other	107	2.8	1.6
Not stated/known	620	16.4	N/A
Total	**3,783**	**100.0**	**100.0**

Source: Hospital Episode Statistics, Buckinghamshire Public Health Intelligence Team.

* This is Census 2021 data.

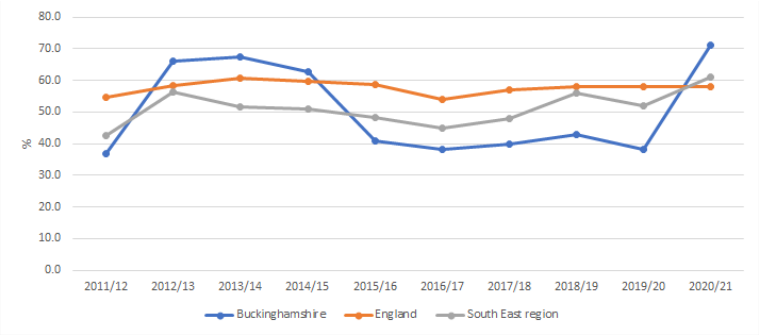
3.3.5 Adults in contact with secondary mental health services

Adults in contact with secondary mental health services who live in stable and appropriate accommodation

Integrated mental health services support people who are receiving treatment to function independently, by helping them with their relationships, to live at home and to access local services. Maintaining stable and appropriate accommodation and providing social care in the setting promotes personalised support and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care[76].

Figure 17 shows that nearly three quarters (71.0%) of adults that were in contact with secondary mental health services in Buckinghamshire in 2020/21 were in stable and appropriate accommodation. This was significantly higher than the England average of 58.0% and South East region average of 61.0%. Before 2020/21 the proportion in Buckinghamshire was significantly below the national average, however there has been a significant increase in 2020/21 from 38% in 2019/20. This increase could in part be due to better recording through the Mental Health Services Data Set (MHSDS) and a change in recording which took place in 2020/21 as well the impact of the COVID-19 pandemic. Note that the pandemic had a direct impact on health services and data should be treated with care for this period.

Figure 17: Buckinghamshire adults in contact with secondary mental health services (who live in stable and appropriate accommodation), compared to the South East region and England averages, 2011/12 to 2020/21



Source: NHS Digital. Measures from the Adult and Social Care Outcomes Framework. Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

Gaps in Employment

The Individual Placement Service (IPS) supports patients into employment. The proportion of IPS patients in paid employment is currently 11% (June 2022), this equates to 124 out of 1,082 adults. The Individual Placement Service (IPS) supports patients into employment. As part of the patients care plans, link workers support patients in each of the Community Mental Health Teams to make job applications, with interviews and beyond. The service is based on the principles of getting people into competitive employment for all who want to work. The service tries to find jobs that are consistent with people's preferences and works quickly by bringing employment specialists into clinical teams to develop relationships with employers based upon a person's work preferences. Unlimited, individualised support is provided for the person and their employer, alongside benefits counselling.

The gap in the employment rate between those who are in contact with secondary mental health services (aged 18 to 69 years) and on the Care Plan Approach, and the overall employment rate was 65.9 percentage points in Buckinghamshire in 2021/22. This was similar to the England average of 66.1 percentage points and the South East region average of 66.7 percentage points. The gap has significantly reduced from previous years (74.6 percentage points in 2019/20) when it is was significantly higher than the national average (67.2 percentage points).

The gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate was 6.5 percentage points in Buckinghamshire in 2021/22. This was not significantly different to the England average of 9.9 percentage points and the South East average of 8.1 percentage points.

Carers

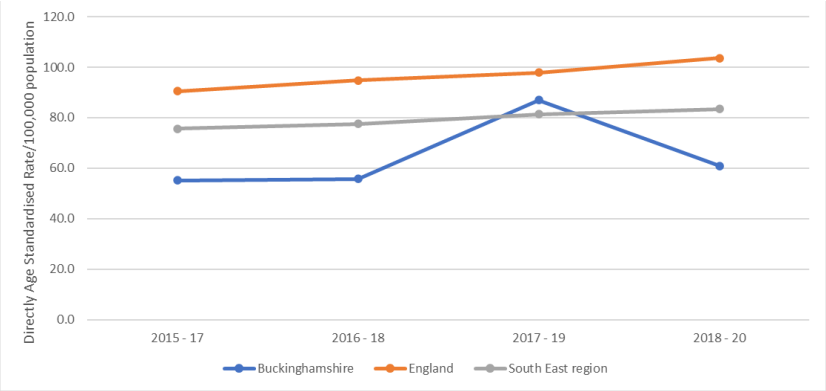
In 2021/22, of the 164 carer assessments completed, 79.9% (131) reported their physical or mental health is or at risk of deteriorating because of their caring role and 80.5% (132) reported their caring role impacts or is likely to impact their wellbeing.

Severe Mental Illness (SMI)

People with severe mental illness (SMI) make more use of secondary urgent and emergency care for both physical and mental health conditions, and experience higher premature mortality rates[77].

The death rate of adults aged 18 - 74 with SMI in Buckinghamshire in 2018-20 was 60.9 per 100,000 population (690 adults). This was significantly lower than the England average of 103.6 and the South East region average of 83.4. Between 2015-18 and 2018-20, the premature mortality rate in adults with SMI seems to be slowly increasing.

Figure 18: The premature mortality rate per 100,000 adult population with SMI in Buckinghamshire, compared to the South East region and England averages, 2015-17 to 2018-20



Source: NHS Digital Mental Health Services Data Set and its predecessors Office for National Statistics: Civil Registration of Deaths (via NHS Digital asset) Office for National Statistics mid-year population estimates. Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

In Buckinghamshire in 2018-20, the excess under 75 mortality risk in adults with SMI was more than four times the risk of premature mortality (416.8%) than adults without SMI. This was higher but not significantly different to the England average of 389.9%, and lower and not significantly different than the South East region average at 436.1%.

Health Checks for people with Severe Mental Illness (SMI)

People living with SMI face one of the greatest health inequality gaps in England. This population group is at risk of dying on average up to 15 to 20 years earlier than the general population, mostly due to preventable physical diseases. This inequality is the same for males but is greater for females. Females with SMI are 4.7 times more likely to die prematurely than females without SMI[78].

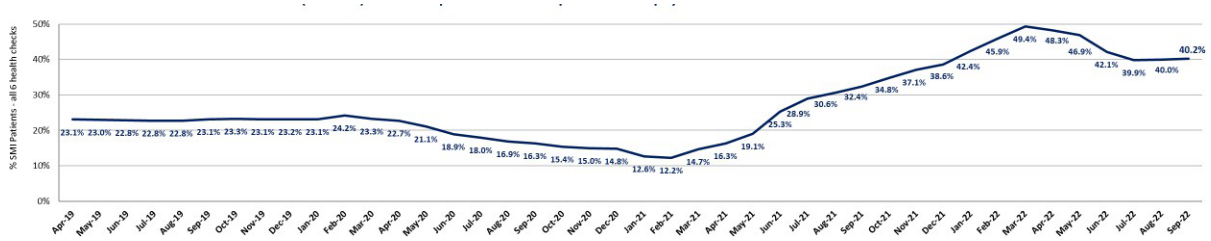
This disparity in health outcomes is partly due to physical health needs being overlooked, both in terms of identification and treatment. NHS England advise that these patients should be actively screened for preventable health conditions relating to a lack of physical activity, smoking and alcohol, such as obesity, diabetes, heart disease and cancer through an annual physical health check. The six elements of the SMI physical health check are measurement of

weight, blood pressure, blood lipids (including cholesterol), blood glucose, alcohol consumption and smoking status.

In addition to existing inequalities in the rate of premature mortality in people with SMI, research suggests that people with SMI have been disproportionately impacted by the COVID-19 pandemic, including higher mortality rates from COVID-19. There is a need to ensure that the physical health of people with SMI is protected. This includes ensuring that people with SMI receive their annual physical health checks and can access their flu and COVID-19 vaccinations (if eligible).

In January 2021, Buckinghamshire Primary Care Networks (PCNs) received NHS England Winter Funding as an incentive to increase the number of physical health checks performed for patients with SMI. Since this date the number of SMI health checks completed has increased significantly, peaking at 49.4% in March 2022 (Figure 19). The national target is 60%uptake.

Figure 19: Buckinghamshire percentage of SMI patients with a completed annual physical health check during the last 12 months, April 2019-September 2022



3.4 Suicide (all ages)

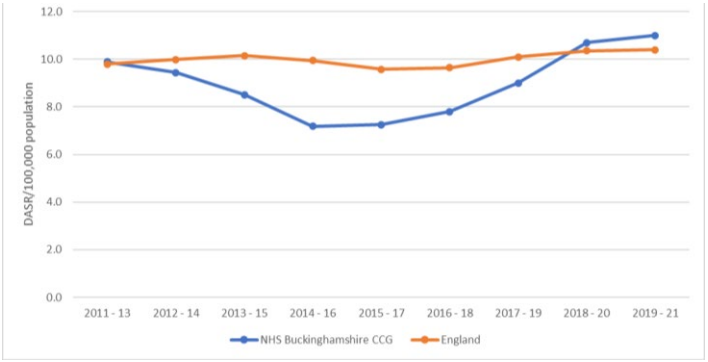
Death by suicide is a leading cause of years of life lost. Suicide is preventable and when someone dies by suicide, the effect on people that are close to them – family, friends, colleagues – can be profound. The impact can extend much wider, to those that have known them and the people in the community around them.

A large international review found that the most robust evidence to date indicated that suicide and self-harm behaviours either reduced, or did not change, during the COVID-19 pandemic[79]. However, the COVID-19 pandemic resulted in more people experiencing bereavement, loss of employment, financial difficulty and poor mental health - all known risk factors associated with suicide. Additionally, there are early indications that the cost-of-living crisis may increase deaths by suicide, with one survey finding as many as one in six people saying they had experienced suicidal thoughts or feelings as a direct result[80].

The suicide rate in Buckinghamshire was 11 per 100,000 population (152 people) during 2019-21. This was not significantly different to the England average of 10.4. Figure 20 shows a significant increase in Buckinghamshire from 2014-16 where the rate (7.2 per 100,000

population) was significantly below the England average, to the current rate in 2019-21 which is now similar to the England average.

Figure 20: The Buckinghamshire suicide rate per 100,000 population (all ages), compared to England average, 2011-13 to 2019-2021



Source: Office for National Statistics. Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

The Buckinghamshire Suicide Audit of local coroner's files for 2017-19 took place in 2022[v]. Of the 141 people who took their own lives during the audit period (all ages), 125 (89%) were resident in the Buckinghamshire area at the time of their death. The highest number of suicides were in Aylesbury and High Wycombe. There was no significant difference between the number of suicides in the least deprived (21%) and the most deprived areas (22%), this may be because the numbers in each quintile are small.

Men were more likely to die from suicide than women, the Buckinghamshire Suicide Audit found there were 95 suicides (67%) among males and 46 (33%) among females. The highest number of male suicides was among those aged 50-54, followed by 18–24-year-olds and 45–49-year-olds. The highest numbers of female suicides in Buckinghamshire were in the 70-74 age group and 50-54 age group.

Where ethnicity was recorded (92 cases), most cases (68 people) were recorded as White British. The only ethnic group, in addition to White British, which had more than five cases was the 'Asian or Asian British' group which had six cases.

Research suggests that there is a strong relationship between unemployment and suicide, especially among men. Of the 141, there were 60 cases (43%) in work at the time of their death, 31 (23%) people were retired and 23 (16%) were unemployed, with six of those 23 seeking work.

[v] Note the Audit uses a different definition to that of the Office of National Statistics . The audit includes deaths with a conclusion of 'suicide' and deaths caused by injury of undeterminable intent. The latter can be assigned a conclusion of 'narrative' or 'open'. ONS excludes narrative conclusions and collects and compare data by residence not county of death.

Self-harm and prior suicide attempts are the biggest risk factors for suicide. In Buckinghamshire, 32 (23%) of the 141 cases audited were recorded as having a history of self-harm, and 38 cases (27%) had a history of suicide attempts.

There were 39 cases (28%) out of the 141 known to secondary mental health services at time of death. Depression was the most common issue with 34 cases. There were 113 cases who had been in touch with their GP. Of these, 40 had a primary care plan and poor mental health was included in 19 of these 40 plans.

Other factors relating to their death included: physical health problems (19%), financial worries and debt (18%), abuse (12%) and substance misuse at time of death (8%). In addition, 27 cases (19%) had current or previous contact with the criminal justice system, which includes police, courts, probation and prisons.

There were 11 cases identified in the audit recorded as using substances at the time of their death (drugs or alcohol), with less than five cases recorded as being in drug and alcohol support services at time of death. There were less than 10 cases where social care was indicated in the records.

4 Current Services, Local Plans and Strategies

4.1 Mental Health Services – Overview

There is a wide range of mental health and wellbeing support offered across the life course in Buckinghamshire, from early intervention and prevention work to specialist and inpatient support. This is delivered by the commissioned mental health trust as well as provision (commissioned and not commissioned) by the voluntary sector through organisations such as Buckinghamshire Mind, Alzheimer's Society, Youth Concern and others.

This review of service delivery focuses on provision by the commissioned mental health provider, Oxford Health NHS Foundation Trust, across Buckinghamshire. Data provided (March 2019 to April 2022) encompasses those who have accessed the mental health trust who are residents of Buckinghamshire or registered to a GP practice within the Buckinghamshire boundaries of the Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care System (ICS).

4.2 Children and Young People's Mental Health Services

Services for children and young people are provided via the Children and Adolescent Mental Health Service (CAMHS) and funded via a Section 75 arrangement with a pooled budget between the BOB Integrated Care Board (ICB) and Buckinghamshire Council.

Support is provided via the following pathways with data provided against the Thrive Model framework (see 'Section 6. Summary Evidence - What Works' for more information).

4.2.1 Getting Advice: Single Point of Access

The Single Point of Access (SPA) processes all referrals (including self-referrals) into the CAMHS service. It offers consultation (pre-referral) to any professionals, families/carers concerned about a child or young person's mental health and signposting to other services. Referrals are triaged for onwards signposting or referral into the relevant pathway determined by need.

Digital services are also provided via Kooth, an online counselling and emotional well-being platform for children and young people, which is free at the point of use.

4.2.2 Mental Health Support Teams

Mental Health Support Teams (MHST) are a multi-functional collaborative incorporating workers from the Buckinghamshire Council Family Resilience Service and Youth Service, voluntary sector organisations and Education Mental Health Practitioners. They provide support to young people and their parents focusing on anxiety, low mood and behaviour difficulties. The Mental Health Support Teams work in education settings to provide advice, support and early help, including cognitive behavioural therapy (CBT) informed interventions, to children and young people identified as needing wellbeing support.

The teams offer support in educational settings including colleges, primary, secondary, special schools and pupil referral units. There are currently five teams in operation across Buckinghamshire (September 2022), reaching a pupil population of 40,000 and covering 93 schools in total: 57 primary schools, 18 secondary schools, two all through schools, four colleges, four pupil referral units and eight special schools.

Funding is allocated across the BOB ICB for MHST services to ensure population coverage against NHS Long Term Plan (LTP) targets. An additional team will be allocated, increasing reach to 48,000 pupils. Criteria for selection has been determined based on need and deprivation measures, including percentage of free school meals.

4.2.3 Getting Help

Children and young people accessing the Getting Help pathway receive support provided from Barnardo's Buddies focused on low mood, anxiety, low self-esteem, self-harm, emotional regulation and exposure work for phobias. They provide Cognitive behavioural therapy (CBT)/Dialectical behaviour therapy (DBT) informed work that can be supported in short, targeted interventions of up to 6 sessions (group or 1:1). For primary school age children, work is completed with parents/carers.

Getting More Help is a pathway for children and young people with moderate to severe mental health disorders including Depressive disorders, Anxiety disorders, Obsessive Compulsive disorder (OCD), Post Traumatic Stress Disorder (PTSD), Somatic syndromes, and Attachment Disorders. Support offered includes specialist assessments and a range of evidence-based interventions including CBT, systemic family therapy and psychotherapy. This pathway includes specialist pathways for:

- **Eating Disorders:** For children and young people where there is a concern about an eating disorder (anorexia nervosa, bulimia nervosa or eating disorder not otherwise specified). Support is offered based on need including family support and therapy, enhanced CBT (CBT-E) and individual therapy, parent support groups.

- **Intellectual Disability:** For children and young people where there is an identified emotional, mental health or behavioural difficulty, a diagnosed intellectual disability, or significant impairment of intellectual and social adaptive functioning (which significantly impacts mental health presentation). Children and young people accessing this pathway will usually have more complex health needs and highly risky behaviours.

- **Looked After and Adopted Children:** For children, young people and their carers who are potentially suffering significant emotional ill health/mental health problems and are either looked after by Buckinghamshire Council, adopted, or under a Special Guardianship Order.

- **Getting Risk Support (Crisis and Outreach):** The Crisis and Outreach services are for children and young people who present with significant risk factors associated with a mental health disorder including risk to self, to others or from others, poor history of compliance to treatment or medication and safeguarding concerns with multiagency involvement. They may have severe mental health problems including presentation of mania or acute psychosis. Crisis and Outreach services also work with children and young people within inpatient units to facilitate appropriate discharge and planning.

4.2.4 Thrive – Other Specialist Services

The Thrive model includes the following specialist services:

- **Dynamic Support Facilitation Team (Keyworkers Early Adopters):** For children and young people with a diagnosis of an Intellectual Disability and/or Autism. They must be either an inpatient or rated red or amber on the Dynamic Support Register and are at risk of admission to inpatient care. Buckinghamshire has been an NHS England early adopter site since 2021.

- **Neurodevelopmental (Children and Young People):** The assessment and diagnostic service for children and young people in Buckinghamshire is delivered by two providers: Oxford Health NHS Foundation Trust CAMHS and Buckinghamshire Healthcare Trust community paediatric service. The service covers pre-assessment support (via a third sector partner), diagnostic assessment for Autism and Attention-deficit/hyperactivity disorder (ADHD) presentation, prescription and getting medication levels right and post diagnostic support.

4.3 Perinatal (Maternal) Mental Health Services

Perinatal mental health services are provided via adult mental health services where children are under two years old.

4.3.1 Specialist Community Perinatal Mental Health

The Specialist Community Perinatal Mental Health (SPMHS) is for women with existing and new moderate to severe/complex perinatal mental ill health during the perinatal period, as well as for women with a previous history of moderate to severe/complex mental ill-health, who may be at risk of relapse during pregnancy. The SPMHS will provide proactive assessment and management of women's mental health during the perinatal period to support reduction in morbidity and the need for admission.

4.3.2 ReConnect

The ReConnect service offers support to parents where the child is under the age of 2 and the child or family is known to social care (i.e. Child Protection Plan, pre-court proceedings and/or high-risk child in need). The service works with parents/guardian to improve their child's emotional wellbeing, reducing the risk of relationship breakdown and/or children at risk of developing a disorganised attachment. A range of treatments to families is offered, including individual therapy, group therapy and parent-child video interaction work.

4.4 Adult Mental Health Services

4.4.1 Healthy Minds (Improving Access to Psychological Therapies)

The Improving Access to Psychological Therapies (IAPT) service provides assessment and treatment for adults and older adults who are experiencing low mood, anxiety, depression, or stress. This includes people with long term physical health conditions.

4.4.2 Early Intervention Psychosis Service

The service is to detect and, where found, treat psychosis from its first onset, so that young people can maximise their potential and minimise the disabling effects of mental illness. The service is accessible from primary sources within the access pathway and works across the CAMHS and Community Mental Health Services (CMHTs) for those aged 14 to 35.

4.4.3 Working Age and Older Age Adults Services

The - Community Mental Health Care team offer community-based services to support adult service users with severe, enduring and complex mental health problems, to manage symptoms of mental illness, and reduce risk, enhance quality of life and promote a strengths-based approach to recovery. The working age adult team supports those aged 18 to 65, and the older age adults' services supports those aged 65+, including those with a dementia diagnosis at any age.

4.4.4 Complex Needs Service

The Complex Needs Service supports adults with longstanding emotional and interpersonal difficulties, with diagnosed or suspected Personality Disorder. The service uses a predominantly therapeutic community model of treatment. This is a group-based psychosocial treatment model incorporating a variety of therapy modalities including psychodynamic, CBT, cognitive analytic therapy (CAT), mentalisation based therapy (MBT), creative and humanistic therapies, social therapy and occupational therapy.

4.4.5 Urgent Care Pathway

The Urgent Care Pathway provides a 24/7 alternative to Accident and Emergency, or inpatient psychiatric admission. It includes several teams that provide the entrance point to local mental health services for service users experiencing an emerging mental health crisis.

This includes the Crisis Resolution and Home Treatment Teams for people experiencing a deterioration in their mental health, and where possible, provides community care as an alternative to inpatient admission, a psychiatric liaison service at Stoke Mandeville Hospital in Aylesbury for people attending Accident and Emergency, in mental health crisis, Street Triage (which sees mental health nurses and Thames Valley Police working to support people in mental health crisis who come into contact with police) and Bucks Safe Haven, run by Bucks Mind and Oxford Health NHS Foundation Trust offering crisis support in a non-clinical environment.

4.4.6 Neurodevelopmental (Adults)

This provides a diagnostic assessment and post-diagnostic intervention service that is outcomes based and needs led, to support adults identified as having autism to access appropriate support to meet their health and social care needs.

4.4.7 Adult Inpatient Services

The Whiteleaf Centre in Aylesbury, run by Oxford Health NHS Foundation Trust, provides inpatient mental health service for people whose needs can no longer be managed safely in the community, due to the level of risk they pose to themselves or others. Services offer a therapeutically appropriate environment during mental health crisis, when all other alternatives to admission have been exhausted, or where safety and risk indicate that an inpatient admission is necessary (either informally or through detention under the Mental Health Act). The Centre has one female and one male acute ward, one mixed rehabilitation ward and one mixed older adult ward.

4.5 Demand Analysis

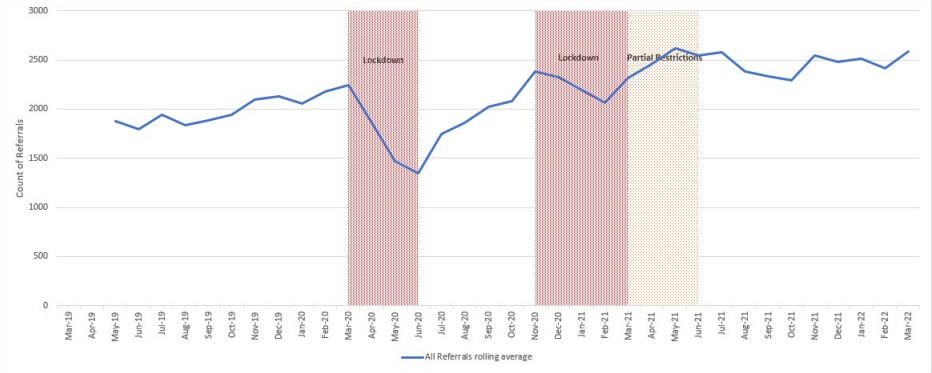
Between March 2019 and March 2022, the demand for mental health services in Buckinghamshire increased, and this has also coincided with the COVID-19 pandemic lockdowns and restrictions.

Referrals are identified by priority: routine within 28 days, urgent within seven days and emergency within 24 hours. The data presented below is for referrals between 2019/20 and 2021/22.

4.5.1 Mental Health Services - Referrals (all ages)

In March 2019 there were 1,943 referrals into mental health services in Buckinghamshire. Between February and June 2020, the number of referrals to mental health services steeply declined coinciding with the first COVID-19 lockdown period. Referrals had returned to pre COVID-19 levels by Autumn 2020. In later periods of COVID-19 restrictions (from November 2020 to February 2021) a smaller decrease in referrals was observed. Service referrals then steeply increased during Spring 2021 and have plateaued around 2,500 referrals since. At the end of the reporting period, March 2022, there were 2,782 referrals made (Figure 21).

Figure 21: Referrals to Buckinghamshire Mental Health Services, all ages, March 2019-March 2022



Services adopted new ways of working to facilitate access during the COVID-19 pandemic, a decrease in face-to-face appointments and an increase in telephone and digital communication methods. As restrictions eased face-to-face appointments increased but to date digital and telephone appointments remain higher than the pre-COVID-19 period.

4.5.2 Children and Young People - Mental Health Service Referrals

Referrals for CAMHS support come into the SPA. Referrals are triaged on the same day for onward signposting, or the appropriate pathway and level of urgency (routine, urgent, and emergency). Referrals for eating disorders come directly into the Eating Disorder pathway.

Routine referrals into the SPA and the Eating Disorders pathway increased between 2019/20 and 2021/22 whereas urgent and emergency referrals remained static (Table 7).

The Eating Disorder pathway has seen a sustained increase in referrals post COVID-19, and eating disorder referrals take up a greater proportion of all routine referrals compared to 2019/20. For October to March 2019/20 eating disorder referrals accounted for 43% of all routine referrals combined in Buckinghamshire compared to 66% in Oct to March 2021/20. The rate of increase has also been greater between these two periods, 11% increase for routine overall and 70% increase for children and young people eating disorders routine

referrals. The service also maintains individuals within the caseload for longer than other services due to the acuity and nature of the illness. This level of demand is not reflected within the referral data.

Routine and emergency referrals into the Getting Risk Support (crisis) pathway reduced, whereas urgent referrals increased.

Table 7: Average Monthly and Total Referrals in Buckinghamshire for CAMHS Pathways 2019/20 - 2021/22

Pathway	2019/20 R	2019/20 U	2019/20 E	2020/21 R	2020/21 U	2020/21 E	2021/22 R	2021/22 U	2021/22 E
Single Point of Access Monthly average	287	0	0.5	396	0.5	0	504	0	0
Total	3445	<5	6	4751	6	<5	6043	<5	<5
Eating Disorders Monthly average	7	<5	0	12	<5	0	15	<5	0
Total	83	11	0	149	9	<5	182	12	0
Getting Risk Support Monthly average	6	18	<5	5	26	0	<5	36	0
Total	68	221	44	57	312	<5	39	427	<5

*R = Routine, U = Urgent, E = Emergency

Table 8 shows waiting time data from NHS England[81] shows that whilst routine cases of eating disorders starting treatment have been increasing over the COVID-19 pandemic years, the proportion starting treatment within four weeks has reduced (33% in 2021/22 compared to 80.6% in 2018/19). This is a similar picture seen in the South East region with increasing numbers and a rise in waiting times (from 82.3% of routine cases completed within 4 weeks in 2018/19 to 63.8% in 2021/22).

Table 8: Children and Young People in Buckinghamshire (up to the age of 19 years) with an Eating Disorder and waiting times for patients starting treatment for an Eating Disorder, 2018/19 to 2021/22.

Source: NHS England

Year	Routine cases: number starting treatment	% within 4 weeks of a referral
2018/19	93	80.6%
2019/20	50	88%
2020/21	137	66.4%
2021/22	165	33%

4.5.3 Maternal (Perinatal) - Mental Health Service Referrals

During the COVID-19 pandemic, very rapid changes were made to perinatal mental health services across the UK. These included re-deployment of staff, reduction of face-to-face contact, and online/telephone assessment. This occurred on a background of huge recent expansion to perinatal health services. Between 2019/20 and 2021/22 routine perinatal mental health service referrals increased, urgent remained static and emergency decreased (Table 9).

Table 9: Average Monthly and Total Referrals in Buckinghamshire for Perinatal Mental Health, 2019/20 - 2021/22

Perinatal	2019/20 R	2019/20 U	2019/20 E	2020/21 R	2020/21 U	2020/21 E	2021/22 R	2021/22 U	2021/22 E
Average monthly referrals	21	4	2	20	3	0	31	4	2
Total referrals	254	50	5	237	39	<5	374	48	8

*R = Routine, U = Urgent, E = Emergency

Adult - Mental Health Service Referrals

Figure 21 and Table 10 show that between March 2019 and March 2022 routine and urgent referrals for working age adults into adult mental health services increased and emergency referrals slightly decreased. There was a decline in routine referrals during the first COVID-19 lockdown period between March and June 2020 followed by a broadly steady increase, with periods of restrictions not having the same impact on any decline in referrals as the earlier period of lockdown. Urgent referrals remained broadly static during the first lockdown and increased from May 2020 reaching a peak in May 2021. To date they remain significantly higher than pre-COVID-19 levels, more than doubling from 2,095 in 2019/20 to 4,891 in 2021/22. Table 10 also shows an increase in the referrals to the complex needs service from 520 in 2019/20 to 616 in 2021/22.

Figure 22: Rolling month averages for working age adults in Buckinghamshire by priority for routine, urgent and emergency, March 2019- March 2022

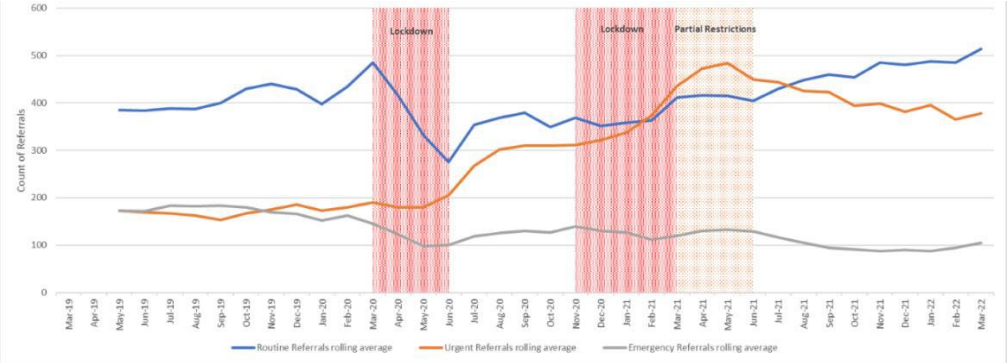


Table 10: Average Monthly and Total Referrals for Working Age Adults and Complex Needs Pathways in Buckinghamshire, 2019/20 - 2021/22

	2019/20 R	2019/20 U	2019/20 E	2020/21 R	2020/21 U	2020/21 E	2021/22 R	2021/22 U	2021/22 E
Working Age Adults Monthly average	425	175	167	354	318	120	465	408	104
Total	5095	2095	1998	4253	3813	1441	5578	4891	1252
Complex Needs Monthly average	43	0	-	47	0	-	51	0	-
Total	520	0		563	0		616	0	

*R = Routine, U = Urgent, E = Emergency

4.5.5 Referrals by Gender

Overall, services receive more referrals for females than for males. Referral rates significantly increased over the period (March 2019 to March 2022) for both males and females. This reflects an overall increasing trend in referrals. Comparing pre-COVID-19 pandemic (October 2019 to March 2020) with more recent data (October 2021 to March 2022) showing female referrals have increased at a significantly greater rate than for males, from 53.6% of referrals to 60% (Figure 23).

Figure 23: Referrals to Buckinghamshire Mental Health Services by gender , March 2019 to March 2022

Note that Perinatal Mental Health Services accept referrals only for women, although the service also supports partners as part of their support package. Support offered to family members is not included within referral data.

Within the CAMHS services, SPA referrals prior to February 2020 were higher for males than females, and this reflects the high number of referrals for males compared to females into the neurodevelopmental pathway. There are also higher numbers of referrals for males than females into the intellectual disability pathway, which is reflective of need. Referrals for females then increase over male referrals from July 2020 onwards.

The remainder of pathways within CAMHS see higher referrals and an increasing number of referrals for females than males. There are particularly large increases in referrals for females for Getting Risk Support and the Eating Disorder Pathways. Both the Getting Help and Getting More Help pathways receive higher number of referrals for females than males, with referrals for males remaining static and slightly decreasing over the period.

Table 11: Average Monthly and Total Referrals per month in Buckinghamshire by gender for five CAMHS pathways, 2019/20 - 2021/22

Pathway	19/20 F	19/20 M	20/21 F	20/21 M	21/22 F	21/22 M
Single Point of Access Monthly average	122	165	208	188	281	223
Total	1468	1985	2494	2257	3375	2671
Neurodevelopmental Monthly average	55	103	58	74	62	91
Total	664	1240	696	887	863	1091
Intellectual Disability Monthly average	1	4	2	3	2	4
Total	13	42	13	23	22	50
Getting Risk Support Monthly average	20	7	26	5	32	7
Total	245	88	308	63	380	86
Eating Disorder Monthly average	7	1	12	2	15	2
Total	87	7	149	9	183	11

In adult Mental Health Services, again there are increased numbers of referrals for females compared to males. There are significantly higher number of referrals for females within adult eating disorders. Within the community mental health services, for older adults' referrals for females increased post the June 2020 COVID-19 lockdown, with referrals continuing to increase throughout the period. For men, referral rates were similar across the period. Within the working age adult services, whilst there was a small increase in referrals for men, there was a much larger increase in referrals for females post the end of the February 2021 restrictions and into 2021/22 (Table 12).

Table 12: Average Monthly and Total Referrals per month in Buckinghamshire by gender for three Adult Mental Health Services pathways, 2019/20 - 2021/22

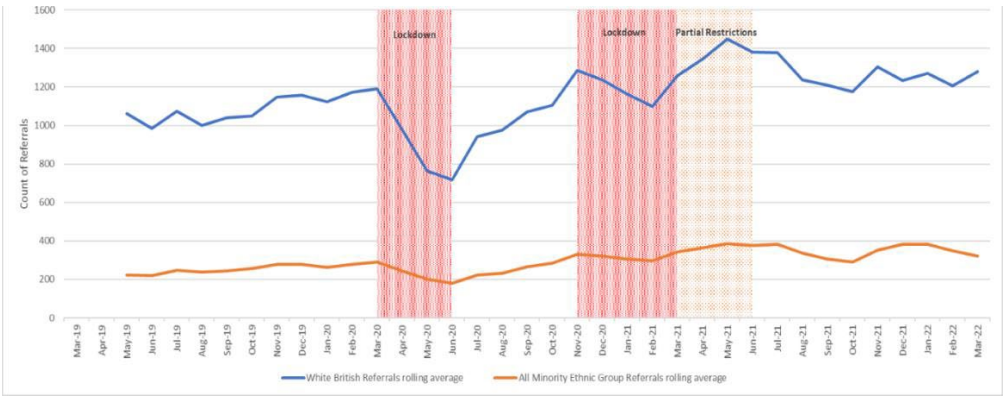
Pathway	19/20 F	19/20 M	20/21 F	20/21 M	21/22 F	21/22 M
Eating Disorders Monthly average	17	1	16	2	19	3
Total	199	10	191	19	226	23
Older Adults Monthly average	137	111	122	84	159	110
Total	1646	1328	1466	1004	1902	1319
Working Age Adults Monthly average	414	352	439	353	567	409
Total	4964	4221	5266	4237	6802	4904

4.5.6 **Referrals by Ethnicity**

Figure 24 shows referrals by ethnic group and it follows the same general trends observed in the general population, coinciding with COVID-19 lockdowns and restrictions. Overall, there has been an increase in referrals, which is reflective of the increase in referrals to mental health services the whole population including all ethnic groups.

There are higher numbers of individuals accessing services from white ethnic groups compared to other ethnic groups, and this is reflected across all service pathways. There are insufficient data to complete fuller analysis at pathway level by ethnic group. This is due to numbers of referrals for those from ethnic minority groups being small in comparison to white groups, and a proportion of service users where no ethnic group has been recorded as part of the referral. There are no significant differences in the trends across the time-period.

Figure 24: Referrals to Buckinghamshire Mental Health Services by ethnicity, March 2019 to March 2022



For children and young people, access to online services provided by Kooth suggests that those who are less likely to access traditional services are in some cases accessing online

support. For example, at the end of 2021/22, of 1533 new online registrations to Kooth 31.6% identified as coming from an ethnic minority group.

4.5.7 Referrals by Deprivation

The greatest number of referrals received into all services are from residents in the most deprived fifth (or quintile) of the Buckinghamshire population (DQ5). Referrals get lower for each category and are lowest in the least deprived fifth of the population (DQ1). There are no statistically significant differences in referral rate between the quintiles.

The majority of perinatal referrals are from the most deprived fifth of the population, particularly increasing from September 2019 until February 2020. Referrals from Deprivation Category 3 increase from November 2021, above all other referrals before decreasing from January 2022.

Within CAMHS services, referrals from SPA, Getting More Help and Neurodevelopmental follow the main referral trajectories and patterns. The Getting Help pathway also follows the main trends, however there is an increase in referrals from Deprivation Category 2 above all other categories from January 2021, peaking in April 2021, before returning to the main trajectory in July 2021.

The Eating Disorder pathway shows increasing number of referrals for those from the least deprived quintiles of the population (DQ2 and DQ1) from Autumn 2020. Referrals from the least deprived fifth of the population remain higher than all other categories from March 2021 until January 2022.

For adult services, the most deprived fifth of the population has higher referrals than all other groups throughout the whole time-period for the service pathways of adults of working age, complex needs and psychological therapies. The older adult pathway has a higher number of referrals from the least deprived quintile than other groups throughout the majority of the period, with similar number of referrals for all other categories.

4.6 Stakeholder Engagement and Feedback

Services and commissioners undertake regular engagement, feedback and coproduction activities both with service users and their families and/or carers, organisations and professionals who interact with services, as well as the wider public within Buckinghamshire.

Engaging with a wide range of stakeholders enables services and commissioners to ensure that all aspects of health care are improved. This includes patient safety, experience and health outcomes. Working in partnership ensures that better decisions about service delivery and changes are made, learning from the experiences of those who access services, as well as considering gaps in service delivery. It enables health inequalities to be addressed, by understanding Buckinghamshire population needs, and developing solutions with them[82].

4.6.1 **Children and Young People's Services**

Article 12 is a national requirement for commissioned services to engage with children, young people parents and carers. In Buckinghamshire there is a full-time participation worker who supports this and a service user group which inputs into transformation plans and has become an integral part of the CAMHS service.

During 2020/21 the service completed the National Youth Agency, Hear by Right assessment and validation process. This is designed to help organisations achieve best practice in the safe, sound and sustainable participation of children and young people in the services and activities they take part in. The service achieved the higher Flagship level award.

A Parent Dialogue Group (Previously known as Parent Advisory Group (PAG)) meets four times per year. The group includes parents from various backgrounds whose child/young person has used the service. It offers insights on experiences and recommends how services can be improved.

The Neuro-Developmental Parental Dialogue meets four times a year and enables parents and carers to feedback specifically on the cross-provider pathway arrangements, pre- and post-diagnostic support offer across the Neuro-Development Diagnostic Clinic (NDC), as well as broadly across the CAMHS service offer.

A stakeholder survey was completed in October 2021 for children, young people, parents and carers and professionals in contact with CAMHS services. The following key themes were identified as critical areas of development and have now been integrated into service development plans:

- Management of referrals including waiting times and communication of referral outcomes.
- Transitions to adult services and services for young adults aged 16 to 25.
- Care leavers and looked after children.
- Reporting outcomes to show how the service has made a difference.
- Developing links and pathways across the early help offer within Buckinghamshire, including access to support for early intervention and prevention.
- Addressing waiting times for neurodevelopmental assessments and development of the pre and post diagnostic support pathway.
- Schools knowing who to contact in CAMHS and links between education and mental health services, including an increased MHST offer.
- Response to crisis for children with complex needs, including opportunities to prevent admission to inpatient mental health care.

- Children who are not in education, employment or training (NEET) and those with Emotional Based School Avoidance.
- Support for parents/carers in helping the child/young person understand their diagnosis.
- Development of the eating disorder pathway.

4.6.2 Adult Services

Healthwatch Bucks are an independent organisation set up by the government to ensure that health and social care services put the experiences of people at the heart of their work. Healthwatch Bucks have undertaken focus groups with stakeholders on behalf of the mental health provider. The feedback collected will provide information about barriers to accessing mental health services, in conjunction with the development of the Community Mental Health Framework.

Feedback is focused on health inequalities, collecting information from those who are from LGBT+ backgrounds, minority ethnic backgrounds, those living in areas of deprivation and those who have experienced homelessness or domestic abuse. The analysis will be available Spring 2023.

5 Summary of Evidence – What Works

Improving the population's mental health and wellbeing, and preventing mental illness and suicide is a key priority for public health. Like much of public health, this priority requires action across many sectors, including those working across early years, education, health and social care, business, welfare and housing, criminal justice, neighbourhoods and communities. The mental health and wellbeing of the population is influenced throughout the life-course, from birth to older age and by individual, family, community and society level factors.

5.1 National Strategy and Guidance

National strategy and guidance emphasise the benefits of promoting positive mental wellbeing to the individual and society, and the importance of shifting the focus to preventing mental ill-health.

The NHS Five Year Forward View (NHS FYFV)[83], envisioned that local communities would be supported to develop effective Mental Health Prevention plans by using the best data available to commission the right mix of services to meet local needs. Also, that plans should focus on public mental health, including promoting good mental health, addressing the wider social determinants of mental health problems, local approaches to challenging stigma, and targeting at risk groups with proven interventions.

The prevention agenda is a key policy driver for the local authority, Adult Social Care, Public Health, the NHS and other key partners, as has been highlighted in the NHS Long Term Plan[84]. The plan sets out a vision for the NHS, not just to treat illness but also to support people to live healthily, and to help people with long-term conditions to self-manage and prevent emerging issues from worsening.

An important recent example of investment in prevention is that of the implementation of Mental Health Support Teams in schools and colleges following the green paper on Transforming Children and Young People's Mental Health Provision.

5.2 Local Strategy and Guidance

The Buckinghamshire Joint Local Health and Wellbeing Strategy[85] makes a commitment to take a preventative approach where possible to ensure people are healthy physically, mentally and emotionally. Through its priorities (Start Well, Live Well and Age Well), it commits to improve mental health support across the life-course.

The Public Health and Community Safety Service Plan[86] includes a priority to work with residents, communities and partners to improve mental health and wellbeing for key groups and to prevent suicide.

The Children and Young People's Mental Health and Emotional Wellbeing Local Transformation Plan is a nationally NHS mandated document and sets out how local services will invest resources to improve children and young people's mental health across the 'whole system', meeting both the NHS Long Term Plan and locally based targets. It has been in place across the system since 2015 and the plan is in the process of being refreshed for 2023[87].

The strategies align with the priorities set out in the NHS FYFV and NHS Long Term Plan; to have an integrated mental and physical health approach, to promote good mental health and prevent poor mental health by helping people lead better lives as equal citizens, and to ensure that everyone has equal opportunity to get the best start in life, to live well and to age well.

5.3 What Works - Children and Young People

Prevention and early intervention are key at this stage in life. Mental health promotion activities can help children develop positive mental health and wellbeing and prevent mental illness.

Pre-school and early education programmes are highlighted in the Under 5's Healthy Child Programme and results in improvements in cognitive skills, school readiness, academic achievement and family outcomes, including siblings. They are also effective in preventing emotional and conduct disorder.

As children grow older, whole school approaches to mental health promotion interventions can improve wellbeing, with resulting benefits for academic performance, social and emotional skills and classroom behaviour. The following are good example guides for promoting emotional and mental wellbeing in schools and colleges:

- Public Health England (PHE) guidance on a whole school and college approach to promoting children and young people's emotional health and wellbeing[88].
- The NICE Guideline NG223 for 'Social, emotional and mental wellbeing in primary and secondary education'[89] aims to promote good social, emotional and psychological health to protect children and young people against behavioural and health problems. It covers ways to support social, emotional and mental wellbeing in children and young people in primary and secondary education (key stages 1 to 5), and people 25 years and under with special educational needs or disability in further education colleges.

The Healthy Child Programme, introduced in 2009 offers routine development reviews lead by school nurses for those aged 5-19 years old. High impact areas include ensuring resilience and wellbeing, promoting healthy lifestyles, keeping safe and supporting the transition to adulthood.

Child and young people mental health services employ the iTHRIVE model[90]. The NHS Long Term Plan recommended the iTHRIVE framework (Figure 25) as a model for Children and Adolescent Mental Health Service (CAMHS) to distinguish between support and treatment and categorises people by type of input they require.

Figure 25: CAMHS iThrive Model

The central group of 'thriving' focusses on broader population need that gets supported by public health interventions. The four outer groups distinguish between the need of individuals, the skill mix needed to meet these needs, the main terminology used to describe this need (e.g., wellbeing, ill health, or support), and resources needed to meet those needs. They do not distinguish between severity or type of problem.

This model also extends beyond 18–25-year-olds, considering current transition arrangements between children and adult services.

5.4 What Works - Perinatal (Maternal)

Supporting parents and carers is key to promoting children's mental health during the perinatal phase and in the early years. A secure parent/child relationship is a building block

for the development of positive attachment and helps to build emotional resilience in children. The following are particularly supported in the literature:

- Promotion of sensitive parenting and child development.
- Early years education programmes.
- Fostering greater involvement of fathers in parenting.
- Techniques to promote a trusting relationship and develop problem solving abilities among parents.
- Social support or counselling for mothers experiencing depression or anxiety.
- Intensive support through for example Family Nurse Partnerships to at-risk first-time mothers.
- The NICE Clinical Guideline CG192[91] for 'Antenatal and postnatal mental health: clinical management and service guidance' covers recognising, assessing and treating mental health problems in women who are planning to have a baby, are pregnant, or have had a baby or been pregnant in the past year. It covers depression, anxiety disorders, eating disorders, drug- and alcohol-use disorders and severe mental illness (such as psychosis, bipolar disorder and schizophrenia). It promotes early detection and good management of mental health problems to improve women's quality of life during pregnancy and in the year after giving birth.
- The Healthy Child Programme introduced in 2009 offers routine development reviews lead by health visitors for those aged 0-5. High impact areas include promoting breast feeding, maternal mental health, managing minor illnesses and ensuring healthy weight and nutrition.

5.5 What Works - Adults

The following have good evidence for the improvement of public mental health in adults:

- Housing interventions such as re-housing; supported housing for high-risk groups and families; and interventions that address fuel poverty.
- Physical activity is associated with reductions in depression, improved wellbeing, and better cognitive function.
- Access to green and open spaces.
- Positive psychology interventions and mindfulness promote positive thoughts and emotions.

- Secure employment, support for unemployed people, and work based mental health and stress management interventions.
- The NICE Guideline NG13[92] for 'Workplace health: management practices' covers how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of line managers.
- Improving Access to Psychological Therapies (IAPT) services provide evidence-based psychological therapies to people with anxiety disorders and depression. NICE guidance is available for a range of conditions managed by IAPT[93].
- The Five Ways to Wellbeing[94] approach has been widely adopted by the NHS, local authorities and mental health charities as a framework for providing advice and interventions to improve people's resilience and feelings of wellbeing. They are based on five actions (1. To connect, 2. To be active, 3. To take notice, 4. To keep learning and 5. To give) which are sufficiently broad in scope to enable individuals at varying levels to take up.

There is evidence that the following interventions can have a beneficial effect on mental health and wellbeing in older adults:

- Befriending programmes.
- Volunteering opportunities.
- Addressing sensory impairment such as hearing loss.
- Physical activity programmes.
- Interventions to promote household warmth.
- Interventions to prevent social isolation.
- The NICE Guideline NG32[95] for 'Older people: independence and mental wellbeing' covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline.
- NICE also recommends a range of activities for older people including support sessions to assist with daily routines and selfcare, community based physical activity programmes, walking schemes and training for practitioners - A quick guide is available for registered managers of care homes for promoting positive mental wellbeing for older people[96].
- The NICE Quality Standard QS50[97] for 'Mental wellbeing of older people in care homes' covers the mental wellbeing of older people (aged 65 and over) receiving care in care homes (including residential and nursing accommodation, day care and respite care). It focuses on support for people to improve their mental wellbeing so that they can

stay as well and independent as possible. It describes high-quality care in priority areas for improvement.

6 Recommendations

Following review of local and national data sets, for the local area to consider the following recommendations:

1. Across all ages and service areas, undertake work to improve access, experience and outcomes for those from deprived and ethnic minority groups. This should include robust data collection, provision of information about mental health support, awareness of support available to address stigma and engaging communities to ensure services meet their needs.
2. Across all ages and service areas, consider opportunities to promote information and awareness of support available to men, where access to services is lower, and female referrals have increased significantly compared to male referrals.
3. Embed action to strengthen perinatal mental health services to ensure women are appropriately supported.
4. Identify opportunities to improve and protect the mental health and well-being of children and young people, with an emphasis on addressing mental health inequalities and responding to emerging priorities, such as self-harm and eating disorders.
5. Review data collection and reporting mechanisms to identify those with co-morbid mental health needs, which may include, but is not limited to, those with learning disabilities and/or autism. And consider actions that required for identified groups to improve access, experience and outcomes.
6. Ensure equity across the local area for patient access to eating disorder services for all age groups, in line with the NHS Long Term Plan recommendations.
7. Work with partners across the Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care System (ICS), including the Provider Collaborative, to review the local offer of mental health inpatient services or alternatives to inpatient care for children and young people, such as hospital at home or day services.
8. Further investigate the number of mental health inpatient admissions for older people aged 65+, including reasons for admission, review the support package and early interventions to reduce inpatient admissions where appropriate.

9. Consider further utilisation of local data down to community board level to ensure that resources are focused on populations with greatest level of need, for example to target support at those within the most deprived groups and Opportunity Bucks (levelling up) wards.

10. Review the stakeholder feedback for adult services, to be available Spring 2023, and identify further actions and service development that may be required.

11. Consider reviewing the utilisation of digital services in delivery of mental health services, including how those from digitally excluded communities can be supported to access mental health services.

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