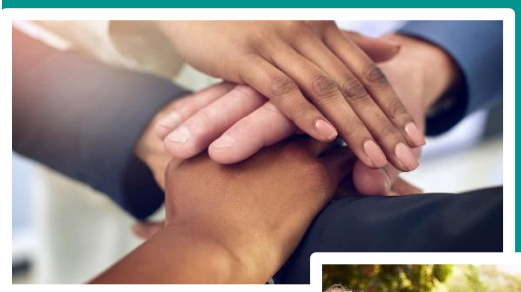
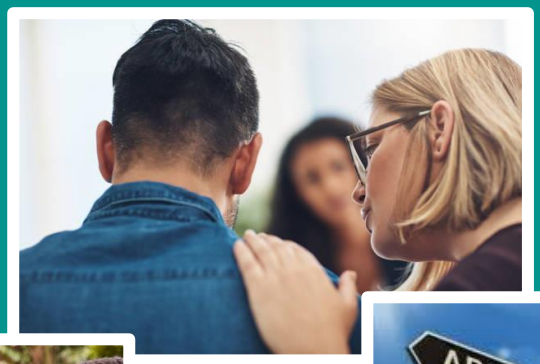
PUBLIC HEALTH





Joint Strategic Needs Assessment (JSNA)

Mental Health and Dementia Needs Assessment

East Riding of Yorkshire Council

EAST RIDING
OF YORKSHIRE COUNCIL

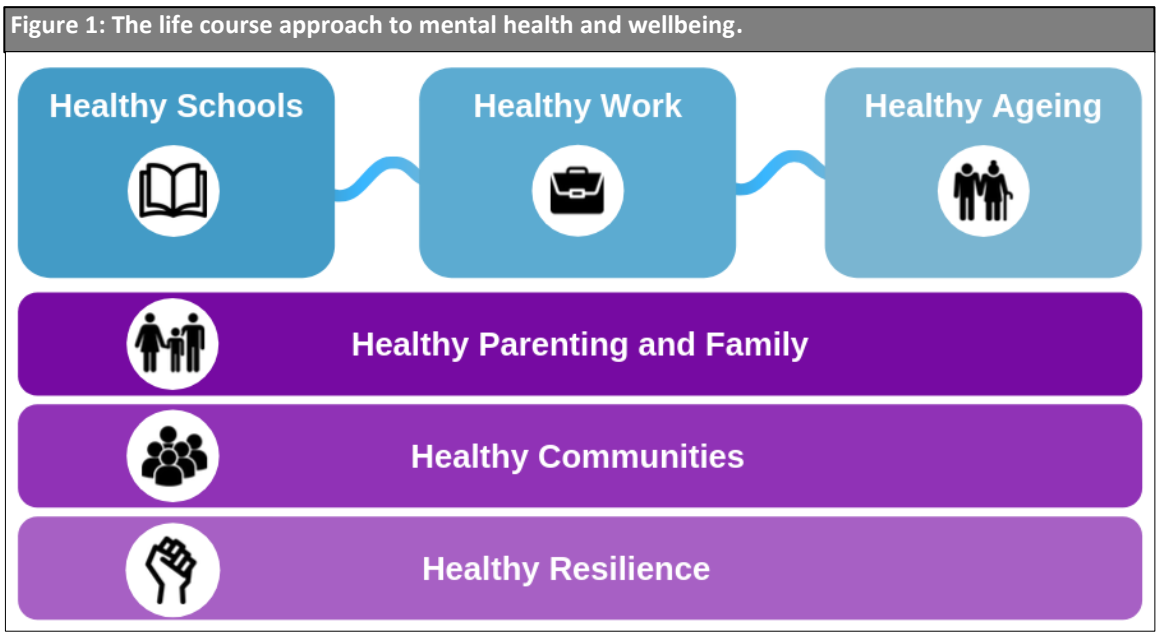
Executive Summary:

Mental health for each individual is different and is affected by individual factors and experiences, social interaction, social structures and resources, in addition to cultural values. An individual's mental health is influenced throughout the life course and events throughout life can impact each individual differently. Mental health conditions affect more than 25% of people at any time and no other health condition matches this in terms of prevalence, persistence and breadth of impact.

Mental health is a public health issue and reducing the prevalence of mental health conditions is one of public health's most major challenges. The promotion of wellbeing and prevention of mental health problems are crucial as mental health and physical health are linked.

A mental health and dementia needs assessment of the population with mental health problems in the East Riding of Yorkshire (ERY) across the various life course stages was undertaken by the Public Health team at East Riding of Yorkshire council (ERYC). The life course approach has been used to focus on the factors which can influence a healthy start to life and identify the different environmental, social and economic factors that can have profound influence over mental health and wellbeing (figure 1). Through a literature review and using national, regional and local data sources, this needs assessment was produced.

Figure 1: The life course approach to mental health and wellbeing.



Key data findings:

Prevalence:

- ERYC has fairly good mental health outcomes for its financial budget, compared to other local authorities. However, not all mental health outcomes are better than peer comparators.
- 8.9% of ERY children (aged 5-16 years) experience mental health disorders and 1.4% of school age children have emotional and mental health needs both these rates are statistically similar to national average.
- Vulnerable children and young people experience more mental health problems than other groups.
- 13.1% of ERY pupils have Special Educational Needs, significantly lower than England average (14.4%).
- 59% of ERY children aged 15 experience bullying which is significantly worse than national average of 55%.
- 14.2% of NHS ERY CCG patients aged 16 and over experience common mental health problems compared to 14.4% of NHS Vale of York CCG patients, 20.5% of NHS Hull CCG patients. NHS ERY CCG has a lower estimated prevalence than compared to the estimates for England (16.9%).
- More than half (52.4%) of the social care users experiencing depression and anxiety.
- According to PANSI 9.8% (~33,000) of ERY residents have long-term mental health problems and this is expected to increase to 10.6% (~34,000) by 2025.

Vulnerable Groups:

- 21.2% of benefit claims are for mental and behavioural disorders, which is lower than the England average.
- In ERY, 76% of 16-64 year olds were in employment in 2016/17, 3.8% were unemployed and 20.6% were economically inactive.
- Across the region there are 32,000 farm workers. This population are high risk for poor mental health.
- Carers are vulnerable to poor mental health outcomes. Within ERY, 2.6% of the population provide unpaid care which is significantly worse than the national (2.4%) proportion.
- The recorded prevalence of dementia in the over-65 population is approximately 4% which is lower than the England prevalence of 4.3%. ERY has a high 65+ population and a high expected prevalence of dementia.
- 47.4 per 1000 of ERY patients are in contact with mental health or learning disability services which is significantly higher than national average (38.7 per 1000).
- Within ERY, a high proportion of the population is of retirement age or older.
- Suicide rates in males within ERY is twice that of females. The suicide rate in ERY is higher to the national and regional rate.

Service Use:

- Hospital admissions for intentional self-harm are significantly lower in ERY (160.7 per 100,000) than compared to England (183.5 per 100,000).
- Hospital admissions for children with mental health conditions (0-17 years) in the ERY was 70.2 per 100,000 (2018) which was similar to the national average rate of 84.7 per 100,000.
- From 2015/17, there have been 110 premature deaths due to mental and behavioural conditions, and 61 deaths due to intentional self-harm.
- In a 6-month period, ERY social prescribing received 589 referrals to the service for social isolation and loneliness, for individuals' aged 20-95 years.
- In ERY, 20-24 year olds have the highest self-harm hospital admission rates (463 per 100,000 in 2017/18).
- There are significantly higher rates of prescribing for mental health related disorders in ERY (69.4 per 1000; ~10,000 drug items on average every quarter) compared to the national average (62.4 per 1000).
- The percentage of ERY CCG patients with schizophrenia, bipolar affective disorder and other psychoses on the Care Programme Approach (CPA) is significantly lower than the national average (71.7% compared to 78.4%).
- In 2018/19, 13,415 IAPT referrals were received by NHS ERY CCG to mental health services which was significantly higher than the England number of referrals.

Service Review:

According to the Public Health England Spend and Outcome Tool (SPOT), Public Health at ERYC has a lower spend than other local authorities and mental health outcomes are generally higher. However, public mental health spend is low and outcomes for hospital admissions relating to mental health conditions are worse (low spend and worse outcome). Some of the outcome indicators from adult services (like people in contact with mental health in employment, stable accommodation and under 75 mortality rates) are significantly better than England average.

The NHS East Riding of Yorkshire CCG expenditure on common mental health disorder prescriptions in primary care settings (i.e. antidepressants and venlafaxine) is significantly higher than the national average. Outcomes related to Improving Access to Psychological Therapies (IAPT) are similar to the national average (see section 8.19 for more information).

At present, a wide range of services are available to support and improve the mental health and wellbeing of the ERY population.

The Improving Access to Psychological Therapies (IAPT) programme has seen an improvement across the country for patient access of mental health services. According to the Psychological Therapies Annual report on the use of IAPT services England 2018/19, 13,415 referrals were received by NHS ERY CCG to mental health services. Within the same period, 6470 referrals entered treatment and 5285 clients finished treatment. One of the aims of the IAPT programme is to ensure that patients referred for IAPT services do not wait longer than necessary to begin their treatment. Government targets for waiting times have been introduced and are based on referrals that finished a course of treatment. Government targets are that 75% of patients are seen within 6 weeks and 95% are seen within 18 weeks.

The Care Programme Approach is the system which coordinates the care of many specialist mental health service patients. CPA requires health and social services to combine their assessments to make sure everybody requiring CPA receives properly assessed, planned and coordinated care. By the end of 2018/19, ERY CCG people on CPA was significantly lower (71.7%) than the national average (78.4%). During the same period, the proportion of all people in contact with mental health services on CPA is significantly better (49%, 8715 people) than the national average (15%) and neighbour CCGs. Information from NHS Digital indicates for 2018/19 the proportion of people using NHS funded secondary mental health, learning disabilities and autism services on CPA was 20% for the ERY compared to the England proportion of 10.5%.

Within the ERY, NHS, third sector and local authority commissioned services work to reduce the incidence and prevalence of mental health conditions. Within the local area there is the availability of CAMHS, counselling and cognitive behavioural therapy (CBT).

SMASH is a term-long group programme which works with young people who have complex systemic issues affecting their mental health. These children may not have mental health issues which meet the threshold for CAMHS intervention.

The Community Mental Health Services for adults in the ERY are recovery based community mental health services for those within the county who have enduring mental health problems. This is a partnership service between ERYC and Humber Teaching NHS Foundation Trust, except from Pocklington and Stamford Bridge where mental health services are provided separately by Tees Esk Wear and Valleys NHS Trust and ERYC.

Following the publication of the Adult Mental Health and Dementia System Strategy 2018-2023, further effort has been made in the screening and diagnoses of dementia within ERY. Additionally, there is now a dementia

specific sub-group called 'Dementia Delivery Group'. This is a system wide group led by the Adult Social Care service at ERYC.

Future Service Demand:

In 2020, the number of people aged 18-64 years with a common mental health disorder in the ERY is estimated to be around 35,500 people by the Projecting Adult Needs and Service Information System (PANSI). Other mental illnesses, such as personality disorder and psychoses, are also projected to increase over the next 10 years, but at a lower rate.

In the ERY, currently 2705 people (aged 18+) have Autistic Spectrum Disorders and this is projected to increase to 2751 by 2025. In 2019, 4542 people aged 18-64 years and 1856 people aged 65+ had a learning disability in the ERY. By 2025, the number of people with learning disability is likely to change to 4420 people (18-64 years) and 2049 people (aged 65+). As per the Autistica charity report, autistic adults with a learning disability are 40-times more likely to die prematurely. Autistic adults without a learning disability are 9-times more likely to die from suicide.

The ERY population aged 65 years and over is projected by POPPI (Projecting Older People Population Information System), to increase from 88,700 in 2019 to 90,100 by 2020 and 98,300 by 2025. Rates for the prevalence of depression and severe depression, applied to these population figures, suggest there are currently an estimated 7,588 people aged 65 and over with depression in ERY and this is projected to increase to 7,723 by 2020 and to 8,398 by 2025. So by 2020, there is a projected 2% rise in the number of older people with depression in ERY, and a 10% rise in that group by 2025, which may be attributable to the increase in this population.

Recommendations:

- With the ageing population of the ERY, it is recommended good mental health is promoted in a way that best reaches and is appropriate to older people.
- Early prevention of mental health issues should be considered for the entire population, including the increased availability of resilience training schemes such as SMASH, ELSA, mindfulness, mental health first aid and mental health interventions by social prescribing.
- Link with Primary Care Networks to identify local patient needs.

Healthy Schools:

- Investigate the training needs of education staff and maximise the services provided to pupils in schools to promote resilience.
- To increase understanding of mental health issues to promote good mental health and wellbeing for young people and to tackle stigma.
- Ensure carers are trained and supported to meet the needs of children with SEND.

Healthy Work:

- Engage with organisations and businesses to promote wellbeing in the workplace and encourage good practice in supporting the mental health of employees.
- Engage with children looked after to ensure their specific emotional and mental needs are met.
- Engage with carers to provide advice, training and support for their own mental health needs and the wellbeing of their dependent.

Healthy Families:

- Enquire about the training needs of children and youth workers to enable identification of adverse childhood experiences.
- Engage with communities in the most deprived areas across the county to ensure their specific emotional and mental needs are met.
- Engage with individuals from vulnerable populations including homeless, deprived, LGBTQ, black minority ethnic, refugees and gypsy travellers.
- Support for resilience in later life.

Healthy Ageing:

- Support for retirement transition.
- Improve the promotion and uptake of dementia screening within the over-65 year's population.
- Promote and support the development of Dementia Friendly Communities across the county.
- Engage with individuals diagnosed with dementia and their family to continue to ensure there is no gap between needs and service provision.

Healthy Communities:

- Engage with local planners and developers to minimise the risks of suicide opportunities.
- Commissioners should review the support available to carers, whether statutory, voluntary or peer support.

Healthy Resilience:

- Evaluate the capacity and resources of community teams within the population to ensure they are appropriately trained and staffed to meet the need for services.
- Promotion of lifestyle factors relationship with mental health to encourage the population to be proactive in the prevention and resilience of their mental health outcomes.

Mental Health Care Provision:

- Improve joint working relationships to improve data sharing and partnership working.

Abbreviations:

ACEs	Adverse Childhood Experiences
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
ERSCB	East Riding Safeguarding Children Board
ERY	East Riding of Yorkshire
ERYC	East Riding of Yorkshire Council
GAD	General Anxiety Disorder
IMD	Index of Multiple Deprivations
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
NEET	Not in Education, Employment or Training
NICE	National Institute for Health and Clinical Excellence
PTSD	Post-Traumatic Stress Disorder
SEND	Special Educational Needs and Disability
SMI	Severe Mental Illness
UK	United Kingdom
Y&H	Yorkshire and the Humber

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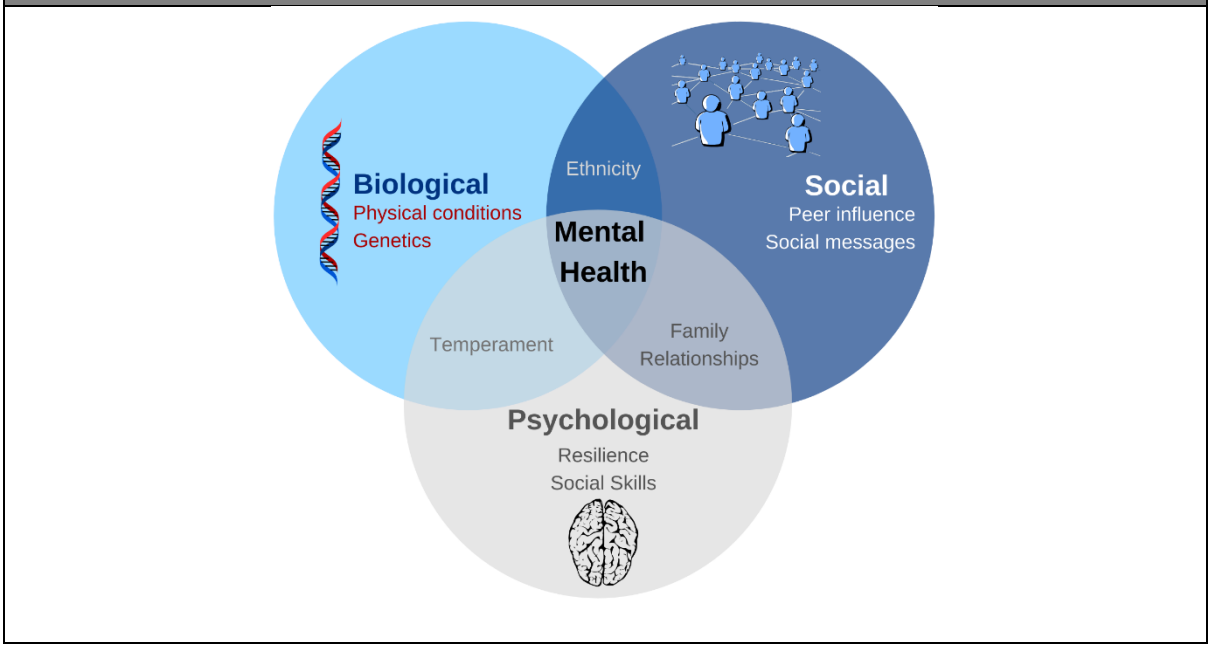
1. Introduction

Mental health is a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community[1].

Health and wellbeing has a history to focus on the physical attributes of health – fitness, absence of physical illness and ability to thrive independently. However, in recent years the notion and recognition of mental health and its vital importance to health and wellbeing has been increasingly recognised. Through the promotion of mental health it is now defined as an integral part of health which is more than the absence of illness, and which is intimately connected with physical health and behaviour.

Mental health for each individual is different and is affected by individual factors and experiences, social interaction, social structures and resources, in addition to cultural values. An individual's mental health is influenced throughout the life course and events throughout life can impact each individual differently.

Figure 2: Factors which influence mental health across the life course.



This document aims to outline the life course influences, risk behaviours, mental health prevalence and support within the ERY. This document will inform the commissioning of mental health and dementia services.

This document aims to do the following:

- Consider how an individual's mental health can be affected at each stage in life
- Consider the wider determinants of health, such as housing, employment, and look at how these affect mental health
- Draw comparisons between the ERY, Yorkshire and the Humber (Y&H) region, and England to identify if ERY has significant differences in the mental health state and support of its population.
- Provide recommendations to enhance the mental health and dementia services provided within the East Riding and to inform the progress made thus far with the Mental Health Strategy.

2. Healthy Schools and Home Education

The early years and childhood are pivotal for influencing mental health and developing resilience. Schools and educational environments (i.e. home-schooling) can be major determinants for supporting good mental health and wellbeing. Good childhood mental health depends on many factors, such as having good physical health, eating a balanced diet and regular exercise. Children need time to play indoors and outdoors, they need to be part of a family that gets along well most of the time, to attend a school concerned with pupil wellbeing and to take part in activities for young people.

According to 2018 estimates, there were 66,562 children and young people (aged 0-18 years) within the ERY and 54,320 school aged children (4-18 years). School-aged individuals equate to 16% of the entire ERY population.

It is important that schools promote good mental wellbeing for all pupils. Education about relationships, sex and health can be important vehicles through which schools can teach pupils about mental health and wellbeing. There are things that schools can do for all pupils to intervene early to create a safe and calm educational environment and strengthen resilience before serious mental health problems occur. Mental health problems are also higher among children who do not engage in activities which protect mental health, such as exercise and eating a balanced diet. Public health is well placed to work with schools and relevant services to build on efforts to increase child participation in physical activity and to promote healthy lifestyles.

The East Riding of Yorkshire Transformation Plan is a document which sets out the aims to develop and invest in opportunities to improve the emotional and mental health of children and young people in the ERY. The work surrounding children and young people has seen particular progress made in relation to emotional wellbeing in schools. The full transformation plan can be accessed here.

2.1 Bullying:

Bullying is the repetitive, intentional hurting of one person or group by another person or group, where the relationship involves an imbalance of power. It can happen face-to-face or online[3].

Some groups of people are more likely to experience bullying than others. There are multiple forms of bullying which target high-risk groups such as Identity-based bullying (focussing on race, faith, gender, disability, sexual orientation or Trans status); Appearance-related bullying (focussing on a person's appearance such as size, height or perceived difference); Homophobic, Biphobic and Transphobic (HBT) bullying (focussing on an individual's sexuality). Other high-risk groups for bullying are looked after children (LAC), young carers, and children with special educational needs or disability (SEND). Research identified 7-year olds with SEND are twice as likely as similar children their age to be persistently bullied[4]. Lesbian, gay, bisexual, transgender and queer (LGBTQ) young adults are at greater risk of being bullied than their heterosexual peers[5].

Bullying is not childhood specific and can occur at any point during the life course. Like in childhood, those who are differently abled, LGBTQ or have alternative lifestyle choices can be likely targets of bullying. Bullying at any life course stage can have profound effects on the mental and emotional wellbeing of victims and perpetrators[6].

2.1.1 National and Regional Prevalence:

The Ditch the Label Annual Bullying Survey 2018[7] is a UK-wide project working with secondary schools and colleges about bullying. In 2018, the sixth annual survey engaged with over 14,000 young people and yielded a sample of 9,150 people aged 12-20. According to survey results, 22% of participants had been bullied, 22% had witnessed bullying, and 2% had bullied others.

2.1.2 Victims:

From those who identified as having experienced bullying within 12-months of the survey, 34% were bullied at least once a week and 51% were bullied at least once a month. Victims were asked why they thought they were bullied, with personal appearance and personal interests being the most prominent reasons (table 1).

Table 1. Reasons why victims of bullying thought they were targeted.
Source: Ditch the Label, 2018.

Reason:	Proportion of victims:
Attitudes towards their appearance	57%
Attitudes towards their interests or hobbies	40%
Attitudes towards their clothes	24%
Being accused of being homosexual (even if not)	20%
Attitudes towards their mannerisms	19%
Attitudes towards their higher grades	18%
Attitudes towards their low grades	14%
Attitudes towards their disability	11%
Attitudes towards low household income	10%
Attitudes towards high household income	9%
Attitudes towards their sexuality	9%
Attitudes towards their race	9%
Attitudes towards their social culture	9%
Attitudes towards their religion	7%
Attitudes towards their gender identity	6%

Perpetrators of bullying were most commonly a classmate (59%), somebody else from school (33%) or an ex-friend (33%). Perpetrators were also mentioned as being teachers (9%), a sibling (11%) or someone online (9%).

Those who experienced bullying reported a variety of impacts (table 2). Nearly half (47%) of study participants reported a moderate to extreme mental health impact. Those who were bullied reported their studies, self-esteem, social life and confidence were all affected by bullying.

Table 2. The impacts of bullying on victims.
Source: Ditch the Label, 2018.

Impact:	Proportion of victims:
Felt depression	50%
Felt anxious	45%
Had suicidal thoughts	34%
Self-harmed	28%
Truanted from school/college	21%
Developed an eating disorder	15%
Developed anti-social behaviour	12%
Attempted suicide	11%
Ran away from home	11%
Abused drugs and/or alcohol	7%
Engaged in risky sexual behaviour	4%

Bullying often goes unreported. 54% of victims claimed their parents or guardians knew about their bullying; 32% said parents were aware of some of the bullying and 14% stated their parents or guardians were unaware.

2.1.3 Perpetrators:

It is recognised those who perpetrate bullying can have mental health and wellbeing issues. Those who self-identified as bullying others claimed it made the feel guilty (44%), angry (42%), in control (36%), upset (32%), powerful (29%), indifferent (25%), excited (21%), numb (16%) and jealous (9%).

Perpetrators were asked of their motives (table 3). Understanding the motives and psychological profiles of those who bully others is essential to reducing the incidence.

Table 3. The motives of perpetrators of bullying.
Source: Ditch the Label, 2018.

Motives:	Proportion of perpetrators:
The victim deserved it	56%
They disliked the victim	55%
They found it funny	34%
It helps with their own stress/anger	32%
They are unhappy	24%
To make their friends laugh	24%
Because they were being bullied themselves	21%
The victim is an easy target	21%
To scare the victim	20%
To prevent others bullying them	20%
It made them feel good about themselves	14%
They were jealous of the victim	12%
To be noticed by others	11%

2.1.4 Witnesses:

1-in-5 surveyed participants had witnessed bullying in the previous 12-months. Witnessing bulling caused individuals to feel sympathy (59%), upset (39%), guilty (31%), scared (18%) and stressed (20%). However, for some, witnessing bullying was entertaining or enjoyable (4%) [7].

Witnesses can be affected by bullying but also they have the potential to minimise the incidence and effect of bullying by intervening. However, many (51%) respondents claimed they were unaware of how to intervene. Effort to encourage children and young people to make a stand against bullying by informing them of useful ways to do so could be extremely beneficial to the mental health and wellbeing of all involved.

2.1.5 Regional Prevalence:

There is no statutory duty for local schools or educational institutions to produce an anti-bullying strategy, nor collect data or information on the prevalence of bullying. However, as highlighted in the East Riding of Yorkshire Anti-Bullying Strategy 2017-2020, it is vital stakeholders work with children and young people and other settings to challenge bullying and discrimination of any form, and ensure all children and young people are safe[8].

2.1.6 Services for anti-bullying:

Across the UK there are a number of national charities and services which aim to help children and young people affected by bullying. There are also school-based interventions including counselling, and restorative practice.

National charities, which are accessible by the local population include ChildLine, Bullies Out, the StandUp Foundation, Anti-Bullying Alliance and many more. All charities have a confidential helpline which parents or children can use to talk to someone about their experiences and receive advice and support on how to deal with, report and cope with bullying.

Across schools and other settings, there is the strong common theme that it is the whole-system approach to preventing and tackling bullying that is vital. This means schools are proactive in engaging with teaching and non-teaching staff, pupils, parents, carers and governors to tackle bullying[9]. Schools and other settings, such as the workplace, colleges and universities, publicise the ethos of anti-bulling and train all staff members to be engaged with the anti-bullying ethos.

Headlands School in Bridlington has an extensive anti-bullying policy which adopts a whole-system approach to minimise the incidence and effect of bullying. The secondary school offers peer mentor reporting and support for victims of bullying and actively encourages the reporting of bullying to members of staff. Pupils can also report bullying by sending letters, or recording incidents online using Cyber Mentors via Moodle or the school website. The full Headlands Anti Bullying, Harassment and Discrimination Policy can be found here.

Restorative practice, as defined by the Anti-Bullying Alliance, is a method of working with conflict that puts the focus on repairing the harm that has been done[10]. This practice encourages children and young people to consider how they are thinking, and how their thoughts are influenced by their feelings and effect their behaviour. Through restorative practice, children and young people become more reflective and empathetic. Through involving everyone, including bullies and their victims, the practice aims to resolve differences and diminish bullying within an institution. The Restorative Justice Council started the approach in the criminal justice system, but has since been extended into schools in order to reduce in-school conflict and help reduce exclusions. Bullying is one of the most common reasons children are excluded. In 2014/15, there were 30 permanent exclusions for bullying nationally – there were no permanent exclusions in the ERY for the same time period. In 2014/15, there were 10 fixed-term exclusions within ERY which was significantly lower than this, with 3420 fixed-term exclusions nationally[8].

Within the recommended resources for additional information, the ERSCB Anti-Bullying Strategy 2017-2020 identifies the Restorative Justice Council as a useful resource for preventing bullying. Statistics regarding the number of schools using restorative practice does not appear to be available, however, there is evidence of a select number of ERY primary school (e.g. Elloughton Primary School) websites that schools are adopting this practice as a means to establish, maintain and improve student relationships.

It is not just during school hours that bullying can occur. Transport to and from school can be a vulnerable time for student. Buswise is a partnership scheme here in ERY between the council, schools, parents, pupils and the local bus companies. The scheme aims to ensure everyone has a safe and pleasant journey using either the school bus or public transport. If children or young people bully others whilst on the transport can be reported to transportation services, the school or the bus company. The severity of any bullying, harassment or disruption can result in suspension from travel, paying for damages or even prosecution[11].

Outside of school, in work and private lives, reporting bullying can be more difficult. Adults may be more reluctant to report incidents of bullying for fear of judgement or uncertainty of where to do so. In the workplace, the Advisory, Conciliation and Arbitration Service (ACAS) advises those who experience harassment or bullying to report this to their line manager, a colleague or their union representative. Additionally, there are numerous UK wide helplines for individuals of all ages, such as the National Bullying Helpline, Bullying UK, Ditch the Label, The Mix and many others which provide advice and support for victims of bullying.

2.2 Exam Pressure:

In the last few of years, there has been a growing competition for better jobs and this has been reflected on students being put under increasing pressure to perform better in schools. According to the National Society for the Prevention of Cruelty to Children, ChildLine delivered a record breaking 3,135 counselling sessions related to exam stress in 2017/18 – a rise of 11% over the past 2 years. Out of these, around 20% of these calls took place during exam period with main concerns including excessive workload, feeling unprepared and struggling with subjects[12]. While previously it used to be the younger students from age group 12-15 years seeking counselling, there has been an increasing trend in the older students seeking help. An increase of 21% in counselling sessions for the age group 16-18 years was reported which may be due to the increased competitiveness for university places and the university application process becoming more challenging[12].

Exam stress was reported to be having a direct adverse impact on the mental health of students of all ages, with some stating that it was leading them to increased depression, self-harm and increased anxiety[12]. According to a survey conducted of more than 2000 school leaders and governors, 81% of school leaders worry about their pupil's mental health during the assessment period more than they did 2-years ago[13]. Research suggests that on average, 30% of students' exhibit debilitating signs of stress during exams[14]. Data available investigating exam pressure and its repercussions on students is only estimates, and there is a chance that this may not truly represent the current effect of exam pressure on the mental health of young people.

2.2.1 Potential effects of exam pressure:

Measuring the prevalence of exam pressure is difficult, as academic pressures are experienced differently for each individual, and not everyone voices how they are feeling. For some people, academic pressure can be motivating, but for others it can be detrimental to their emotional, mental and physical wellbeing.

According to research conducted by the University of Manchester, in 2014-2015 there were 922 suicides by people under aged 25 years old in England and Wales. 316 of these deaths were in people under aged 20. The study identified 51% of these individuals were in education at the time of death. 63 individuals (43% of those in education) were experiencing academic pressures at the time of suicide. Of this number, 25 individuals were experiencing exam-related stress (including sitting exams and awaiting results). The highest number of deaths in those experiencing academic pressures were in May, April, June and September. This study identified a correlation between academic pressures and suicide attempts, however it is not definitive exam pressure was the cause of the suicides.

2.3 Peer Pressure:

Peer pressure is a multidimensional social issue affecting various aspects of life. Peer pressure is the influence from members of a person's peer group, whether this is classmates, friends, colleagues or family. Peer pressure can be linked to bullying, drug abuse, sexual abuse, financial difficulties and it can directly affect an individual's mental health. Peer pressure can lead to risky behaviour, such as alcohol consumption, smoking and unprotected sex, but can also lead to mental health issues such as depression.

Everyone at some stage feels pressure to fit in with their peers and people they admire, but for teenagers this pressure to conform and receive approval can be acute. Secondary school, and sometimes higher education, can be notorious for being filled with cliques and high levels of peer pressure amongst the young people involved. In order to fit in with cliques and certain other individuals, teenagers often feel they must change things about themselves, or pretend to be someone other than they are. As teenage years are already a difficult period for

individuals deciding who they are and discovering what they are like as a person, the additional element of peer pressure can lead to these children feeling confused and lead to low self-esteem, anxiety and depression[15].

The mass use of social media, and platforms like Instagram, is a new public health challenge. Social media has major influence over individual's self-worth. The notion of popularity and peer support being measured in 'likes' means self-esteem and self-worth is being compromised. The true detrimental effects of social media on common mental health conditions and body image issues are still unknown. However, it is recognised that social media is now a major risk factor for mental health[16].

Peer pressure can lead to bullying as teenagers attempt to fit in by exploiting the differences in others. This leads to creating separations in schools (and can also occur in the workplace) and can make people feel excluded. This can lead to low self-esteem, anxiety and depression in the victims of bullying, as well as lead to serious mental health issues such as self-harming.

According to a study conducted by University College London (UCL), peer pressure is one of the most influential factors affecting young people's alcohol consumption. Children whose friends drink alcohol are five times more likely to drink than those whose friends do not, with 1 in 7 11-year olds having tried alcohol[16, 17].

See section 7.7 for more information on risky behaviour and mental health.

2.4 Higher Education:

Higher education is the post-school education at universities or colleges to diploma and degree level. Higher education institutions have an important role in providing support to students with mental health difficulties[18]. In universities, mental health problems, including depression and anxiety, affect one in four students, whilst student suicides have reached a record level in recent years and university dropouts have trebled[19, 20, 21].

It is recognised by mental health researchers and organisations that students have different needs and vary in their experience of mental health difficulties than the general population[18]. The underlying causes vary for each person, but transition points in life can be particularly challenging: at the start of their courses, many students are likely to be adapting to significant changes in their lifestyle at a time when they are adjusting to studying and being away from home[18].

Within East Riding, there are two colleges (East Riding College and Bishop Burton) which provide courses for all ages. There is no university within the ERY but within the Y&H region there are 12 universities, with the University of Hull being the closest to the area.

According to figures from East Riding College, 12% of all learners progressed to higher education, and 61% of all learners progressed onto further college courses.

2.5 Emotional Wellbeing:

Emotional wellbeing is a positive sense of wellbeing which enables an individual to be able to function in society and meet the demands for everyday life. Emotional wellbeing and mental health are intrinsically linked. Wellbeing is a key issue as people with higher wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

Mental health problems affect about 1 in 10 children and young people. These include depression, anxiety and conduct disorder. These mental health problems are direct responses to the events and experiences in their

personal life. The emotional wellbeing of children is just as important as their physical health. Good mental health helps children and young people develop their resilience to cope with life and become well-rounded, healthy adults[22].

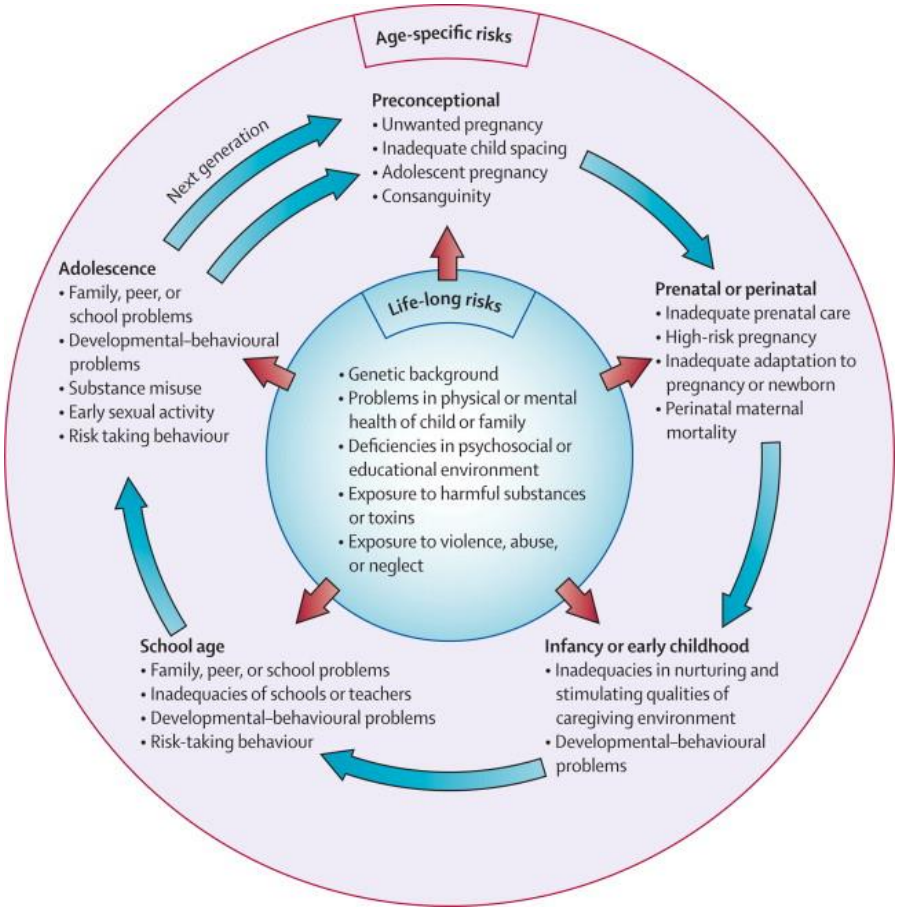
The mental health of a child depends on the environment into which they are born and grow up in. Several social factors have been found to be closely associated with increased risk of developing mental and emotional problems. These include the makeup of the family, the employment situation and education of parents, their income and the characteristics of the neighbourhood in which they live. Adverse childhood experiences (ACEs) are factors which play a key role in developing mental and emotional problems in children and young people.

See section 4.5 for more information on ACEs.

Although most children grow up mentally healthy, current research suggests more children and young people have problems with their mental health today than 30-years ago. This is attributed to the way we live now (including new technologies, social media and family dysfunctions) and how life events affect the experience of growing up. 75% of adult mental health problems develop by the age of 24 which reinforces the necessity of prevention and early intervention to support children and young people with their mental and emotional wellbeing. There is also a distinct difference between males and females, with females reporting worse emotional wellbeing as they age. However, men are less likely to discuss emotional difficulties and prevalence of poor emotional wellbeing may go unreported[23].

Figure 3: Factors influencing the emotional wellbeing of children and young people. The cycle here depicts the lifecycle approach to risk factors for mental health problems. Childhood environment, including home and educational settings, all influence the mental and emotional wellbeing of individual's throughout their life[24].

Source: Kieling *et al.,* 2011.



2.5.1 National Policy Context:

The national policy context for Children and Adolescent Mental Health Service stemmed from the 1995 publication 'A Handbook on Child and Adolescent Mental Health'. Since then, there has been multiple iterations of this document. In 2011, the UK government published a mental health strategy for England, '*No Health without Mental Health*': a cross-government mental health outcomes strategy for people of all ages. This strategy aimed to improve the mental health of individuals and the population as a whole, with a focus on early intervention. In 2012, the Children and Young People's Health Outcomes Forum produced a report on the Mental Health Strategy and aligned its main objectives to focus on the mental health and emotional wellbeing of children and young people.

2.5.2 Local Policy Context:

The emotional health and wellbeing of children and young people is a key priority for the ERY Local Strategic Partnership which consists of the council, CCG and wider partners.

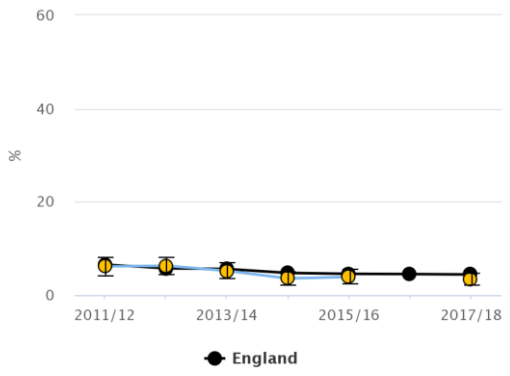
The Health and Wellbeing Strategy has 3 long-term priority outcomes for health and wellbeing in the ERY:

1. ERY residents achieve healthy, independent ageing;
2. Health and wellbeing inequalities in the ERY are reduced;
3. Children and young people enjoy good health and wellbeing.

2.5.3 Measuring wellbeing:

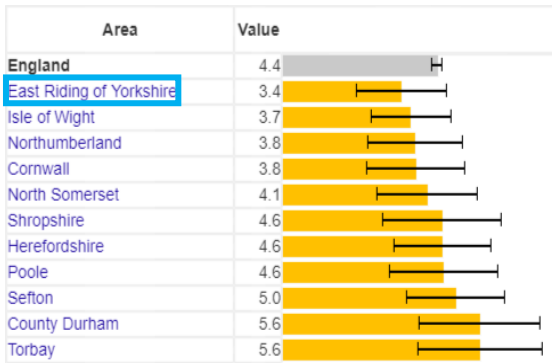
Acknowledging how the emotional health and wellbeing of young people can influence their cognitive development, physical and social health means monitoring children and young people's wellbeing is a priority for local authorities. According to the 2015 'What about YOUth (way)' survey, the mean WEMWBS-14 score for ERY was 47.5. This was similar to the national (47.6) and regional (47.7). This is positive as this cohort study indicates that young people in ERY have a relatively high level of wellbeing. Studies also identified that there is a small proportion of people within ERY with low satisfaction which is better than the national proportions (figures 4 and 5).

Figure 4: Self-reported wellbeing – proportion of people with low-satisfaction.



Source: PHE Fingertips, 2019.

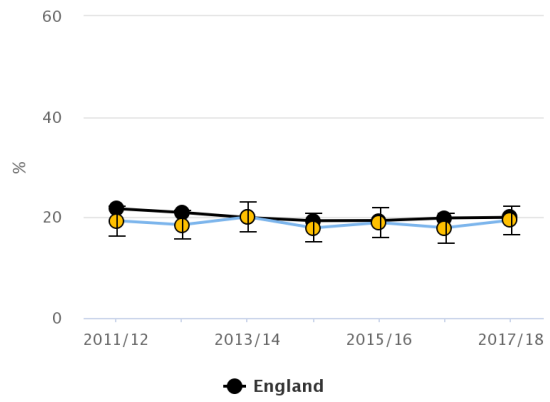
Figure 5: Self-reported wellbeing – proportion of people with low-satisfaction, comparing ERY to its CIPFA nearest neighbours.



Source: PHE Fingertips, 2019.

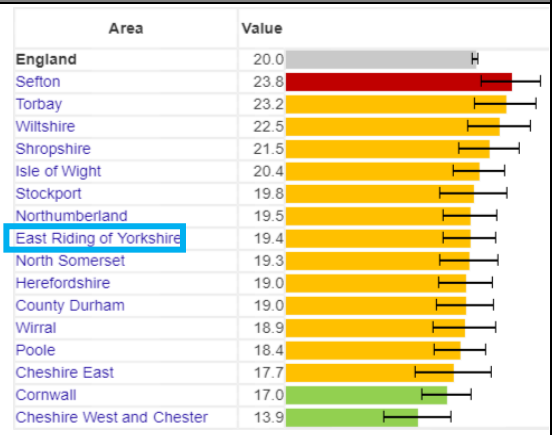
Additionally, almost a fifth of survey participants self-reported high anxiety (figures 6 and 7).

Figure 6: Self-reported wellbeing – proportion of people with a high anxiety score.



Source: PHE Fingertips, 2019.

Figure 7: Self-reported wellbeing – proportion of people with a high anxiety score.



Source: PHE Fingertips, 2019.

Estimating the prevalence of mental, emotional and conduct health disorders and hyperkinetic conditions is useful for ensuring services are able to meet demand. Table 4 provides previous estimates for the prevalence of common mental health disorders in children and young people.

Table 4. Estimated prevalence's of different mental and emotional disorders in children and young people. Since these are estimates, statistical significance has not been calculated. However, the ERY has lower prevalence for all mental and emotional type disorders compared to the national and regional estimates.

Source: PHE Fingertips, 2019.

Indicator	Period	England	Y&H	ERY
Estimated prevalence of mental health disorders in children and young people: % population aged 5-16 years	2015	9.2	9.6	8.9
Estimated prevalence of emotional disorders in children and young people: % population aged 5-16 years		3.6	3.7	3.5
Estimated prevalence of conduct disorders in children and young people: % population aged 5-16 years		5.6	5.9	5.3
Estimated prevalence of hyperkinetic disorders in children and young people: % population aged 5-16 years		1.5	1.6	1.4

2.5.4 Services for emotional wellbeing in children and young people in ERY:

Social Mediation and Self-Help (SMASH) is a project designed to improve the emotional resilience and mental health of young people at schools within the ERY. The programme aims to equip young people and their families with strategies and tools to self-manage socially and emotionally in everyday life and in stressful times. SMASH also assists with promoting positive mental health and outcomes for the present and in the future. A SMASH pilot ran in ERY between October 2016 and February 2017 with 10 schools participating. Of 215 participants

aged 11-16 years, 50% reported increased confidence and self-esteem[25]. Currently the programme is running in a number of schools across the ERY.

Emotional Literacy Support Assistant (ELSA) is a programme designed to build the capacity of schools to support the emotional needs of their own pupils with their own resources[26]. Teaching assistants are trained to recognise, address and support pupils with emotional needs, such as anxiety or grief. Across the ERY, all educational psychologists are involved in the training and supervision of ELSAs. Currently, 121 schools within the ERY have had ELSA training. These schools consist of primary, secondary and special schools.

MIND is a leading mental health charity which provides advice and support to empower people experiencing mental health issues. Hull and East Yorkshire Mind have offices in Hull and Bridlington and their services cover Hull and the whole ERY. With the national charity, the local services provides services including talking therapies, crisis helplines, drop-in centres, employment and training schemes, counselling and befriending[27]. Promotion of local services like this is recommended to maximise outreach to those in need.

Other local services include the East Riding counselling unit which provides information on issues affecting young people. This is a free confidential counselling service for young people (ages 13-25 years).

There is also the Educational Psychology service from ERYC. This service works predominantly in schools to help teaching staff find solutions to improve the learning outcomes and social and emotional development of children and young people. This is a free service for all children and young people (ages 0-25 years). The service assesses the difficulties children and young people may be having emotionally, behaviourally or with their learning and use psychological models and approaches to help them make progress[28].

2.6 Children's Mental Health:

According to the Mental Health of Children and Young People in England (2017) publication [29], 1 in 8 (12.8%) of 5-19 year olds had at least one mental disorder when assessed in 2017. The rates of mental health disorders increased with age. 5.5% of 2-4 year old children experienced a mental disorder, compared to 16.9% of 17-19 year olds. Data from this survey revealed a slight increase over time in the prevalence of mental disorder in 5-15 year olds. Mental health disorders have increased in prevalence from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017.

Emotional disorders have become more common in 5-15 year olds, going from 4.3% in 1999 and 3.9% in 2004 to 5.8% in 2017. All other types of disorder, such as behavioural, hyperactivity and less common disorders, have remained in similar prevalence for this age group since 1999.

CAMHS is the Child and Adolescent Mental Health Service which helps young people (up to aged 18), who are struggling with their emotions, relationships, personal development or their behaviour[30]. Table 5 presents the NHS ERY CCG Humber Foundation Trust figures for 2018/19.

Table 5. Number of individual children and young people aged under 18 accessing treatment. This shows the number of children accessing mental health services during the 2018-19 period*.		
Clinical Commissioning Group	**Provider**	**Number of children and young people under 18 accessing treatment, 2018-19.**
NHS ERY CCG	Humber Teaching NHS Foundation Trust (HFT)	1275**
*This figure is from an experimental data set. This is a basic measure of caseload including people in contact with learning disability services and CAMHS. HFT is the ERY CAMHS provider. **The number of children and young people accessing treatment was provided by the provider. The figure has been rounded to the nearest 5. **Source:** NHS Digital, 2019. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/number-of-children-and-young-people-accessing-nhs-funded-community-mental-health-services-in-england-april-2018-to-march-2019-experimental-statistics		

2.7 Body Image and Eating Disorders:

There are cultural, social, physical and psychological changes that occur in adolescents during puberty that can affect their self-perception of body image. Having a poor body image has been found to be negatively associated with self-esteem and depression, particularly amongst teenage girls and may account for the higher prevalence of depression and low self-esteem amongst girls[31]. A large study in the UK (around 40,000 households take part every year) showed that 1 in 10 children aged 10-15 years old were unhappy with their appearance (11% in 2011/2012 and 10% in 2012/2013). The proportion of girls reporting that they are unhappy with their appearance is around double that of boys (14% of girls compared with 7% of boys in 2012/2013)[32].

Constant negative feeling about body image can not only affect emotional health, leading to depression, but can also be the strongest predictor of disordered eating behaviours and clinical disorders across psychosocial variables, such as perfectionism and locus of control.

Eating disorders are mood disorders which are characterised by a persistent disturbance of eating or eating-related behaviour that results in altered consumption or absorption of food that significantly impairs physical health or psychological functioning. Eating disorders include bulimia nervosa, anorexia nervosa and binge eating disorder.

Anorexia nervosa is an obsession with losing weight where individuals commonly exercise more and calorie count obsessively. Some individuals with anorexia also withdraw from social situations and commonly take up risky behaviours such as smoking. Anorexia commonly starts in the teenage years, and affects 1 fifteen-year-old girl in every 150 and 1 fifteen-year-old boy in every 1000[33].

Bulimia nervosa is a weight-obsessive condition but involves individuals with the condition binge-eating before making themselves vomit and/or use laxatives to get rid of calories. Bulimia often starts in mid-teens. People most often seek help when their life changes – the start of a new relationship or having to live with other people for the first time. About 4 out of every 100 women suffers from bulimia at some time in their lives – this is fewer for men.

Binge eating disorder causes individuals to put on excess weight, as individuals excessively consume food without making themselves vomit. Binge eating disorder is less frequently associated with a mental health condition.

Research previously suggested eating disorders predominantly affected white, more affluent females[34]. However, more recent research testing the association between socioeconomic status and eating disorder features (including binge eating, selective eating, purging and abstaining from food) found eating disorders occur at similar rates across all levels of income, ethnicity and education[35].

Only estimates are available for the prevalence of eating disorders within ERY. The estimated proportion is 6.6% compared to 6.6% for Y&H and 6.7% for England. The estimate proportion for ERY is similar to the estimated proportion for the regional and national comparators.

Between 1st January and 31st March 2019 across England, 3,142 new referrals for young people under age 19 with an eating disorder issue were received by mental health services[36].

2.8 Special Education Needs and Disability:

A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support, we shorten this to SEND.

2.8.1 National prevalence of SEND:

The percentage of pupils with special educational needs has increased to 14.6% across England. The percentage of pupils with a statement or Education, Health and Care (EHC) plan has increased to 2.9%[37]. The most common primary types of needs have remained the same from 2017 – moderate learning difficulty (24% of children across England) is the main SEN need. The primary need for pupils with a statement or EHC plan is Autistic Spectrum Disorder (28.2%).

2.8.2 ERY prevalence of SEND:

The number of children and young people with Education, Health and Care (EHC) plans maintained by ERYC continues to rise, which follows a similar pattern to that reported nationally. Numbers increased from 1,580 in January 2017 to 1,688 in January 2018 which is an increase of 6.8% (108 children and young people). In the ERY, 1187 children have a statement or EHC plan (2.5%). 5072 children (10.7%) of ERY children have SEN.

Children aged 5 to 10 accounted for the largest percentage of CYP with EHC plans in the ERY in January 2018; this differs slightly to the national pattern that shows 11-15 year olds as the largest group.

Table 6: Age groups of children and young people with EHC plans maintained by ERY.
Source: ERY C&YP Team, 2019.

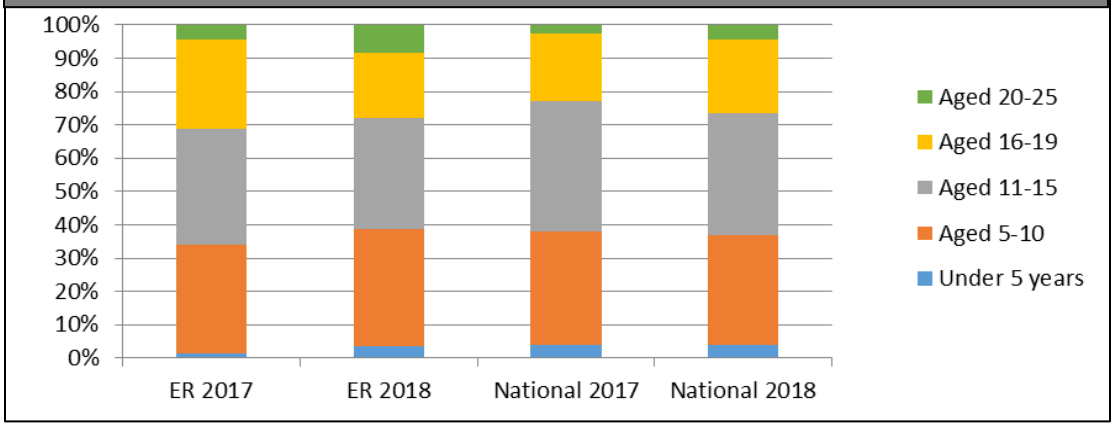
	ERY 2017		ERY 2018		National 2017		National 2018			% change	
Age Group	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**		**ER**	**National**
Under 5 years	19	1.2	58	3.4	11,629	4.0	12,516	3.9		205.3%	7.6%
Aged 5-10	519	32.8	596	35.3	97,379	33.9	105,689	33		14.8%	8.5%
Aged 11-15	551	34.9	565	33.5	112,540	39.2	117,354	36.7		2.5%	4.3%
Aged 16-19	423	26.8	328	19.4	58,034	20.2	70,084	21.9		-22.5%	20.8%
Aged 20-25	68	4.3	141	8.4	7,708	2.7	14,176	4.4		107.4%	83.9%
Total	1,580		1,688		287,290		319,819			6.8%	11.3%

Figure 8 below visualises the age distribution of children with plans between the age groups both in the ERY and nationally in 2017 and 2018.

The number of CYP with EHC plans aged 0-5 has more than doubled in the ERY since 2017, an increase of 205% from 19 to 58. Showing as 3.4% of the overall EHC cohort, this is now more in line with national figures of 3.9%.

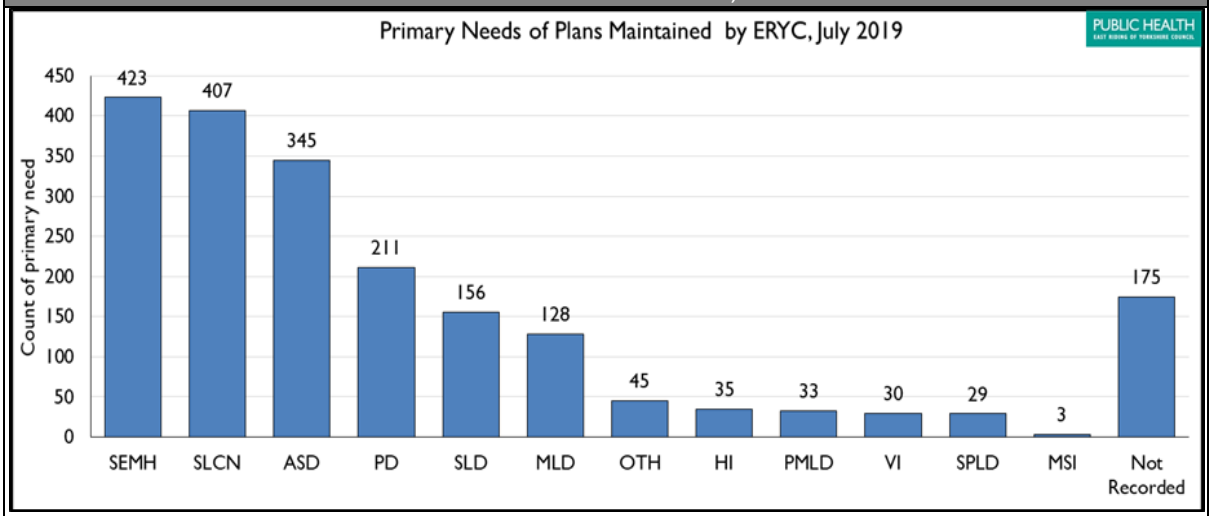
The number of CYP aged 16-19 have reduced by 95 and the number of CYP aged 20-25 have increased by 73. This change can also be seen in the resulting increase and decrease in proportions for these age groups. The proportion of CYP aged 20-25 in the East Riding is 8.4%, almost double the national proportion of 4.4%. The proportion of CYP aged 16-19 in the East Riding is 20.2% and similar to the national figure of 21.9%.

Figure 8: Age groups of children with EHC plans maintained by East Riding Council.
Source: ERY 0-25 special educational needs and disability (SEND) strategy, 2018-2021.



EHCs are provided to children and young people with a range of needs. Figure 9 shows the primary needs for those with EHC plans. "Social, Emotional and Mental Health" needs were the highest number of reasons for EHCs in ERY. This differs from the national primary need for EHC.

Figure 9: Primary needs of EHC plans maintained by ERYC, July 2019. A key is provided below to the abbreviations used.
Source: ERY Children, Families and Schools Performance Team.



KEY:

SEMH	Social, Emotional and Mental Health	**OTH**	Other
SLCN	Speech, Language & Communication Needs	**HI**	Hearing Impairment
ASD	Autistic Spectrum Disorder	**PMLD**	Profound & Multiple Learning Difficulty
PD	Physical Disability	**VI**	Visual Impairment
SLD	Severe Learning Difficulty	**SPLD**	Specific Learning Difficulty
MLD	Moderate Learning Difficulty	**MSI**	Multi-Sensory Impairment

Children with SEND are more likely to suffer bullying or prejudice. See section 2.1 for more information of the potential effect of bullying on mental and emotional wellbeing.

2.8.3 ERY prevalence of LAC SEND:

In 2016/17, there were 149 LAC who were continuously cared for by ERY. Of these, 37 (25%) had an EHC plan which is below national and statistical neighbour comparisons. Of the 149, 34 (23%) had SEN support. This is again lower than all comparators who reported between 28% and 30%.

206 school-age children in need (22%) in 2017 had an EHC plan, which is higher than regional, national and statistical neighbour comparators (17%, 21% and 21% respectively). This is an increase from 2016 when East Riding was lower than all comparators.

201 school-age children in need (21%) in 2017 had SEN support. This remains below all comparators (regional 26%, national 25% and statistical neighbours 24%).

See section 4.7 for more information on CLA.

2.8.4 Services for SEND:

The vision for ERY is that "*All people aged 0-25 years old with special educational needs and/or a disability within the ERY are effectively supported to live happy, safe and fulfilling lives*". To ensure this, it is imperative that individuals with SEND have the support to thrive. The Children and Young People's Strategic plan aims to do so through three objectives:

1. Deliver an excellent educational experience for all, with attainment and achievement gaps narrowed
2. Provide the support that parents and carers need when they need it
3. Promote good health and wellbeing for ERY children and young people, recognising the importance of emotional and mental health.

Within the ERY, Education, Health and Care (EHC) plans are implemented for SEND children and young people. These plans are person-centred and outcomes are focussed, aspirational and realistic for the capabilities of the individual and their specific needs.

ERYC also aims to ensure SEND children and young people receive appropriate and accessible high-quality education. When appropriate, SEND individuals are encouraged to attend mainstream educational institutions. Alternatively, there are three schools within the ERY which are specialist Special Educational Needs Schools:

- St Anne's Community Special School - Welton
- Riverside Area Special School - Goole
- Kings Mill Special School - Driffield

2.8.5 SEND transitions:

The transition from childhood to adulthood is difficult for every individual but is generally a time that is emotionally and mentally challenging. Resilience during this period is pivotal to the potential for individuals to thrive as they move through life. See section 2.9 for more information on transition and its impact on mental health and wellbeing.

The movement from EHC within a school environment to further education, employment or training is an important stage of transitioning from childhood to adulthood and can be extra challenging for those with SEND.

21% of learners participating in further education in the ERY in 2017/18 identified themselves as having a learning difficulty and/or disability. This is slightly higher than the nationally reported figure of 18%.

69 of the 75 young people (92%) in the ERY with EHC plans who completed Key Stage 4 in 2015/16 were in a sustained education or employment/training destination six months later. This also applied to 253 of 275 young people (92%) with SEN support and 96% of 3,000 young people without SEND. This is above national comparators of 90% and 88% respectively.

52 of the 55 of young people (94%) in the ERY with SEND in schools who completed key stage 5 in 2015/16 progressed to a sustained education and/or employment destination in 2016/17. This is an improvement from 81% in 2015/16 and above the national figure of 86%.

6.5% (53/819) of adults with learning disabilities in the ERY aged 18-64 who received support from social care services in the 2017/18 financial year were in paid employment; higher than the England average of 6.0% but lower than the regional average of 7.4%. This is an improvement from 5% in 2016/17.

71.6% of adults with learning disabilities aged 18-64 in the ERY who received support from social care services in the 2017/18 financial year lived in their own home or with their family; a slight reduction from 72.5% the previous year and lower than the 2017/18 national and regional comparators of 77.2% and 80.9% respectively.

2.9 Transitions:

The progression through childhood to adulthood can be exciting and difficult. Transitions throughout the life course can affect the individual, their family and friends.

Many things can change during the transition such as an individual's education, employment circumstances, finance and benefits, the home environment, health and medical needs and social care needs. Resilience of the individual is important throughout this process.

2.9.1 School progression:

School transitions can be challenging for children and in all cases will require some level of readjustment. Difficult transitions can be a significant risk factor for poor mental health in children[38].

Children at increased risk of struggling with transitions include those who: feel less ready than their peers, struggle to develop relationships with staff, don't feel a sense of belonging to the school, have experienced loss or are in care, have been bullied, have mental health difficulties or autism.

The main transitions around school include beginning primary school, moving on to secondary school and leaving school. Anxieties around transition to primary school can focus around being separated from the primary care-giver, and are sometimes exacerbated by parents own anxiety being projected onto the child. Preparation for primary school can help this transition to run smoothly either at home with activities or by engagement with induction programmes often put on by schools.

The transition to secondary school however is often much more pronounced and can be associated with increased risk of poor attendance, lower grades, school disengagement, reduced confidence and an increase in

symptoms of mental illness[38]. Pupils may struggle with the new larger environment with more peers and social hierarchies and a switch from a child-centred teaching approach to subject-based. The worries most often described by children undergoing this transition are: losing old friends, getting lost in a new larger school, rules and discipline. Pupils who are able to communicate difficult emotions about transitioning to secondary school are more likely to cope, and is a useful protective factor[39]. Other protective factors parents can use to support their children include: good relationships and engagement with school staff, ensuring children have a quiet place to study, tracking homework, showing an interest in studies and wellbeing at school, promoting positive socialising and teaching digital safety skills online.

After school the transition to further education or work can be the most stressful yet. Half of all young adults will have accessed higher education by the time they are 30, but the number of students dropping out of universities due to mental health reasons has trebled in recent years, and rates of suicide among students are on the rise. For many students the transition to the freedom of university life is an enjoyable life-changing experience, but for some it can be much more distressing. Many students move to a different geographical location to attend higher education which can disrupt existing social connections and the informal support they provide. There is also a transition to a more self-directed learning style that requires independence, drive and organisational skills as well as experiencing new personal challenges such financial, domestic and relationships. There is a disconnection between the mental health services available at home and university, resulting in students who already suffer from mental illness struggling to find the same level of support. Risk factors for suffering from poor mental health as a university student include social isolation, being the first to attend further education in the family and having to seek part-time employment whilst studying.

2.9.2 Transitioning for individuals with existing mental health needs:

This time of personal transition in a young person's life also becomes the time that a young person moves from one service to another. The services that have been a source of help and support will say that they can no longer continue. Many young people experience a poor transition to adult services and up to 50% of under 25s disengage from adult mental health services on transition from services for children and young people. Some young people with mental health problems who have received care from secondary care services for children and young people do not meet criteria for secondary care adult mental health services. Transition between services for children and young people and adults typically occurs at age 18 but this may vary. Within ERY (not including Pocklington and Stamford Bridge) there is an agreed transition protocol between children and adult mental health services and transition should start around the age of 17.5 years old. Transition does not always involve a young person transitioning on to another mental health service as transitioning may include other adult services. In some areas there are youth mental health services spanning the ages 14-25 years, while other services span 0-25 years. This means that if the young person needs mental health services, they will need to be referred on to services for adults. This can be a very confusing time for young people and their parents.

As part of the Commissioning for Quality and Innovation (CQUINs) programme nationally and locally, there has been significant work on transitions in mental health. Within the ERY, the CQUIN scheme for 2018/19 identified the indicator of Transition out of Children and Young People's Mental Health Services which aimed to improve the experience and outcomes for young people as they transition out of the Children and Young People's Mental Health services.

Transition is a time of change from one place/service to another. In terms of mental health, this may mean the transfer of clinical care from child (CAMHS) to adult mental health services. It is also possible that a young person may no longer need the support of the CAMHS team, so they will be discharged and will continue to receive support from others, but is not referred on to adult mental health services.

For those young people who do continue to have severe mental health problems that require a transition to adult mental health services, this transition from one service to another should be a smooth process that offers uninterrupted continuity of care. The transition from childhood to adulthood can be a difficult time in everybody's life. Taking responsibility for yourself and your treatment is something not all young people are able to do by a given age.

Many young people treated by professionals in CAMHS will not need to be referred on to adult mental health services. If further support is needed, other services may be able to provide more appropriate help and support.

The GP and the local primary care team may be the only service involved in taking care of their mental health needs. GPs can provide continuity for a young person and their family and they can refer to specialist services if needed. The primary care team may be able to continue with the management of some disorders such as anxiety, depression and eating disorders. The team may also be able to provide or refer to counselling or psychological treatments, such as Cognitive Behavioural Therapy (CBT). They can also refer to adult mental health services if appropriate.

In some local areas, there may be a 16-19 services or team which help adolescents with mental health problems move from CAMHS to adult mental health services. Some young people may have mental illness that can be more severe (requiring hospital treatment or review of medications prescribed for mental illness). They may also have disabilities such as learning disabilities, along with the mental health problems. In this situation, the care and support is likely to be handed on to adult community mental health or adults with learning disability teams.

The NHS Long Term Plan discusses the development of a mental health service that crosses the 0-25 age group. In some cases, this would involve extending CAMHS upwards (to older clients) but in others, adult mental health services may work with younger age groups. An example of this, is NHS ERY CCG providing specialist early intervention in psychosis services that stat at age 14.

A young person can also have physical, social, emotional, educational and financial needs during this transition period. These needs may or may not be related to, or affected by, an underlying mental illness. When CAMHS are involved, it is possible that support was provided alongside other services, such as education and social care.

2.9.3 Transitions and resilience:

For everyone, the changes they face throughout this transition can be challenging mentally, physically and emotionally. Resilient children are better equipped to resist stress and adversity, cope with change and uncertainty, and to recover faster and more completely from traumatic events or episodes. Research indicates children nowadays are less able to cope with and overcome stressors and obstacles that may arise throughout the transition from childhood to adulthood, partly due to their being sheltered from challenging opportunities[40].

The promotion of resilience has been closely associated with children and young people's gains in self-esteem. Facing difficult periods during transition, such as academic pressures, adverse childhood experiences or poverty can reduce self-confidence which can increase the risk of anxiety, stress and depression in children and young people, as well as lead to mental health issues in their future[41].

2.10 Mental Health in Schools:

As 'universal services', schools and colleges play a vital role in promoting positive mental health, identifying need and providing early intervention in cases of mental ill health. The school role in supporting and promoting mental health and wellbeing are:

- **Prevention:** creating a safe and calm environment where mental health problems are less likely, improving the mental health and wellbeing of the whole school population, and equipping pupils to be resilient so that they can manage the normal stress of life effectively. This will include teaching pupils about mental wellbeing through the curriculum and reinforcing this teaching through school activities and ethos;
- **Identification:** recognising emerging issues as early and accurately as possible; identifying ACEs;
- **Early support:** helping pupils to access evidence based early support and interventions; and
- **Access to specialist support:** working effectively with external agencies to provide swift access or referrals to specialist support and treatment

According to a Public Health England and Children and Young Peoples Mental Health Coalition Report[42], in an average class of 30 15-year old pupils:

- 3 could have a mental disorder
- 10 are likely to have witnessed their parents separate
- 1 could have experienced a death of a parent
- 7 are likely to be have been bullied
- 6 may be likely to be self-harming

It is important to note, that there may be significant overlap between these indicators.

Recognising mental health problems is crucial for intervention and improvement. Adversity in children can often lead to mental health problems. PHE Fingertips has school-related adversity and vulnerability indicators which can link with mental health problems in children.

In 2018, 11.7% of ERY pupils (all ages) received free school meals; this is lower than compared to England (13.5%) and the Y&H region (15.5%). In 2016/17, within the ERY, the rate of children with fixed period exclusions due to persistent disruptive behaviour was 1.2 per 100 school aged pupils; this is lower than England (1.4 per 100) and for the Y&H region (2.8 per 100).

Evidence indicates that the educational experience of children up to the age of 12 years should provide opportunities for engagement in tasks considered fulfilling and worthwhile in order to promote their mental wellbeing. Disillusion or exclusion from school are risk factors for children's mental wellbeing. Children with emotional or conduct disorders are more likely than other children to have unauthorised absences. Additionally, children who frequently miss school can fall behind with their work and do less well in exams, which could lead to reduced life chances in later life. The more time a child spends around other children, whether in the classroom or as part of a school team or club, the more chance they have of making friends and feeling included, boosting social skills, confidence and self-esteem.

2.11 Home-Educated Children and Young People:

According to the Education and Skills Act 2018, it is now compulsory for young people to stay in education or training until they are aged 18. In recent years, there has been an increase in the number of children home-schooled in the UK. This trend has seen an increase particularly in children with SEND. There has been a 40% increase in the number of students who are home educated across the UK from 34,000 in 2014-15 to 48,000 in

2016/17[43]. Current estimates for 2018 suggest 57,873 children and young people were home-schooled across the 152 local authorities in England[44]. On average within ERY, 0.3% of school-aged children are home-schooled which when applied to the 2018 population estimates is approximately 15 children.

The increased trend in home education is prevalent throughout the country with 92% of the local authorities reporting year-on-year increases in the number of children and young people being home-schooled. It was also reported by the Association of Directors of Children's Services (ADCS) report that around 10% of these home-schooled children had SEND. Additionally, around 80% of these home-educated students had previously attended mainstream educational institutions. It is worth mentioning that until 2019, it was not mandatory for local authorities to keep a register of all children and young people who were not in mainstream education. This is important to consider when acknowledging the increase in number of children being home educated. Better reporting of home education may be the reason for the increase in prevalence.

Several factors have been mentioned to explain the rise in home-education. Two main theories are social isolation and mental health issues. According to one study, bad experiences with formal provision and the perceived failure of schools to meet children's needs adequately were highlighted by parents as a leading reason for home-educating their children. It was also found that around 48% of children taken out of the mainstream education system were described as having Autistic spectrum condition.

Much of the literature surrounding the impact of home-schooling on children's' mental health and future wellbeing is testimonials from those who have been home-schooled or studies from the USA. Testimonials claim home-schooling enables children to develop more self-confidence, feel less stressed and socially anxious[45].

More children are being educated at home due to mental health issues[43]. Parents claim home-schooling is a more supportive environment for their children to learn in rather than the busier mainstream schools. Socialisation within schools can cause anxiety in children which can lead to peer pressure and risky behaviour in children as they age and try new things. However, researchers have expressed concern about home-schooled children who may not receive the support they require[46].

Home-schooling can have its disadvantages. Those who choose to home-school are often stigmatised by those who attend mainstream education[47]. This stigma and judgement can lead to issues regarding bullying of children or even their parents. Another potential disadvantage of home-schooling is the potential loss of freedom for those children. Those children in mainstream education are able to go out into different environments and interact with a wider populous whereas those who are home-schooled may have limited interaction with anyone outside of their family circle. This can lead to poor emotional development.

It is important local services do not appear to have a high prevalence in the ERY, it is important to ensure this small subset of children and young people are not neglected.

2.12 Children in the Youth Justice System:

Children who end up in custody are three times more likely to have mental health problems than those who do not. These children are also more likely to have multiple mental health problems, to have a learning disability, to be dependent on drugs and alcohol and to have experienced a range of other challenges. Many of these needs go unrecognised and unmet.

At the point of arrest, there is an opportunity to identify these needs early on, to link young people and their families with the support they need and to reduce the chance of people going in and out of the youth justice system. In 2007, the Department of Health and the Youth Justice Board, funded a national programme of six pilot Youth Justice Liaison and diversion schemes for young people with mental health, learning, communication

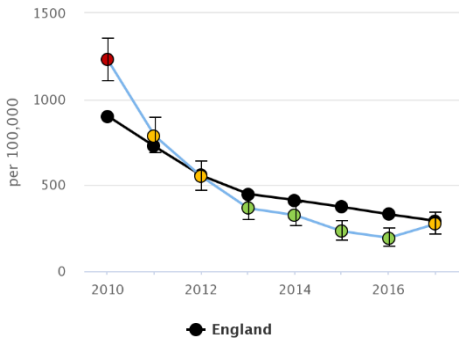
difficulties or other vulnerabilities affecting their physical and emotional wellbeing. The pilot schemes were designed to ensure that children and young people with mental and emotional problems get the help they need as soon as they enter the youth justice system. An independent evaluation found that young people involved in these schemes took longer to reoffend and had significant improvements in depression and self-harming. Data collected from these sites provided useful information on the range and multiplicity of needs of young people entering the Youth Justice System.

Most adults with poor mental health first present with symptoms during their teenage years so early intervention is critical to promote children's life chances and reduce multi-sector costs. Children with poor mental health are more likely to present with unclear symptoms (such as persistent behavioural difficulties) at an early stage in their lives making vulnerability less easy to identify for non-clinicians. These children are more likely to exhibit 'bad behaviour' which can lead to their involvement with the youth justice system.

2.12.1 Youth justice figures for ERY:

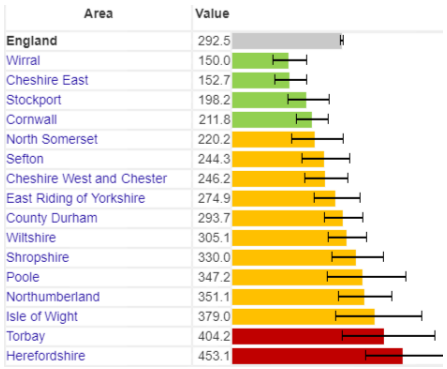
According to PHE Fingertips, the rate of first time entrants to the youth justice system for ERY was 249.9 per 100,000. This was lower than the regional and national rate. The rate of young people aged 15 years in the youth justice system in 2015/16 was significantly worse for the Y&H region (3.1 per 1000) compared to the national rate (2.5 per 1000).

Figure 10: First time entrants to the youth justice system (crude rate per 100,000).



Source: PHE Fingertips, 2019.

Figure 11: First time entrants to the youth justice system (crude rate per 100,000) comparing ERY to CIPFA nearest neighbours.



Source: PHE Fingertips, 2019.

Youth justice prevention is a major national effort. Within ERY, there are teams in Bridlington and Goole with specialist prevention service staff who work in hubs to ensure that children, young people and families have quick and easy access to help if and when it is required.

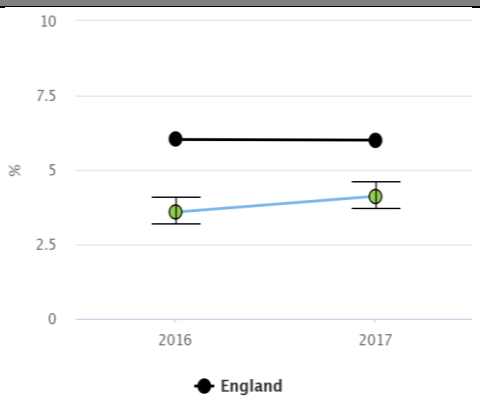
2.13 Not in Education, Employment or Training:

Young people who are not in education, employment or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. Youths with mental health problems often have difficulties engaging in education and employment.

To support more young people and reduce the risk of young people becoming NEET, legislation was introduced in 2013 that all young people remain in some form of education or training until the end of the academic year in which they turn 17. From September 2016, the Department for Education relaxed the requirement on authorities to track academic age 18-year-olds. Local authorities are only required to track and submit information about young people up to the end of the academic year in which they have their 18th birthday. In 2017, the proportion of 16-17 year olds NEET within the East Riding was 4.1% (280 16-17 year olds).

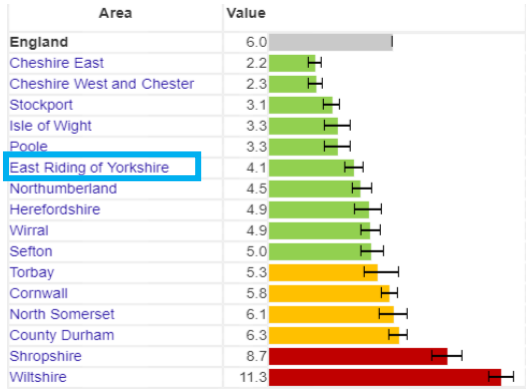
This was significantly better than the regional (5.8%) and national (6%) proportions (see figures 12 and 13).

Figure 12: 16-17 year olds not in education, employment or training (NEET) or whose activity is not known.



Source: PHE Fingertips, 2019.

Figure 13: 16-17 year olds not in education, employment or training (NEET) compared to ERY CIPFA nearest neighbours.



Source: PHE Fingertips, 2019.

According to the Department of Education, those who attend 'Outstanding' or 'Good' Ofsted-rated schools at the end of key stage 4 (the two years which incorporate GCSEs) have a lower proportion of NEET that compared to schools with 'Inadequate' ratings. There are 165 schools and colleges within the ERY. Of these, 124 have an Ofsted rating of 'Outstanding' or 'Good'. There are 15 schools and colleges within the ERY with a rating of 'requires improvement' but no schools are rated as 'inadequate'.

2.14 Children Who Are Carers:

Children can become the predominant carer for their parents, family member or siblings. This can mean some children are unable to enjoy their childhood due to taking on extra responsibilities, including domestic chores or taking care of a physical or mental condition. Many child carers go unrecognised but can struggle educationally, suffer bullying, suffer from stress, become isolated and suffer mental health conditions including anxiety and depression.

Early identification of young carers is key to improve their quality of life. Children charities, such as Action for Children, Barnardos and the local authority work to identify young carers as early as possible. Teachers often play a crucial role in this identification, as they can notice child absenteeism, or if the child seems preoccupied. Additionally, teachers can be seen as a confidant to whom young carers can discuss their situation with.

According to the 2011 Census, there were 545 children (0.98%) (aged 0-15 years) providing unpaid care to a relative or someone they knew. This was significantly lower than the proportion of children across the region (1.02%) and nationally (1.11%).

Within the ERY, young carers can access the East Riding Young Carers and Siblings Service for support. Additionally, advice and support are available from pastoral staff within schools and from the Families Information Service Hub.

3. Healthy work

Being in good work is better for your health than being out of work. 'Good work' is defined as having a safe and secure job with good working hours and conditions, supportive management and opportunities for training and development. **T**here is clear evidence that good work improves health and wellbeing across people's lives and protects against social exclusion. Conversely, unemployment is bad for health and wellbeing and is associated with an increased risk of mortality and morbidity.

For many individuals, in particular those with long-term conditions such as mental health problems, musculoskeletal (MSK) conditions and disabilities, health issues can be a barrier to gaining and retaining employment. 1 in 6 adults will have experienced a common mental health disorder. 7.6% of sickness absences in the UK are attributed to stress, depression and anxiety every year. 14.3 million working days are lost per year in the UK due to common mental health disorders.

3.1 Workplace Wellbeing:

"Being in good employment is protective of health. Conversely, unemployment contributes to poor health." Marmot Review 2010

As adults in employment spend a large proportion of their time in work, our jobs and our workplaces can have a big impact on our health and wellbeing. In fact, employment can impact both directly and indirectly on the individual, their families and communities. Therefore, work and health-related worklessness are important public health issues, both at local and national level.

There is clear evidence that good work improves health and wellbeing across people's lives, not only from an economic standpoint but also in terms of quality of life. 'Good work' means having not only a work environment that is safe, but also having a sense of security, autonomy, good line management and communication within an organisation.

There is also evidence that shows that good quality work protects against social exclusion through the provision of income, social interaction, providing a sense of identity and purpose, and providing individuals with a core role. Conversely, there is also clear evidence that unemployment is bad for both mental and physical health as it is associated with an increased risk of mortality and morbidity, including CVD, suicide risk, and health-harming behaviours and limiting long-term illness.

Mental health issues within the workforce is an expensive health issue which costs UK employers approximately £42 billion per year, including £8 billion in sickness absence. Three out of every five employees experience mental health issues because of work (including stress, depression and anxiety). 31% of the UK work force has been formally diagnosed with a mental health issue, and of these individuals, only 13% feel comfortable discussing their mental health state with their line manager.

3.1.1 Bullying in the workplace:

People occasionally experience excessive amounts of stress in the workplace due to difficult relationships or even bullying and harassment. Bullying can occur overtly in the form of arguments and rudeness, but can happen

subtly by excluding, ignoring contributions and overloading with work. Excessive stress in the workplace can put people at risk of developing a mental health problem and makes existing problems much harder to cope with[48].

3.2 Job loss and Unemployment:

Work, worklessness and health is an important public health issue at both local and national level and is highlighted in many health and wellbeing strategies, devolution plans and in the Five Year Forward View and sustainability and transformation partnerships for the NHS.

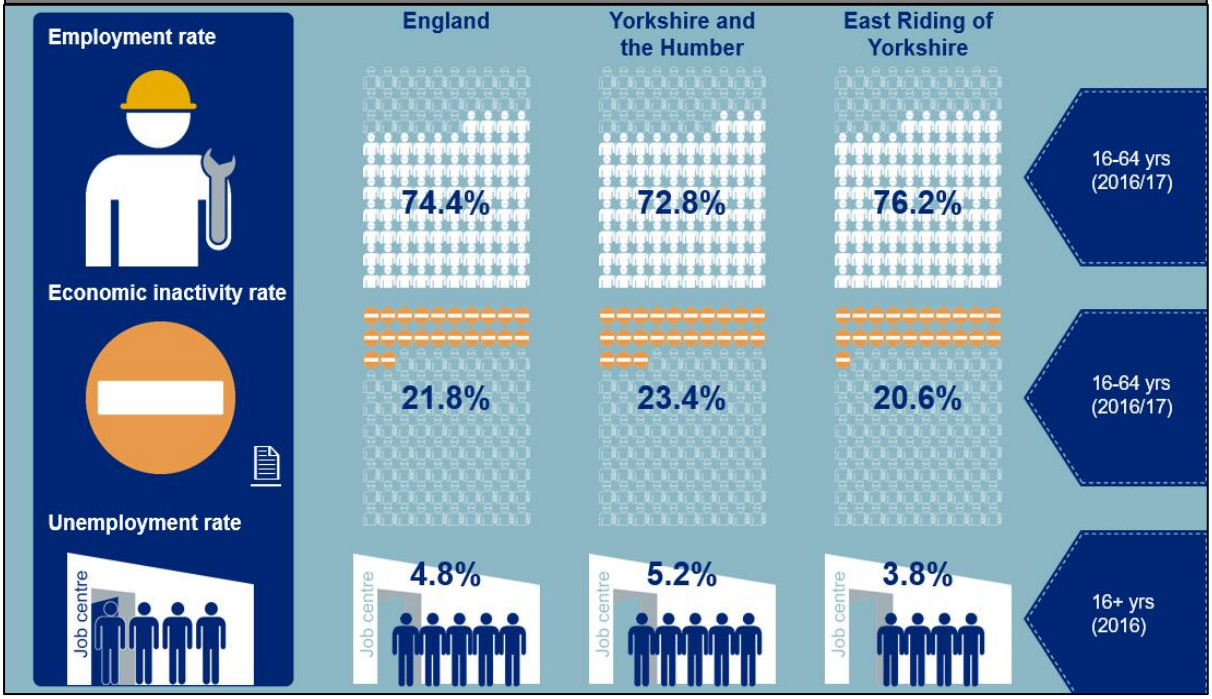
With combined costs from worklessness and sickness absence amounting to over £100bn annually, greater than the annual budget of the NHS, there is a strong economic case as well as a moral and ethical case for greater action.

Research on the health consequences of unemployment often draws on stress theory[49]. According to this perspective, unemployment is a major source of psychological distress in the life course and the experience of distress may directly impact health through cortisol responses[50]. Previous studies have shown that unemployment is associated with increased morbidity and negatively impacts mental health.

Families affected by unemployment often experience poverty and hardship, strained relationships, poorer health and housing stress. There may even be negative consequences for future generations harming children's development and employment prospects. Children of unemployed parents can often adopt this lifestyle. Through childhood exposure to unemployment, generations can grow-up considering this normal and thus either remain unemployed throughout their own adult life, or grow-up without aspirations. This can have detrimental effects on their own mental wellbeing and risks financial hardship.

The infographics below are produced using the PHE infographic tool for employment. The indicators match those which appear on Fingertips. The unemployment rate in ERY is significantly lower than the regional and national rates.

Figure 14: Employment, economic inactivity and unemployment in ERY compared to England.
Source: Public Health England, 2019.



The gap between the employment rate for people supported by secondary mental health services and the overall employment rate is a good reflection on how well the local mental health system, is enabling people with mental health conditions to achieve their employment potential.

The gap in employment rate for those in contact with secondary mental health services and the overall employment rate for 18-69 year olds (2016/17) is 58.2% for ERY, 63.6% for Y&H and 67.4% for England. The gap in employment rate is significantly better for ERY than compared to England.

The percentage of total Employment Support Allowance claimants with primary condition of mental and behavioural disorders (2017) was 41.8% for ERY, 48.9% for Y&H and 49.1% for England.

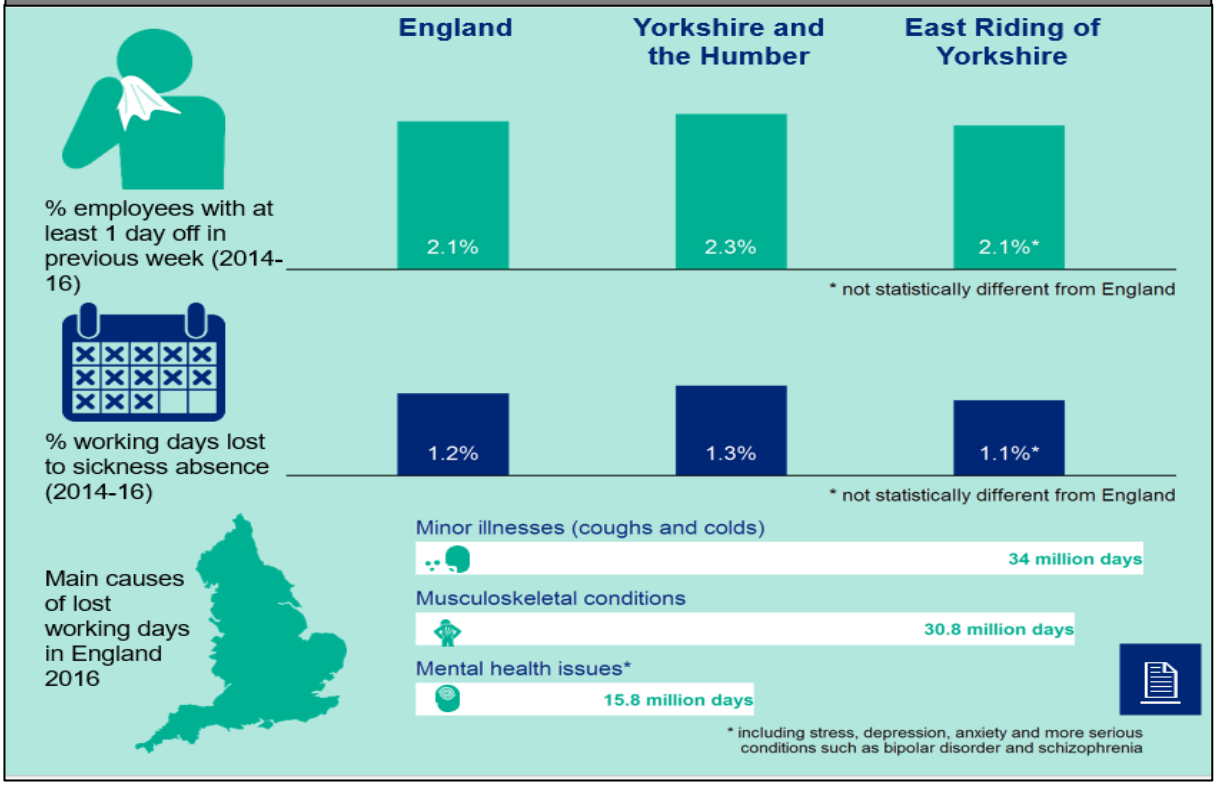
A national survey in England found that almost 1 in 6 people of a working age (16-69 years) have a diagnosable mental health condition. This equates to potentially 37,000 people in ERY having a diagnosable mental health condition (based on the mid-year population estimates 2017 [222,020 16-69 year olds within ERY]).

Sickness absence provides a high level indicator of the way local businesses are supporting staff health and wellbeing. It reflects both employers' efforts to support staff to remain well in work when affected by chronic health issues, as well as supporting their general health and wellbeing and how quickly staff are supported to return to work after a period of ill health.

The sickness absence data provides an opportunity to focus on how employers are supporting health and wellbeing issues in the workplace and how the local public health system is supporting action across every size and sector of industry and business in the local area.

Figure 15: Sickness absence in ERY compared to England.

Source: Public Health England, 2019.



3.3 Volunteering and Mental Health:

Volunteering has been found to be very beneficial for mental health. It has been found to reduce stress, improve wellbeing and even benefit physical health. These altruistic behaviours promote physiological responses in the brain associated with happiness, and those who practice them report feelings of belonging, social connection and new perspectives.

When putting other needs ahead of our own it is also important to recognise our limits. We can help others but not at the detriment of our own health or wellbeing. The benefits of helping others can be experienced without significant contributions of money or time.

3.4 Access to Employment:

Around 25% of people in the UK are currently unemployed for a variety of reasons including redundancy, sickness, and lack of opportunities, relocation and dismissal. Access to employment can have profound effects on mental health. Without the opportunities to work, individuals can feel without purpose. Lack of access to employment can cause stress and anxiety within families, prompting financial and housing concerns. Additionally, access to employment can have profound influence on the mental health and social cohesion within communities.

3.5 High Risk Occupations:

Within the ERY, 90% of the land is used for agricultural purposes and there are many established farming communities. There are over 32,000 farm workers in the whole of Yorkshire and the Humber[51]. Many people working agriculture and other associated industries struggle with poor mental health. About one agricultural worker takes their life every week across the UK[52]. Heavy workload, isolation and the perceived stigma around mental illness within the farming community undoubtedly contribute to this issue. People who work in similar industries such as commercial fishing are also known to be at increased risk of poor mental health.

4. Healthy Parenting and Families

Many parents with young, dependent children experience short- or long-term mental health problems and many would be affected by a mental health problem as a result of their parenting role. Children can cope well with short-term emotional and behavioural problems experienced by their parents; however, more severe and long-term parental mental health problems can have a significant negative impact on every aspect of a child's development. It is important to note, however, that this is not to say that all children of parents who experience mental health problems will develop a problem themselves. Approximately 68% of women and 57% of men with mental health problems are parents.

As per the Joint Commissioning Panel for Mental Health, the most common mental health problems experienced during pregnancy and after birth are anxiety, depression and PTSD.

- Women experiencing maternal mental health problems:
- Postpartum psychosis: 2 per 1,000
- Serious mental ill health: 2 per 1,000
- Severe depressive illness: 30 per 1,000
- Mild-moderate depressive illness and anxiety states: 100-150 per 1,000
- PTSD: 30 per 1,000
- Adjustment disorders and distress: 150-300 per 1,000.

Poor maternal and paternal mental health has been associated with poor outcomes in children but not all children of parents who have mental health problems are at risk. A number of biological dispositions, sociocultural contexts and psychological processes are likely to interact and can serve as protective factors or risk factors for both parents' and children's mental health.

4.1 Perinatal Mental Health:

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of women, and covers a wide range of conditions from transient psychological problems to depression, anxiety, psychosis and PTSD[53]. If left untreated, conditions can have significant and long lasting effects on the woman and her family. Perinatal mental health problems can also have long-standing effects on children’s emotional, social and cognitive development.

It is reported within the literature that post-natal mental health issues affect approximately 10-15% of women worldwide but the true prevalence is suspected to be much higher due to the lack of appropriate research and data from developing countries.

The Avon Longitudinal Study of Parents and Children (ALSPAC) reported that 14.6% of women scored above the threshold score for anxiety at 18 weeks post-birth. Research has also identified between 2.8% and 5.6% of women experience PTSD at 6-weeks postnatal[54]. Postnatal depression still remains one of the main mental health problems with estimates suggesting an incidence rate of 5-22% and a prevalence of 13.8% within the UK[55].

Currently only mothers can be formally diagnosed with a perinatal mental health problem[56]. However, paternal and maternal mental health can be negatively affected during the perinatal period. Paternal and

maternal depression can have negative impacts on how parents interact with children and can have long-term if untreated.

Studies into postnatal depression in fathers suggest around one in five men experience depression after becoming fathers[56]. This is the same estimation for women, with studies suggesting one in five women will experience a mental health problem during pregnancy or in the year after giving birth[56]. Incidence of depression and obsessive compulsive disorder is common in parents postnatally.

NICE guidelines recommend men and women with an existing mental health disorder who are pregnant or planning a pregnancy, and women who develop a mental health disorder during pregnancy or the postnatal period, should be given culturally sensitive information at each stage of assessment, diagnosis, course and treatment about the impact of their disorder and its treatment on their health and the health of their child[57].

4.1.1 Perinatal health in ERY:

The figures available on PHE Fingertips are estimates based on national prevalence estimates and do not take account of socio-economic or demographic differences or anything else which is likely to cause variation across area. Within ERY, 15.4% of the population (2015) was of childbearing age (15-49 years); this is lower than the regional (19.1%) and national (19.4%) proportion.

Postpartum psychosis was estimated to affect 1265 women across England in 2015/16. In 2017/18, it was estimated there was 4 women within ERY who experience postpartum psychosis.

Severe depressive illness was estimated to affect 18965 women across England (2015/16) and 85 women within ERY.

Mild-moderate depressive illness and anxiety in the perinatal period is estimated to effect 285-425 women in ERY (2015/16 figures) compared to 63205-94810 women in England[57].

Adjustment disorders and distress during the perinatal period is estimated to have affected 425-845 women in ERY in 2015/16 compared to 94810-189615 in England. It was also estimated 85 women experienced PTSD in the perinatal period during the same time period.

Within the ERY, 93.3% of new mothers receive a Health Visitor visit within 14-days of birth. This is higher than the regional (82.5%) and national (87%) rates (2015/16).

Perinatal health is considered locally within the Transformation Plan.

The perinatal mental health community services development fund from Humber, Coast and Vale (a new service building on the existing locally funded service) aimed to expanding a small existing service across the whole STP area using a hub and spoke/co-location model in conjunction with South Yorkshire and Bassetlaw STP and West Yorkshire and Harrogate STP.

4.2 Paternal Mental Health:

The rates of paternal mental ill health varies between 5-10% and this number appears to be increasing. According to a longitudinal population based study looking at more than 10,000 men, it was reported that the

depressive symptoms score increased on average by 68% during the first 5 years of a child's life[53]. Research suggests policies identifying early on the men at high risk of developing mental health is required in order to improve health outcomes for the whole family.

Depressed fathers exhibit poorer parenting behaviours, lower likelihood of child engagement, and greater likelihood of parenting stress and child neglect than non-depressed fathers[57, 58]. This translates down to the children who are more at risk of developing psychiatric conditions, poorer language and reading development and increased behavioural problems.

Paternal mental health has an important role to play in their own wellbeing, their child's health and the stability of the family environment[59]. The father's mental health symptoms in the pre-school years are likely to adversely affect both boy's and girl's socioemotional behaviours at school entry[59]. A research study identified adolescents with depressive symptoms and children with behavioural problems were more likely to be offspring of fathers who had depression or anxiety during the postnatal period[60].

NHS England announced in 2018 that fathers would be offered mental health checks and treatment under new action to support the mental health and wellbeing of families[61].

4.3 Parenting Mental Health:

Parenting is formally defined as the process of promoting and supporting the physical, emotional, social and intellectual development of a child from infancy to adulthood. Research has shown the importance of childhood, particularly the first few years of life, for future mental, social and emotional development[62]. The mental health and emotional wellbeing of parents is pivotal to their own quality of life and for positive parenting. For more information, see the East Riding of Yorkshire Parenting Strategy.

When a parent becomes mentally unwell, it can be difficult for them to explain to their child what is happening and for the child to make sense of their behaviour. Additionally, the parent may find it difficult to cope whilst suffering from poor mental health[63, 64]. Parents also expressed feeling guilty about having a mental health problem whilst raising children which creates stigma around parents seeking help for their mental health issues and in turn can be detrimental to the health and wellbeing of both parents and the children[65].

Parenting can influence, or contribute, to the development of mental health issues, including anxiety, depression and post-natal depression. Societal pressures to be the 'perfect parent' contributes to anxiety in many parents, with parents doubting their abilities to be a 'good parent'.

Large numbers of children grow up with a parent who has a mental health problem. Many of these parents will have a mild or short-lived problem. Many children live with a parent who has a long-term alcohol problem or drug dependency, sometimes combined with a mental health problem such as depression. Children can also live in households which have or personally experience domestic violence.

Some parents have a severe and enduring mental illness. These long-term conditions include schizophrenia, personality disorders and bi-polar disorder. Estimates suggest that between 50-66% of parents with a severe and enduring mental illness live with one or more children under age 18. That amounts to about 17,000 children and young people in the UK[65].

Research shows that children of parents with severe and enduring mental illness experience greater levels of emotional, psychological and behavioural problems than children and young people in the rest of the population. This may be because of genetics, but could also be due to the situation and the environment in which they are growing up. Parents with severe mental illness are more likely to live in poverty which can in turn affect the

child's mental health[65]. The child may feel insecure and anxious that their parent will become unwell, and they may also have to live with the stigma attached to mental ill health and may be bullied in school.

As well as worrying about their parents, children may be reluctant to ask for help for fear that they will be taken away from their parents. Children may become carers for their parents and lose out socially and educationally. Estimates suggest that about 175,000 young carers in the UK who are caring for a parent or other family member with mental health problems[65].

4.4 Adverse Childhood Experiences:

Adverse childhood experiences (ACEs) are very traumatic and stressful experiences that occur in childhood and can lead on to suffering from physical and mental health conditions in adulthood. ACEs can cover a multitude of events from maltreatment, violence (including sexual assault and domestic violence), coercion and prejudice through to inhumane treatment, adult responsibilities (being a young carer), bereavement and surviving an accident or illness. They can impact a child's development and their relationships with others which could result in social isolation and mental health problems.

Figure 16: Forms of adverse childhood experiences that can impact mental and emotional wellbeing. These influences can have profound and lasting effects on the mental health of individuals[66].

Source: NHS Highland, 2018.

There are direct and indirect experiences which form the basis of ACEs[67]. The three direct experiences are verbal, physical and sexual abuse. The indirect experiences are parental separation, domestic abuse, mental illness, alcohol and drug use, or incarceration.

According to the Harvard University Centre for the Developing Child, chronic or toxic stress due to adverse childhood experiences can fundamentally alter the nervous, hormonal and immunological system development of young people.

It is quite difficult to measure accurately the prevalence of ACE but a study looking at this in Wales found for 47 per 100 adults suffered at least one ACE, and 14 in 100 suffered four or more ACE[68]. ACEs have prolonged impacts on the health of the individual throughout their lives and can also lead to early deaths. Bellis and colleagues also identified adults who have ACE are 20 times more likely to be incarcerated and 16 times more likely to do drugs such as cocaine or heroin.

Primary prevention of ACEs is essential to improve the health of populations across the life course. Research shows preventing ACE can reduce the prevalence of other health-harming behaviours such as unintended

teenage pregnancies, incarceration, violence perpetration, violence victimisation, drugs and alcohol abuse, poor diet and smoking rates.

ACE directly impact organic conditions as well with COPD four times more likely in adults who have suffered ACE and 2.5 times more likely to suffer from hepatitis. These conditions are affiliated with risky behaviours such as smoking and unprotected sex, two activities which have a high incidence in young people following ACE [68, 69].

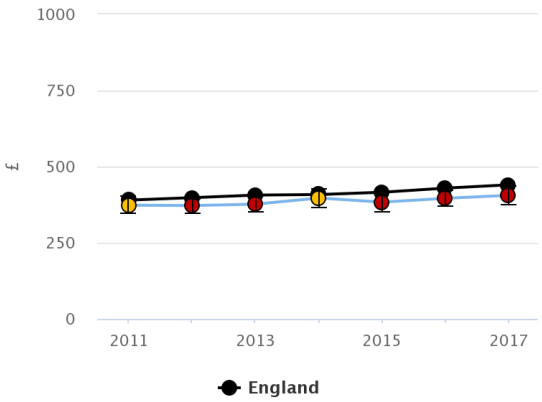
Contextual safeguarding aims to reduce the incidence of ACEs and improve child mental and emotional outcomes. For more guidance and information regarding contextual safeguarding, access the Contextual Safeguarding Network's guidance on the subject here.

4.5 Poverty:

There is a strong socioeconomic gradient in mental health, with people of lower socioeconomic status having a higher likelihood of developing and experiencing mental health problems. According to the Marmot Review[70] children and adults living in households in the lowest 20% income bracket in the UK are 2-3 times more likely to develop mental health problems that those in the highest. Analysis of data from the Millennium Cohort Study[71] found children in the lowest income quintile to be 4.5 times more likely to experience severe mental health problems than those in the highest.

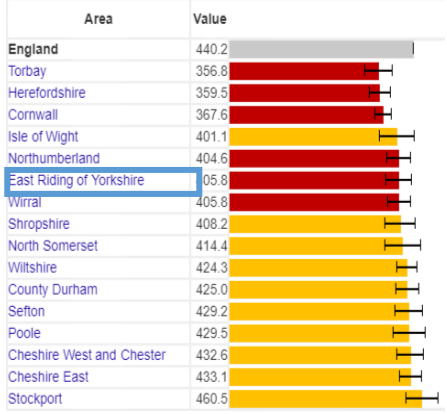
Poverty and mental health problems are not marginal experiences of a separate group in society: anyone can experience either over their lifetime and there is clear intersection between mental health and poverty. Neither poverty nor mental health is a static experience therefore, what an individual, family or community needs in terms of protective, and preventative and promotional resources changes. For individuals, these needs and resources change over the life course – particularly at transition points between these stages and at pressure points. Given the cumulative impacts on mental health of disadvantages and advantage over the life course, the WHO has stressed the importance of early intervention and consideration of Mental Health in All Policies.

Figure 17: Average weekly earnings of full and part-time employees based upon workers resident location.



Source: PHE Fingertips, 2019.

Figure 18: Average weekly earnings of full and part-time employees based upon workers resident location.



Source: PHE Fingertips, 2019.

4.5.1 Poverty in ERY:

Generally the ERY is an affluent county. However, there are specific areas where deprivation is greater. See section 7.13 for more information.

Children in low income families (under 16s) are more likely to have mental health problems and suffer from bullying and difficulty socialising. Child poverty is an important issue for public health as the Marmot Review[70] suggests there is evidence childhood poverty leads to premature mortality and poor health outcomes for adults. According to HM Revenue and Customs, in 2015, 11.6% of ERY children under the age of 16-years were in low income families; this is lower than the regional (19%) and national (16.8%) level.

Income deprived older people (60-years and older) are also affected by poverty. In 2015, 12.6% of the over-60s ERY population were income deprived compared to 16.2% nationally. 12.6% of the ERY over 60s population in 2015 equates to 13,190 older people living in deprived circumstances.

4.6 Children Looked After:

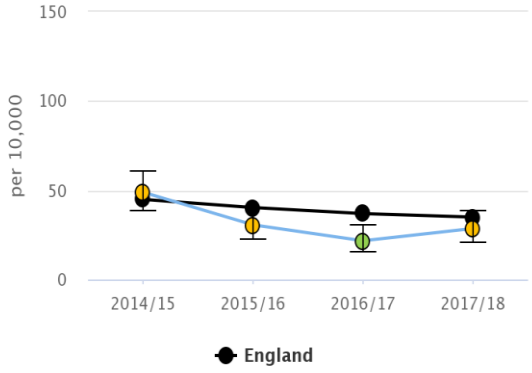
Young people come into the local authority care system following trauma and difficulties in their lives. Most of these children will have suffered abuse or neglect, or experienced bereavement, disability or serious illness in one or both parents. Many children in care (now termed children looked after (CLA)) are from disadvantaged backgrounds. Being looked after can involve major and sometimes traumatic upheaval.

Changes and a lack of permanence in the arrangements for many CLA are unsettling and can hamper effective work by professionals. The stigma of being looked after and the unhappiness that young people may feel can inhibit their asking for help or wanting to use any facilities or services on offer. This can worsen existing attachment problems in addition to introduce new ones. Social care staff often have difficulty in finding appropriate placements that meet basic emotional, physical and cultural needs of looked-after people. Issues in caring for CLA with mental health problems arise due to services having difficulty providing specialist mental health support to children without a permanent residence.

A number of children have positive experiences in the care system and achieve good emotional and physical health, do well in their education and have good jobs and careers, however, entering care is strongly associated with poverty and deprivation. About 60% of those CLA in England have been reported to have emotional and mental health problems and a high proportion experience poor health, educational and social outcomes after leaving care. Being in care is a determinant of adult mental health and is associated with increased levels of antisocial behaviour, emotional instability and psychosis.

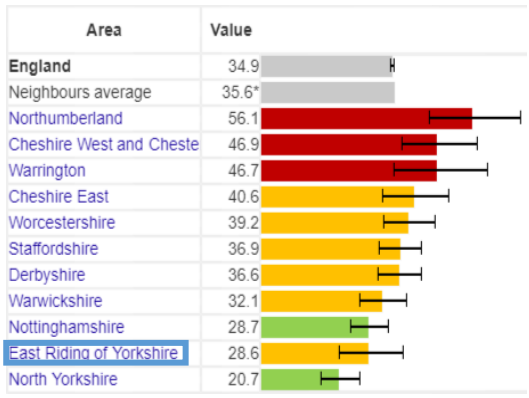
4.7.1 CLA in ERY:

Figure 19: Children looked after aged under 5 years old in ERY.



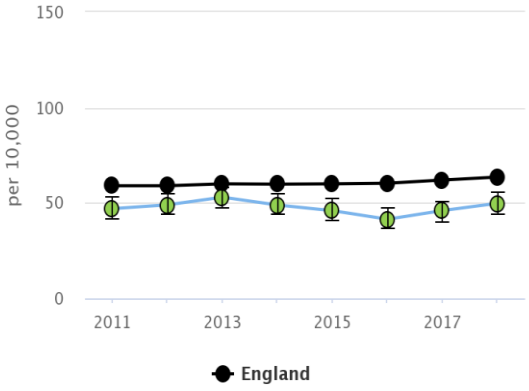
Source: PHE Fingertips, 2019.

Figure 20: Children looked after aged under 5 years old in ERY compared to CIPFA nearest neighbours.



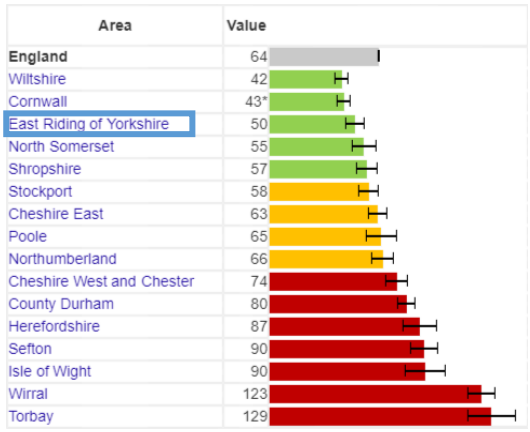
Source: PHE Fingertips, 2019.

Figure 21: Children in care in ERY compared to England.



Source: PHE Fingertips, 2019.

Figure 22: Children in care in ERY compared to CIPFA nearest neighbours.



Source: PHE Fingertips, 2019.

CLA can come from a variety of backgrounds and environments. Figure 23 shows the areas within the ERY where the highest number of CLA come from. Due to the small numbers involved, it is not possible to show most of the wards where CLA in 2018/19 originally lived. This figure shows higher rates in South East Holderness (64.5 per 10,000 population) and Bridlington South (58.2 per 10,000) where there were respectively counts of 18 and 17 children who became looked after during 2018/19.

Figure 23: Children who became looked after in 2018/19, by area of original residence (ward level).
Source: Children, Families and Schools Performance Team.

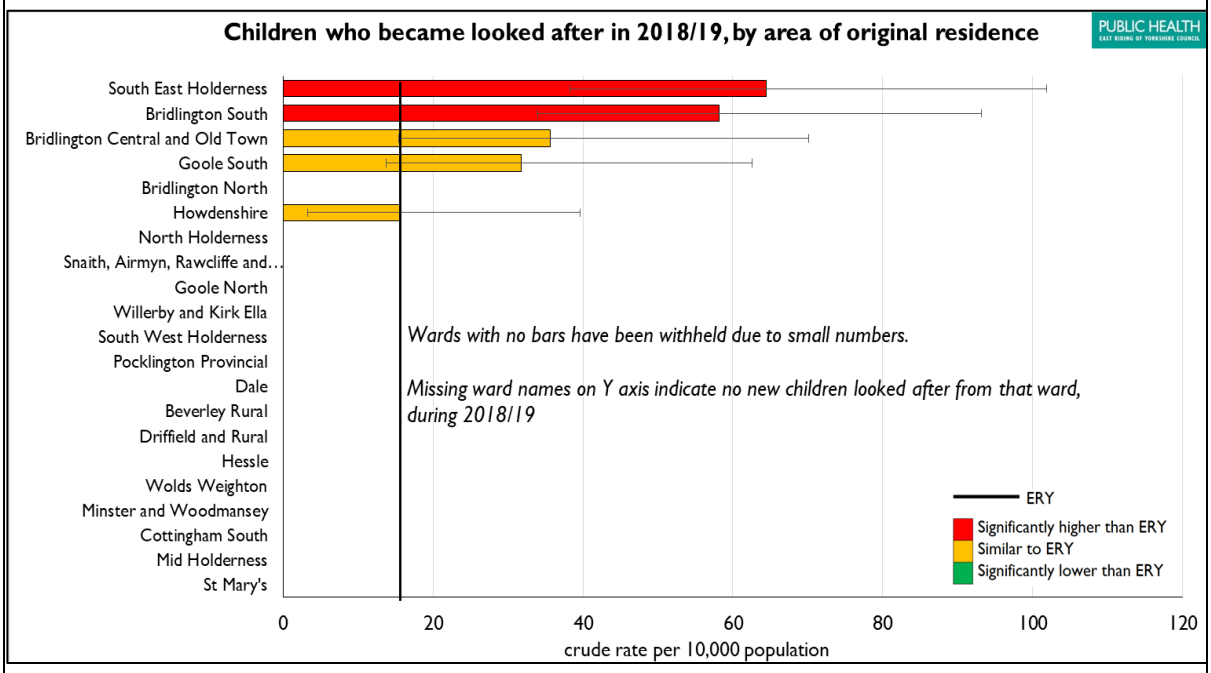
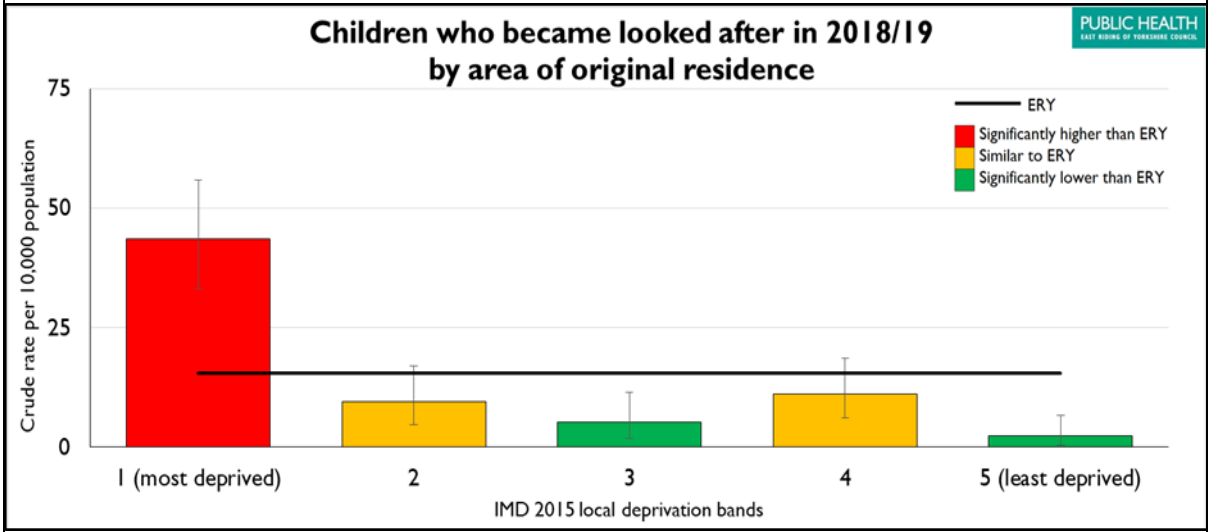


Figure 24 displays the deprivation quintiles for the same indicator. The rate of children who became looked after in the most deprived quintile was almost 20 times higher than the rate in the least deprived quintile, and almost

3 times the rate of the ERY average. However, it is important to note that deprivation is not the only factor in determining children becoming looked after.

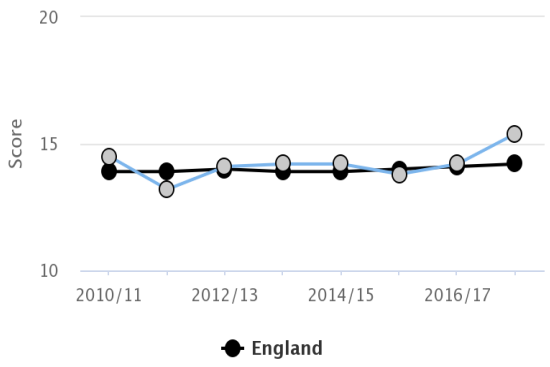
Figure 24: Children who became looked after in 2018/19, by area of original residence (local deprivation band quintiles, IMD 2015).

Source: Children, Families and Schools Performance Team.



The mental health of all children is important. With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional wellbeing issues is very important. The cross government mental health strategy, *No Health without Mental Health*, identifies CLA as one of the particularly vulnerable groups at risk of developing mental health problems. Those children with higher difficulty scores are more vulnerable to poor mental health outcomes than those with lower difficulty scores.

Figure 25: Average difficulties score for all CLA aged 5-16 who have been in care for at least 12-months on 31st March.



Source: PHE Fingertips, 2019.

Figure 26: Average difficulties score for all CLA aged 5-16 who have been in care for at least 12-months on 31st March, comparing ERY to CIPFA peers.

Area	Value
England	14.2
Neighbours average	-
Wiltshire	15.7
North Somerset	15.6
East Riding of Yorkshire	15.4
County Durham	15.4
Herefordshire	15.0
Torbay	14.7
Northumberland	14.6
Cheshire West and Cheste	14.5
Isle of Wight	14.4
Cheshire East	14.1
Stockport	14.0
Cornwall	13.4
Shropshire	13.2
Wirral	12.5
Sefton	11.2

Source: PHE Fingertips, 2019.

Experiencing abuse and/or neglect, is detrimental to an individual's mental health and wellbeing. Neglect is the persistent failure to meet a child's basic physical and/or psychological needs such as failure to provide adequate

food, shelter or clothing, protect a child from physical or emotional harm or to ensure appropriate medical treatment.

Children who are neglected and who do not get the love and care they need from parents or family are more likely to experience mental health problems including depression, PTSD, attention deficit disorder and hyperactivity disorder. Because of poor attachment in early life, they may also find it difficult to maintain health relationships with their peers and other people in later life, including their own children – thus repeating the cycle of neglect[71].

Children of all ages can be affected by destructive inter-parental conflict with effects throughout the life course of the child[71]. Unhappy or 'broken' family units can have lasting impact on a child or young person's ability to form their own emotional connections with others.

4.7 Carers:

A carer is anyone who looks after a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Although for many carers, caring can have positive and rewarding aspects, there are lots of reasons why caring can leave individuals feeling like they need support. Caring for a loved one can have an impact on many aspects of an individual's life including but not limited to[72]:

- Money and benefits:
    - Caring can lead to poverty as individual's have to give up work to care, or manage on benefits. The aids and equipment needed to help care can add an extra drain on tight finances.
- Health and wellbeing:
    - Caring can make individual's physically exhausted through physical care, as well as exhaustion due to taking on too much (i.e. caring for a person plus looking after the rest of a family and working etc.);
    - Caring can leave individual's feeling emotionally exhausted because of the strain of seeing someone experiencing pain, distress or discomfort;
    - Caring can lead to stress, depression and other mental health issues;
    - Caring can affect other relationships.

4.7.1 Carers in ERY:

Often carers are providing substantial amounts of unpaid care (+50 hours a week) which is detrimental to their health and wellbeing, including their financial circumstances. According to the 2011 census, 2.57% of the ERY population were providing unpaid care. This is significantly worse than compared to the national proportion (2.37%) and higher than the regional proportion of unpaid carers (2.56% in Y&H).

71% of carers have poor physical or mental health[73]. According to Carers UK, there were over 5,000 carers across the UK, with 84% revealing they were stressed, 78% felt anxious and 55% reported that they suffered from depression as a result of their caring role, all of which were higher than in the survey results in 2014. 38% of young carers report having a mental health problem, yet only half report receiving additional support from a member of staff at school[74].

Support from social services can alleviate some of the burden experienced by carers. Interaction with social services can also reduce some experiences of stress as carers do not feel they are alone. Overall satisfaction of carers with social services declined from 51.7% to 45.9% from 2012-2015 in ERY. However, the level of

satisfaction with social services was higher in ERY than compared to the region and nationally (43% and 41.2% respectively in 2014/15).

For further information on carers, the ERYC Carers Joint Strategic Needs Assessment is available here. The ERYC Carers Strategy for Adult Carers 2019-2024 is available here.

4.8 Housing and Homelessness:

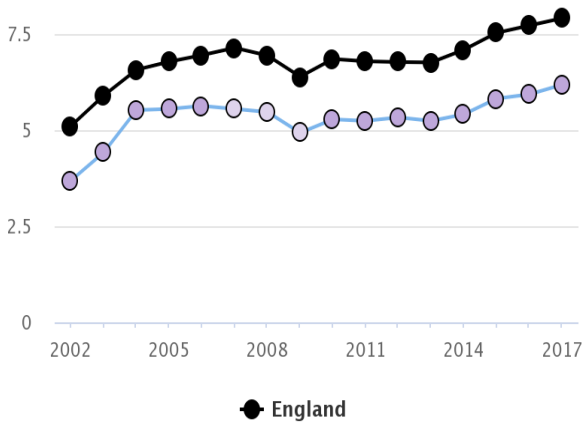
Housing and mental health are often linked as poor mental health can make it harder to cope with housing problems, while being homeless or having problems in your home can make your mental health worse.

According to research conducted by Mind, four in five (79%) of people with mental health problems said a housing situation has made their mental health worse or caused a mental health problem. More than two in three (69%) of people Mind surveyed said they had issues with their quality of their housing such as damp, mould, overcrowding and unstable tenancies. One in four tenants with mental health problems are behind on paying rent and are at risk of losing their home.

Housing affordability affects where people live and work, and factors that influence health including the quality of housing available, poverty, community cohesion and time spent commuting. Housing is an important social determinant of health, and the link between housing and health is widely acknowledged. There is increasing evidence there is a direct association between unaffordable housing and poor mental health, over and above the general financial hardship. Type of housing tenure may be an important factor in determining how individuals experience and respond to housing affordability and cost-related outcomes, supporting the mechanism that unaffordable housing is associated with trade-offs and reduced discretionary spending on health-related expenses. It is possible that, over time, these trade-offs may have a deleterious effect on health. Lack of housing affordability may be a sensitive marker for other forms of material deprivation such as food insecurity.

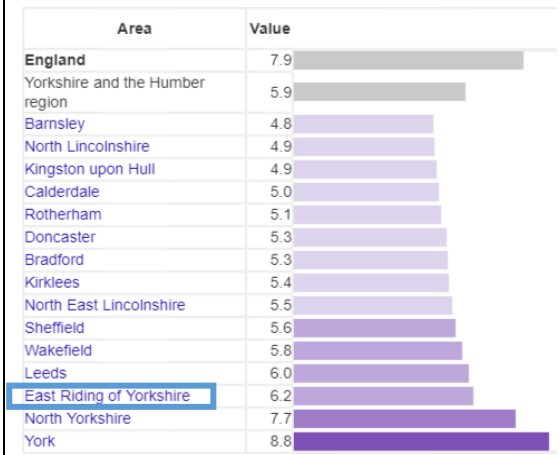
PHE produced an indicator which looks at the median house price to median gross annual residence-based earnings. This indicator identified ERY has worse affordability of home ownership than compared to England consistently from 2002-2017.

Figure 27: Affordability of home ownership within ERY compared to England.



Source: PHE Fingertips, 2019.

Figure 28: Affordability of home ownership within ERY compared to CIPFA nearest neighbours.

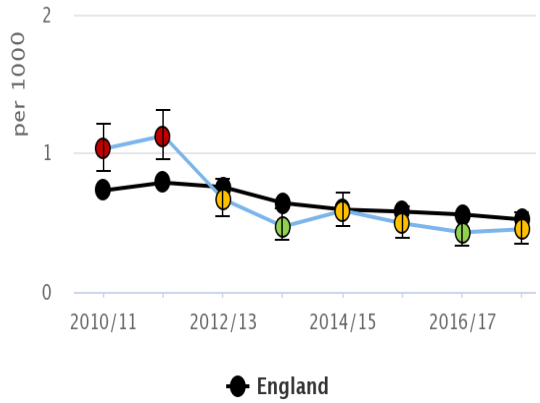


Source: PHE Fingertips, 2019.

Homelessness is associated with severe poverty and is a social determinant of mental health. The UN Convention on the Rights of the Child highlights the right of every child to an adequate standard of living. Children from homeless households are often the most vulnerable in society. The level of family homelessness in ERY has improved from 2011-2017.

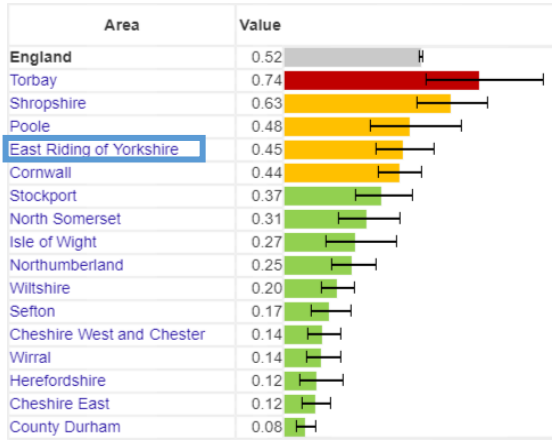
Homelessness has a serious impact on both the young people affected and the wider society. Young people describe their lives as being 'on hold' while they are homeless, making it much harder for them to achieve their goals and ensure their own wellbeing. Homeless young people are much more likely to not be in education, employment or training and they often experience a disrupted education. Poverty and desperation means some homeless young people turn to crime which further decreases the change of them finding work and escaping their situation. Homeless young people are also more likely to be victims of crime, as their situation puts them at risk of exploitation, particularly if they become homeless at a very young age. The often chaotic and unstable lives of homeless young people mean that poor physical and mental health is common, as is substance misuse.

Figure 29: Homeless young people aged 16-24 years old (crude rate per 1000).



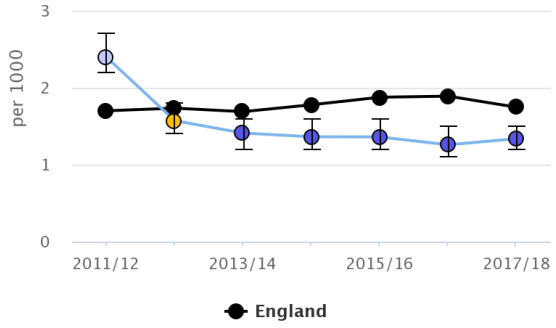
Source: PHE Fingertips, 2019.

Figure 30: Homeless young people aged 16-24 years old (crude rate per 1000) comparing ERY to CIPFA nearest neighbours.



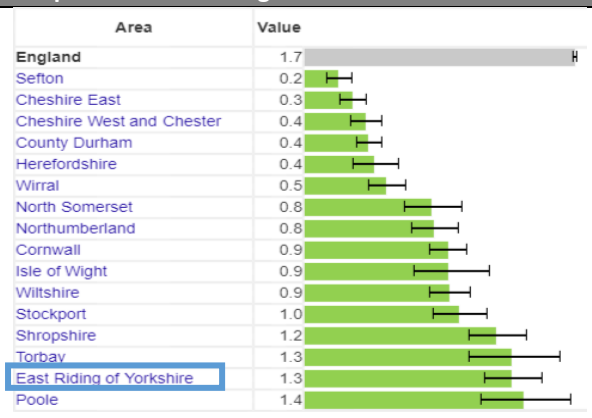
Source: PHE Fingertips, 2019.

Figure 31: Family homelessness (2017/18).



Source: PHE Fingertips, 2019.

Figure 32: Family homelessness (2017/18) in ERY compared to CIPFA neighbours.



Source: PHE Fingertips, 2019.

Arranging a place to live is likely to pose difficulties for people with learning disability. As part of their role in assisting those to live as independently as possible, local authority social service departments commonly help individual's with learning disabilities, and often mental health conditions, to find and keep accommodation. Types of accommodation can be divided broadly into 'settled' accommodation, where the person can reasonably expect to stay as long as they want and 'unsettled' accommodation which is either unsatisfactory or, where, like in residential care homes, residents do not have security of tenure. Local authorities are asked each year about the sort of accommodation the working age adults with learning disability for whom they provide long-term support are living in. Categories of 'unsettled' accommodation include:

- Rough sleeper/squatting
- Night shelter/emergency hostel/direct access hostel
- Refuge
- Placed in temporary accommodation by the council (including homelessness resettlement)
- Staying with family/friends as a short term guest
- Acute/long stay healthcare residential facility or hospital
- Registered care home
- Registered nursing home
- Prison/Young Offenders Institution/Detention Centre

According to the Short and Long Term Care statistics, ERY was significantly worse than the national and regional proportions of supported working age adults with learning disability in unsettled accommodation from 2014-2016. In 2015/16, ERY had 29.8% of working age adults with learning disability living in unsettled accommodation, compared to 16.9% for Y&H and 19.8% in England.

In 2017/18, the proportion of the ERY population in contact with secondary mental health services who live in stable accommodation was 82% which was significantly higher than the England average of 57%.

4.9 Relationship Breakdown:

There is a general consensus among public health and social scientists that marriage and being in a relationship is better for an individual's mental health due to the support and stability provided by marriage. Research indicates that stable relationships are associated with decreased depression rates, decreased psychotic episodes and overall better life satisfaction[75]. Social relationships connect individuals to society and make a positive impact on their health overall.

Although good and fulfilling relationships can greatly benefit mental health and emotional wellbeing, problems in relationships can have adverse effects. After a relationship breakdown, individuals' may feel a range of powerful emotions such as fear, anxiety, anger, loneliness and isolation, and often a sense of failure. All of these emotions can have profound effects on an individual's mental health[76]. Relationship breakdown has a strong correlation with suicide, particularly with men.

The divorce rate has been declining in the last few years with the number of divorces among opposite-sex couples in England and Wales in 2017 of 101,669, decreasing by 4.9% from 2016. Although the number of divorces has decreased, so has the number of marriages, consistently reducing since the 1970s. This is perhaps attributable to the increase in number of cohabitating couples, with marriage no longer being seen as a social necessity. According to the 2011 Census, 11.3% of adults within the East Riding identified as divorced or separated. This was lower than the regional (11.9%) and national (11.6%) proportions.

Culture and peoples beliefs about marriage is changing and for marriages of opposite-sex couples, the average age for men marrying in 2015 was 37.5 years old, and for women it was 35.1 years old, compared to 1973 when the average male age was 28.8 years old, and 26.1 years old for women[77].

There is a limited amount of research available on mental health and relationship status and this is an area that can be difficult to analyse. It is recognised that there is a bidirectional relationship between major depression and marital disruption[78]. Relationship breakdown (married or otherwise) can be due to mental health problems or the mental health problems can be secondary to the relationship breakdown making it a cause and effect. A multinational study of mental disorders found there to be a direct relationship between the premarital mental disorders and the lower likelihood of ever marrying but also with an increased likelihood of divorce[79].

According to a report by the Centre for Social Justice[80], family breakdown in all its forms is strongly associated with poor mental health in adults and children. It is also acknowledged that the development of mental health issues in children and young people is often rooted in broken relationships and family dynamics. The Good Child Inquiry identified how a parent's mental health and relationship breakdown has a negative long-term effect on the child's mental health.

Even though there is now more acceptance and less stigma around divorce, it still has a massive impact on all the associated parties, including children and family members. Marriage dissolution, relationship breakdown and widowhood have all been associated with a decline in wellbeing and can all invoke a severe mental crisis.

Relationship breakdowns affect people in different ways depending on factors such as race, gender, culture, marital quality and previous mental health[75]. Relationship breakdown can provoke a similar mental state as going through bereavement (see section 7.10).

5. Healthy Ageing

The World Health Organisation defines healthy ageing as "*the process of developing and maintaining the functional ability that enables wellbeing in older age*". Functional ability is about having the capabilities that enable people to be and do what they value. Functional ability in old age includes an individual's ability to meet their own basic needs, make decisions, be mobile, maintain relationships and contribute to society[81].

5.1 Older People Mental Health

Older people's mental health is now recognised as a significant health and wellbeing issue. The wider relationship of mental health and physical health problems and ageing upon an individual is clear. With the ageing population and the growing proportion of older people within the ERY population, it is vital the needs of older people are recognised and services are tailored to their specific needs.

5.1.1 Challenges facing older people:

Ageism is the stereotyping and discrimination against individuals or a group of people based on their age[82]. Commonly misconceived as a workplace issue, ageism can occur in everyday life during activities such as when shopping or visiting the GP[82]. Ageism can influence the behaviour of older people, making them less likely to seek help for all kinds of issues, including social care or mental health, due to apprehension over how they will be perceived[81]. Older people are often perceived as burdens, frail, ill and incompetent[83]. This stereotype can be damaging to the mental health of older individuals who feel they perhaps lose their role in society. Ageist perceptions also contribute to anxiety, depressive symptoms and general stress in older people[84.]

Bereavement can be extremely detrimental to the mental health and emotional wellbeing of older people. Often bereavement at later life can be a life-long partner, close friend or relative. Bereavement at an older age can cause individuals to become socially isolated and lonely. Grief can cause feelings of emptiness, depression See section 7.10 for more information on bereavement and its effects on mental health.

As individuals age, the likelihood of developing co- or multi-morbidities. With people now living longer, non-communicable diseases are manifesting disproportionately in the older population as conditions such as chronic obstructive pulmonary disease (COPD), diabetes, cancer and depression[85]. Multi-morbidities can include physical and mental health conditions. Living with multiple conditions can affect an individual's mental wellbeing, particularly if their resilience and sufficient support is not available.

5.1.2 Conditions that are prevalent in older people:

According to the WHO, approximately 15% of adults aged 60 years and older suffer from a mental disorder (not including dementia). Mental and neurological disorders among older adults account for 6.6% of the total disability-adjusted life years for this age group[86]. All older adults make important contributions to society as family members, volunteers and sometimes as part of a workforce and most have good mental health. However, many older adults are at risk of developing mental and neurological disorders or substance misuse problems which are detrimental to their quality of life[86].

The most common mental and neurological conditions which affect this age group are depression and dementia which affect approximately 5% and 7% of the general older population[87]. Anxiety disorders affect nearly 4% of

the older adult population. Substance misuse problems affect approximately 1% of the older population but are often overlooked for other more age-associated conditions (i.e. dementia) [86, 87].

See section 5.3 for more information relating to dementia.

5.1.3 Interventions for older people's mental health:

According to Joint Commissioning Panel for Mental Health, interventions and services targeting older people's mental health must adopt an integrated approach with social care, primary care and community services[88].

There is a growing source of evidence that shows physical activity can prevent, or lighten, some aspects of mental health in older people such as depression, anxiety and dementia[89]. However, physical activity can only contribute to the prevention of vascular dementia and would need to occur regularly over a prolonged period of time before dementia onset. Physical activity can contribute to improving older people's mental and emotional wellbeing with development of community groups such as walking clubs, chair-based exercise classes and sports clubs can providing social interaction and reducing loneliness.

Within ERY, there is a range of council-run and commissioned services which are on offer to meet the needs of older people experiencing mental health issues (table 9).

Table 7: Services available for people with age-related mental health issues.
Source: ERYC, 2019.

Council-run services	Commissioned services
• Specialist social workers who are accessed through the care management team. • Safeguarding adults' team. • Short term assessment and reablement services (STARS). • Residential accommodation both permanent and respite care is available. • Daytime opportunities. • Help in your own home.	• Home care providers. • Residential care homes. • Independent mental capacity advocate (IMCA) and generic advocacy.

5.2 Frailty:

Frailty is a distinctive health state related to ageing in which multiple body systems lose their in-built reserves[90]. It is estimated approximately 10% of people aged over 65 years and 25-50% of people aged over 85 years have frailty[90].

Older people with frailty are at risk of dramatic changes in their physical and mental wellbeing after an apparently minor incident, such as a fall[91]. Mental health services need to be equipped to meet the needs of a rapidly rising population of older people, some of whom are frail and among whom the prevalence of mental health problems is itself increasing significantly[92].

In ERY, new partnership programmes, like the Bridlington Falls Prevention Group, are striving to improve the mental health of those living with mild and moderate frailty. This prevention group aims to improve older people's knowledge of exercises which can aid their mobility and frailty, as well as create a community-based social group which brings older people together.

5.3 Dementia:

Dementia is a syndrome associated with an ongoing decline of brain function. This can include memory loss, loss of judgement, reduced mental sharpness and quickness, along with mood and capability changes. Alzheimer's and Vascular Dementia make up the majority of dementia cases. According to the Alzheimer's Society, there are 850,000 people in the UK with dementia syndrome. People with learning disabilities are at increased risk of developing dementia, particularly people with Down's syndrome: a third of people with Down's syndrome develop dementia in their 50s.

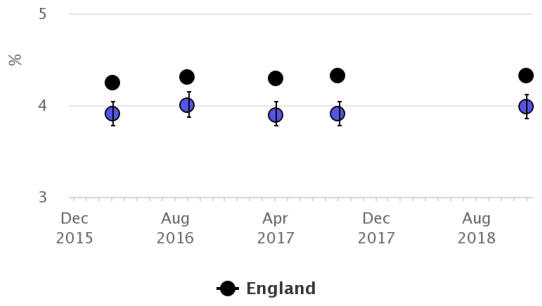
One in 14 people over 60 years old have dementia and the condition affects 1 in 6 people over 80 years old. The number of people living with dementia is increasing because people are living longer. It is estimated that by 2025, the number of people with dementia in the UK will have increased to around 1 million. According to research commissioned by the Alzheimer's Society, 65% of people living with dementia are women, compared to 35% men[93, 94].

5.3.1 Prevalence of Dementia within ERY:

The estimated dementia diagnosis rate (aged 65 and over) at the ERY local authority level (65.5%) is similar to the national average (68.7%). The estimated diagnosis rate (aged 65 and over) for the NHS ERY CCG is 66.6% compared to the national estimated diagnosis rate of 68.7%. The ERY is aiming to increase the number of people living with dementia who have a formal diagnosis. The rationale being that a timely diagnosis enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.

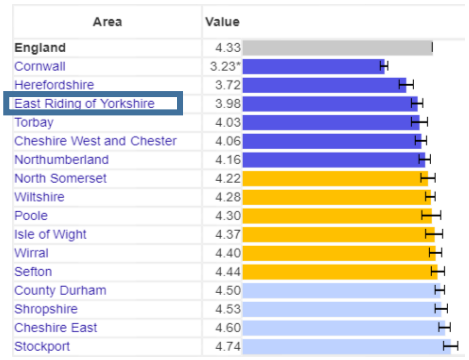
Within the ERY, the recorded prevalence of dementia for aged 65+ is 3.98%; this is lower than the recorded prevalence nationally (4.33%).

Figure 33: The recorded prevalence of dementia for ages 65 and over within ERY compared to England.



Source: PHE Fingertips, 2019.

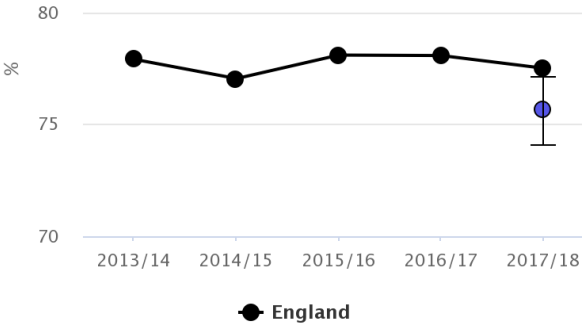
Figure 34: Recorded prevalence of dementia for ages 65+ within ERY compared to the CIPFA peers.



Source: PHE Fingertips, 2019.

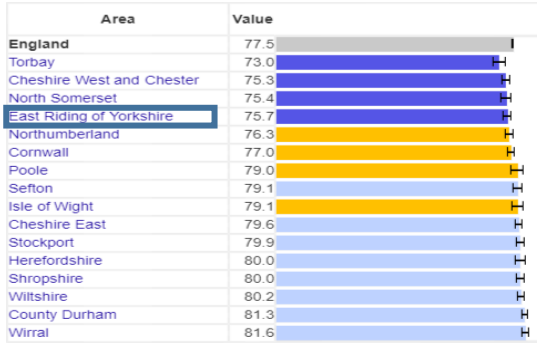
There is no universal consensus on the appropriate diagnostic tests that should be undertaken in those with suspected dementia. Nonetheless, it is important for quality of life and service provision that those with dementia are diagnosed early. Person-centred care and annual reviews of patient and carer needs is important to ensure services provided are considering the physical and mental health needs of the patient and their carers.

Figure 35: Dementia care review documented in the last 12-months.



Source: PHE Fingertips, 2019.

Figure 36: Dementia care review documented in the last 12-months for ERY compared to CIPFA neighbours.



Area	Value
England	77.5
Torbay	73.0
Cheshire West and Chester	75.3
North Somerset	75.4
East Riding of Yorkshire	75.7
Northumberland	76.3
Cornwall	77.0
Poole	79.0
Sefton	79.1
Isle of Wight	79.1
Cheshire East	79.6
Stockport	79.9
Herefordshire	80.0
Shropshire	80.0
Wiltshire	80.2
County Durham	81.3
Wirral	81.6

Source: PHE Fingertips, 2019.

More indicators related to Dementia prevalence, care and related-mortality are available here.

5.3.2 Needs of those with dementia and their carers:

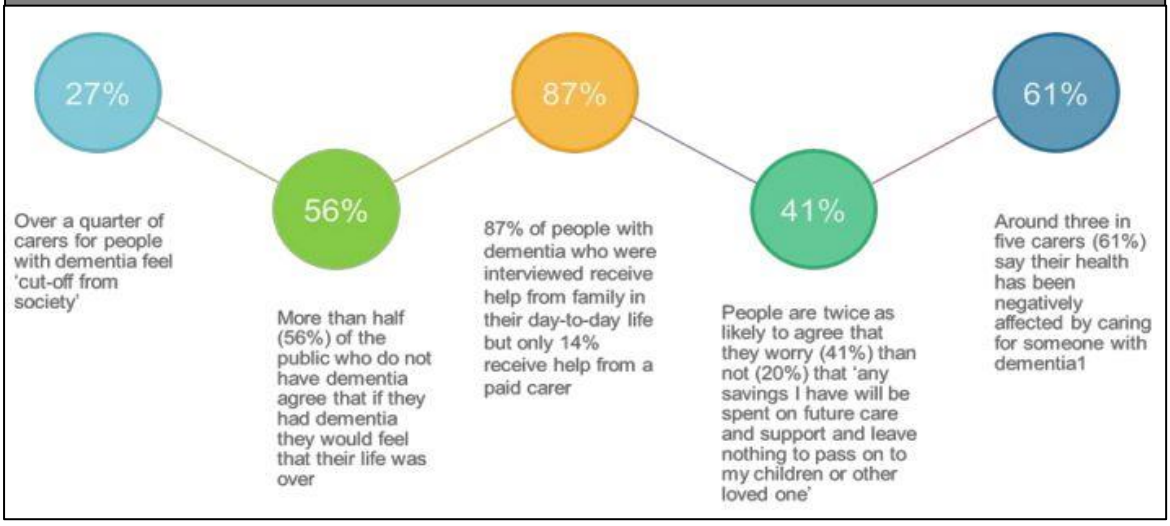
The 'Prime Minister's 2020 Challenge on Dementia' includes a commitment to increase the number of people living with dementia who have a formal diagnosis. The rationale behind this being that a timely diagnosis helps people living with the condition, their carers and healthcare staff to plan accordingly and work together to improve the health and care outcomes.

Dementia has a greater impact on women than men who are more likely to die younger and from of other conditions. Dementia also has a greater impact on women as the majority of carers are women (60-70%). Caring for someone with dementia is challenging emotionally and mentally. Being a carer can also strain, at times to breaking point, relationships with other family members. 20% of female carers have gone from full-time to part-time employment as a result of their caring responsibilities (Alzheimer's Research UK). Women are 2.3 times more likely than men to provide care for someone with dementia for over 5 years.

The 'Prime Minister's 2020 Challenge on Dementia' reports that carers of people with dementia should be made aware of and offered the opportunity for respite, education, training and emotional and psychological support so that they feel able to cope with their caring responsibilities and to have a life alongside caring. Carer-reported quality of life score for people caring for someone with dementia within ERY has increased from 7.5 in 2014/15 to 7.9 in 2016/17. The quality of life score in 2016/17 is higher for carers within ERY than compared to the region (7.8) and national (7.5) scores.

The Mental Health and Dementia Strategy 2018-2023 for East Riding of Yorkshire identified the needs of those people within the population who have dementia and their relatives (see figure below).

Figure 37: Feedback from people with dementia, their families and carers.



Identifying these five key concerns of the population of ERY can aid the development of services and we recommend that commissioners and providers listen to the voices of the people affected by dementia in real-life.

5.3.3 Dementia and older people with learning disabilities:

People with learning disabilities, particularly those with Down's syndrome, are at an increased risk of developing dementia[95]. Individuals with learning disabilities, such as Down's syndrome, are living longer lives now due to advances in health and social care. A consequence of this however, is that now more people with learning disabilities are developing and living with dementia[95]. About 1 in 5 people with a learning disability who are aged over 65 will develop dementia[95] and generally do so at a younger age. About 1 in 4 of the general population will develop dementia which means people with a learning disability are nearly three times as likely to have dementia over 65 years as the population as a whole.

Dementia generally affects individuals with learning disabilities in similar ways to individuals without learning disabilities. Table 10 describes some ways people with learning disabilities are differently affected by dementia:

Table 8: Learning disabilities and dementia. This table describes the differences people with learning disability have with dementia.

Source: Alzheimer's Society, 2019.

People with a learning disability:
• Have a greater risk of developing dementia at a younger age – particularly those with Down's syndrome • Often show different symptoms in the early stages of dementia • Are more likely to have other physical health conditions which are not always well managed • Are less likely to receive a correct or early diagnosis of dementia due to diagnostic overshadowing • May not be able to understand the diagnosis • May experience a more rapid progression of dementia, although this can be confounded by difficulty or delay in diagnosis • May have already learned different ways to communicate (e.g. more non-verbal communication if their disability affects speech) • May already be receiving social care in the family home, or be in a supported living environment, where they are given help to allow them to live independently and so symptoms of dementia may be missed • Will need specific support to understand the changes they are experiencing, and to access appropriate services after diagnosis and as dementia progresses. These may be specialist services for those with a learning disability or general services for older people.

A third of people with Down's syndrome will develop dementia in their 50s and it is most commonly Alzheimer's disease[95]. Studies have shown 1 in 50 people with Down's syndrome develop dementia in their 30s, and 1 in 3 in their 50s. In ERY, there are approximately 5 live births per year of babies with Down's syndrome[96] of an average 3000 live births annually.

Studies also suggest that approximately 1 in 10 people aged 50 to 65 with learning disabilities other than Down's syndrome have dementia.

5.3.4. Dementia and behaviour change:

A person with dementia may experience changes in their mood or behaviour. This can have a massive impact on them as an individual, within their family, and on their carer. Often this is one of the most challenging aspects of living with dementia. These behaviours often happen when the individual with dementia feels confused or distressed. Behaviour changes can vary, from wandering and change of personality, to confusion and aggression.

People with dementia may sometimes behave in ways that are physically or verbally aggressive. This can be extremely distressing for the person and for those supporting them. The aggression may arise as a means for the individual to express a physical or social need[97].

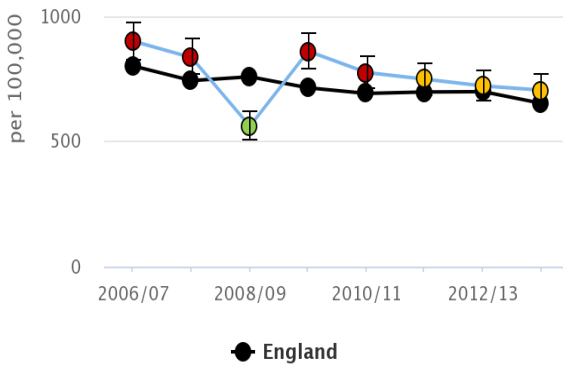
5.4 Social Care:

Adult social care in England is defined as the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty. Providing social care to adults aims to protect people who use care services from abuse or neglect, to prevent deterioration of or promote physical or mental health, to promote independence and social inclusion, to improve opportunities and life chances, to strengthen families and to protect human rights in relation to people's social needs.

Research has indicated that personal budgets impact positively on wellbeing, increasing choice and control, reducing cost implications and improving outcomes. Studies have shown that direct payments increase satisfaction with services and are the purest form of personalisation. The number of older people over the age of 65 who are receiving self-directed support (direct payments) had increased from 2014/15 to 2015/16 from 97% to 97.2%. This is significantly better than the proportion of older people using social care who received self-directed support regionally (93.2%) and nationally (88.6%).

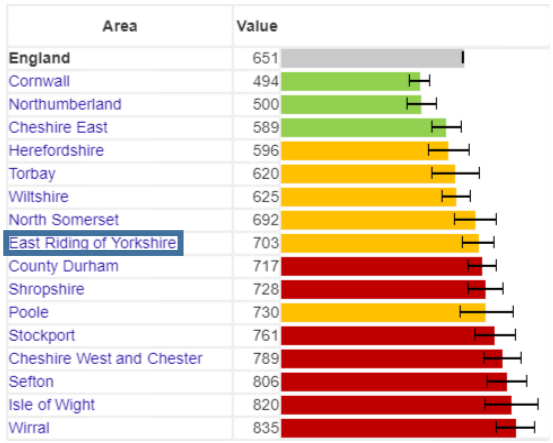
Research suggests people prefer to stay in their own home rather than move into residential care. Avoiding permanent placements in residential and nursing care homes is a good indication of delaying dependency. Within ERY, there is a higher rate of permanent admissions to residential and nursing homes for over-65 year olds than compared to the regional and national comparators (figures 39 and 40). This may be attributable to the increasing older people population as well as people moving to the ERY following their retirement.

Figure 38: Permanent admissions to residential and nursing care homes per 100,000 aged 65+.



Source: PHE Fingertips, 2019.

Figure 39: Permanent admissions to residential and nursing care homes per 100,000 aged 65+ comparing ERY and CIPFA neighbours (2013/14).



Area	Value
England	651
Cornwall	494
Northumberland	500
Cheshire East	589
Herefordshire	596
Torbay	620
Wiltshire	625
North Somerset	692
East Riding of Yorkshire	703
County Durham	717
Shropshire	728
Poole	730
Stockport	761
Cheshire West and Chester	789
Sefton	806
Isle of Wight	820
Wirral	835

Source: PHE Fingertips, 2019.

5.5 Retirement:

Retirement is a major life transition. Not everyone feels ready to retire at the same time as for some individuals work is seen as a major part of their life and discontinuing this can affect social aspects (if employment also provides friendships), a sense of self-worth and self-esteem, and financial security. However, being retired can also be a busy phase of life as friends and family can have plans for your time. The sudden change in life-purpose and lifestyle can affect an individual's mental health. Depression and loneliness are common repercussions of retirement as individual's attempt to adjust to life outside of work[98, 99].

The state pension age will be raised to 66-years old by 2020, leading to a greater number of people working longer years before they can retire. From a mental health point of view, this can have both positive and negative impacts. Due to the ageing population of the county, it is important to make sure proper support and mental health services are provided.

A national survey carried out in the UK looking at the mental health of early retirees identified 22% of early retired men, 22.2% had a common mental health disorder compared to 8.2% still in work.

The rate of common mental disorders of people aged 55-64 years has increased in the last few years and this might be due to the uncertainties regarding the future of extending working lives[99]. Men in this age group have the highest rates of registered suicide.

After reaching the retirement age, we see a trend in improved mental health. The Morbidity Survey of Great Britain showed the prevalence of common mental disorders was lower amongst men at or above the UK state pension age of 65, relative to younger men. Retirees below this age had consistently higher rates of mental disorders than working men (including stress and depression).

5.6 Social Isolation and Loneliness:

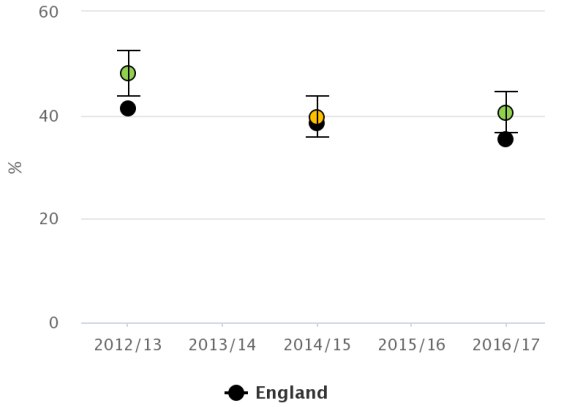
Social isolation is an objective measure of the number of contacts that people have. It is about the quantity and not quality of relationships. People may choose to have a small number of contacts. However, isolation can lead to loneliness[100]. Older people are particularly vulnerable to loneliness and social isolation and the effects on

health that accompany them. According to Age UK, more than 2 million people in England over the age of 75 live alone, and more than a million older people say they go for over a month without speaking to a friend, neighbour or family member. Bereavement, disability and retirement can all lead to older people experiencing loneliness.

Loneliness is a subjective feeling about the gap between a person's desired level of social contact and their actual level of social content. Loneliness is never desired and lessening these feelings can take a long time[100].

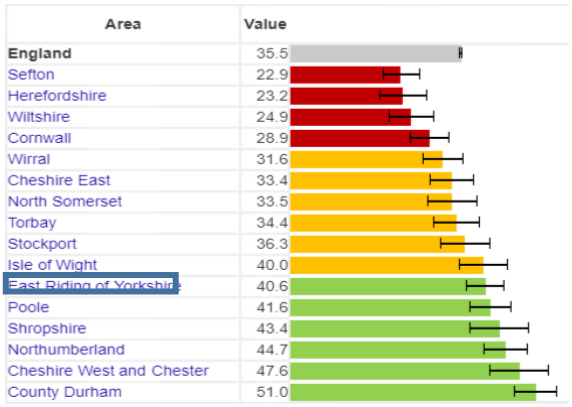
Research shows that loneliness is associated with poorer physical and mental health and lower wellbeing amongst older people (however, it is important to note that social isolation and loneliness can occur in anyone at any age). In particular, loneliness amongst older people is associated with experiencing depression, and older people with a high degree of loneliness are twice as likely to develop Alzheimer's disease as those with a low degree of loneliness. Recent research conducted by social neuroscientists has identified that loneliness causes psychological events that wreak havoc on a person's health.

Figure 40: Social isolation: percentage of adult carers who have as much social contact as they would like.



Source: PHE Fingertips, 2019.

Figure 41: Social isolation: percentage of adult carers who have as much social contact as they would like comparing ERY and CIPFA neighbours.



Source: PHE Fingertips, 2019.

Within ERY, September 2018-Febraury 2019 there has been 589 referrals to the Social Prescribing service for social isolation and loneliness for individuals ranging 20-95 years old. Most referrals were from adults aged 55-years and older and 61% of these referrals were for females. 75% of these referrals were from the Bridlington and Wolds localities.

5.7 Older People and Alcohol:

There is little in terms of official statistics for older people and alcohol consumption in the UK but research over recent years indicates older people consume fewer units than the younger generations but they are more likely to drink on an almost daily basis over the course of a week. A rising number of alcohol-related admissions/discharges and deaths in the UK among those aged 65-years and over highlights the health problems underlying their consumption habits[101].

Too much alcohol can affect an individual's mental health[102]. Excess alcohol consumption can cause anxiety, depression, dementia, hearing voices and confusion.

1 in 5 older men and 1 in 10 older women are drinking enough to harm themselves. These figures have increased by 40% in men and 100% in women over the past 20 years[102]. This, in part, is attributable to the change of the public health definition of harmful drinking.

About a third of older people with drinking problems (mainly women) develop them for the first time in later life. Bereavement, physical ill-health, difficulty getting around and social isolation can lead to boredom and depression. Physical illness may be painful and therefore alcohol may be used as a coping mechanism to make the difficulties more bearable. Drinking alcohol may also become part of an older person's daily routine and be difficult to give up. There may be less pressure to give up drinking than for a younger person, fewer family responsibilities and no pressure to go to work each day[102].

It is possible that health professionals do not spot heavy drinking in older people as often as they should because older people tend not to discuss their drinking. The effects of alcohol consumption can be confused for a physical or mental health problem. Additionally, medical professionals forget that older people may have drink problems so they don't look for it, or asking an older person is not as much of a priority as other potential health issues and therefore does not get asked about.

It is important health promotion of harmful drinking takes into consideration older people and their different attitudes towards alcohol consumption. This could reduce the incidence of drinking problems in the older population. Additionally, engagement with health professionals and ensuring they are aware of the potentially subtle signs of heavy drinking in older people could help the identification of harmful drinking.

6. Healthy Communities

A 'healthy community', as defined by the Centre for Disease Control is "*a community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential*". The following themes are situations and circumstances which can be challenging to individuals within a community and can cause or be exacerbated by having a mental health condition (CDC, 2019).

6.1 Debt Management and Gambling:

Debt is the state of owing money to someone else, a financial institution or a company. Debt management is the strategy which helps someone in debt pay and handle their debt. Management may involve working with creditors to restructure the debt and work round the financial capabilities of the individual in debt.

Research has found an association between debt and health outcomes, such as health satisfaction, mental health, ability to self-care, problems performing usual activities, pain problems and psychological health and increased mortality risks.

Mental health problems can cause severe debt and severe debt can cause mental health problems. Debt can lead to depression, anxiety, stress and is a major cause of suicide in the UK. According to research, more than 100,000 people every year in England are mired in heavy debt and try to end their lives[103]. Research has also identified 13% of people in problem debt – which is around 420,000 people a year – think about suicide and 4% of these people – more than 100,000 – try to end their own life[104]. The same research identified that debt collectors can act inappropriately and in a distressing manner which worsens the mental health of those in debt.

Those with mental health problems, such as depression, dementia, and schizophrenia can find it difficult to manage their personal finances. This can lead to a 'spiralling' situation and the individuals quickly find themselves in debt.

According to the Office for National Statistics, from June 2014-June 2016, 6.6% of ERY households had problem debt; this was similar but higher than the national proportion of 5.8%. In 2016, 107.9 per 10,000 adults demanded debt advice. This was again higher than the national rate of 96.7 per 10,000.

Gambling can become an addictive activity and harmful to our mental health. In particular, gambling can be a source of debt and worsen mental health and financial problems. The compulsive nature of gambling has social and biological causes. Socially, gambling can bring us in contact with others and feel part of a community – a sensation that an individual can desire to always be in. Gambling also releases a neurochemical response triggering the dopamine reward system which provides the sensation that it is a fun and rewarding activity[105].

Within ERY, effort is made to minimise the risk of gambling addiction and its effects. Local gambling licenses are reviewed periodically to ensure those who are vulnerable from gambling harm are protected as much as possible. The local Gambling Harm Reduction Framework considers the socio-ecological model for gambling-related harms at an individual, family, community and societal level.

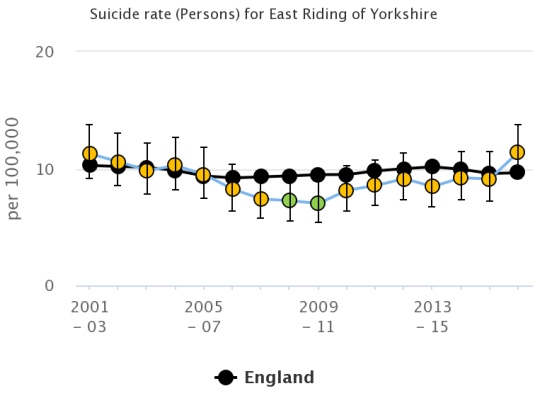
6.2 Suicide:

When someone takes their own life, the effect on their family and friends is devastating. Every suicide affects a number of people directly and often many others indirectly. Estimates suggest each suicides' ripple effect

reaches 6 people directly and an unlimited number indirectly[106]. Suicide is often the end point of a complex history of risk factors and distressing events[106]. In England, one person dies every two hours as a result of suicide[106]. Suicide is the leading cause of death among people aged 20-34[107, 108]. Men are nearly three times as likely as women to die as a result of suicide, but the female suicide rate in England is at its highest since 2005[109] (see chart below).

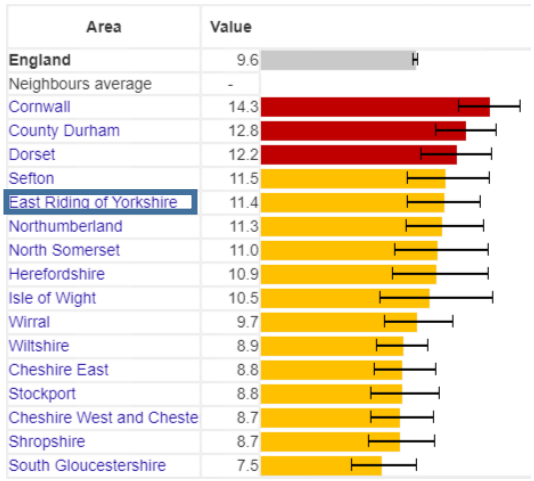
Suicide rate in ERY is higher than the regional and national rates (see chart below). There is an inequality in gender of the rate of suicide, with rates in males being twice that of females.

Figure 42: Suicide rates within ERY for all persons.



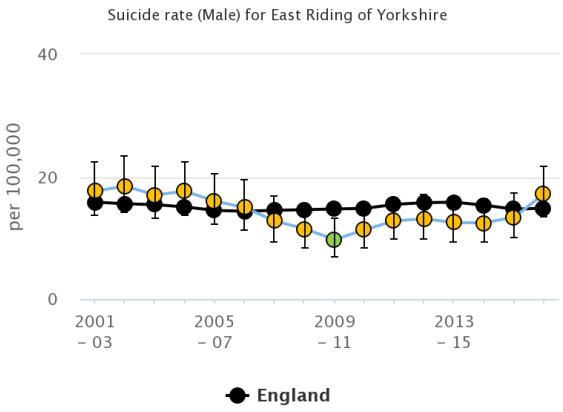
Source: PHE Fingertips, 2019.

Figure 43: Suicide rates within ERY for all persons compared to CIPFA neighbours (2016-19).



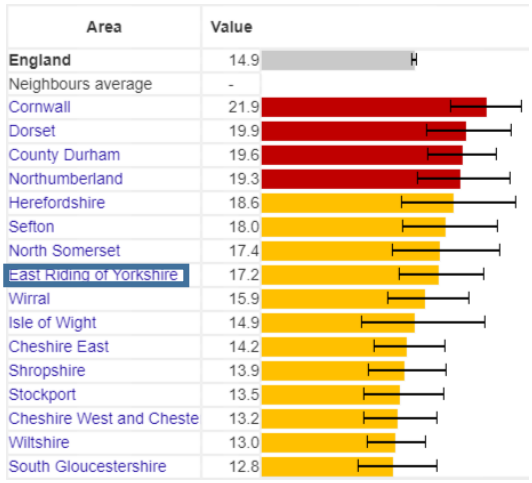
Source: PHE Fingertips, 2019.

Figure 44: Suicide rates within ERY for males.



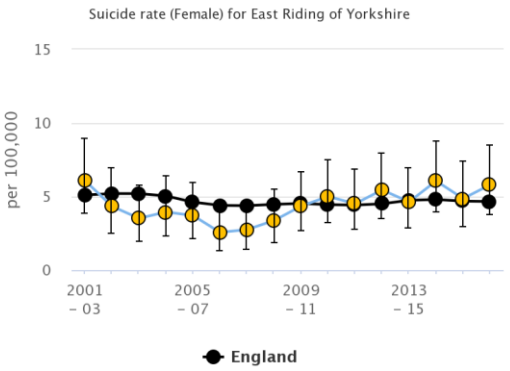
Source: PHE Fingertips, 2019.

Figure 45: Suicide rates for males comparing ERY to CIPFA neighbours (2016-18).



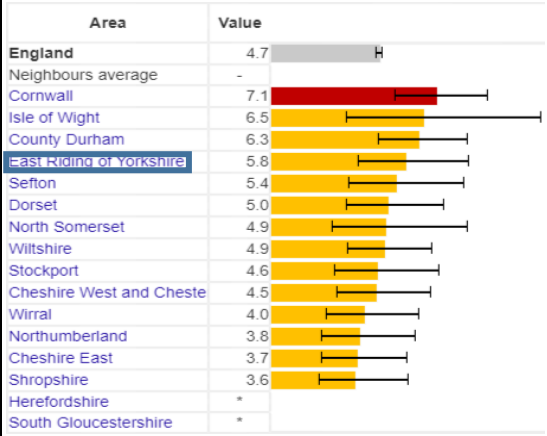
Source: PHE Fingertips, 2019.

Figure 46: Suicide rates within ERY for females.



Source: PHE Fingertips, 2019.

Figure 47: Suicide rates for females comparing ERY to CIPFA (2016-18).



Source: PHE Fingertips, 2019.

According to the latest figures from the Office for National Statistics, in 2018, there were 6,507 suicides registered in the UK (age-standardised rate 11.2 deaths per 100,000) which is significantly higher than the rate in 2017. The last calendar year (2018) was the first year since 2013 to see an increase in suicide rates nationally. Three-quarters of these deaths were males and males aged 45-49 years had the highest suicide rate (27.1 per 100,000). Likewise, the same age-group had the highest suicide rate (9.2 per 100,000) for females. Hanging was the most common method of suicide, accounting for 59.4% of male and 45% of female suicides[110].

In ERY, there were 44 registered deaths due to suicide in 2018. This was significantly higher than the 25 registered deaths due to suicide in 2017.

See section 8.1 for more information on suicide.

6.3 Self-Harm:

Self-harm is when somebody intentionally damages or injures their own body. It is usually used as a coping mechanism or a way to express emotional distress[111]. More than half of people who die by suicide have a history of self-harm. Self-harm is considered to be a coping mechanism and there are different types: cutting or burning their own skin, punching or hitting themselves, poisoning themselves with liquid or tablets. People often try to keep self-harm a secret because of shame or fear of discovery.

Self-harm can be difficult to spot but NHS A-Z recommends looking for the following:

- Unexplained cuts, bruises or cigarette burns on the wrists, arms, thighs and chest
- People keeping themselves fully covered at all times, even in hot weather
- Signs of depression (i.e. low mood, tearfulness or a lack of motivation or interest in anything)
- Self-loathing and expressing a wish to punish themselves
- Not wanting to go on and wishing to end it all
- Signs of low self-esteem
- Signs the individual has been pulling out their hair

Self-harm is far more common than people realise, especially among younger people. It is estimated around 10% of young people self-harm at some point, but people of all ages do. In most cases, people who self-harm do it to help themselves cope with overwhelming emotional issues.

6.3.1 Self-harm in ERY:

According to the Global Burden of Disease Study, 0.11% of all years-lived-with-disability are due to self-harm. According to the same study, 0.73% of all deaths are a result of self-harm (including suicide)[112]. Research shows that 1 in 15 young people in the UK have harmed themselves[113]. Most people who self-harm are aged 11-25.

It is often misbelieved that self-harm is linked to suicide; however the vast majority of young people who self-harm are not trying to end their life but cope with feelings and circumstances. There are many reasons why individuals self-harm, with young people linking it with: being bullied, poor relationships with parents or family members, school-related stress, feeling isolated, bereavement, unwanted pregnancy, ACEs, low self-esteem, self-harm or suicide of someone close to them or problems to do with their own identity[113].

The charts below display the ward-level crude rate per 100,000 population for hospital admissions as a result of self-harm for children and young people aged 10-19 years (between 2013/14-17/18). Bridlington South (rate 563.1; 45 admissions), Cottingham South (rate 561.3; 25 admissions) and Hessle (rate 460.9; 38 admissions) were the wards with the highest rates of admissions.

Figure 48: Hospital admissions as a result of self-harm (10-19 years) in ERY wards. Crude rate per 100,000 population. 2012/13-2016/17 (5 years pooled).

Source: NHS Digital*

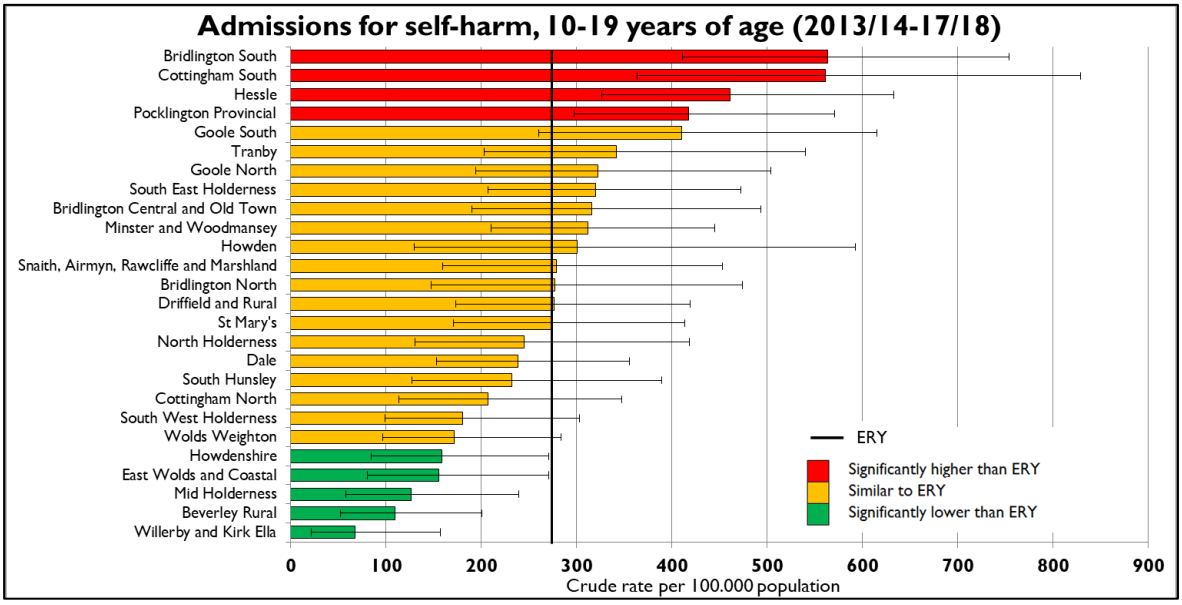
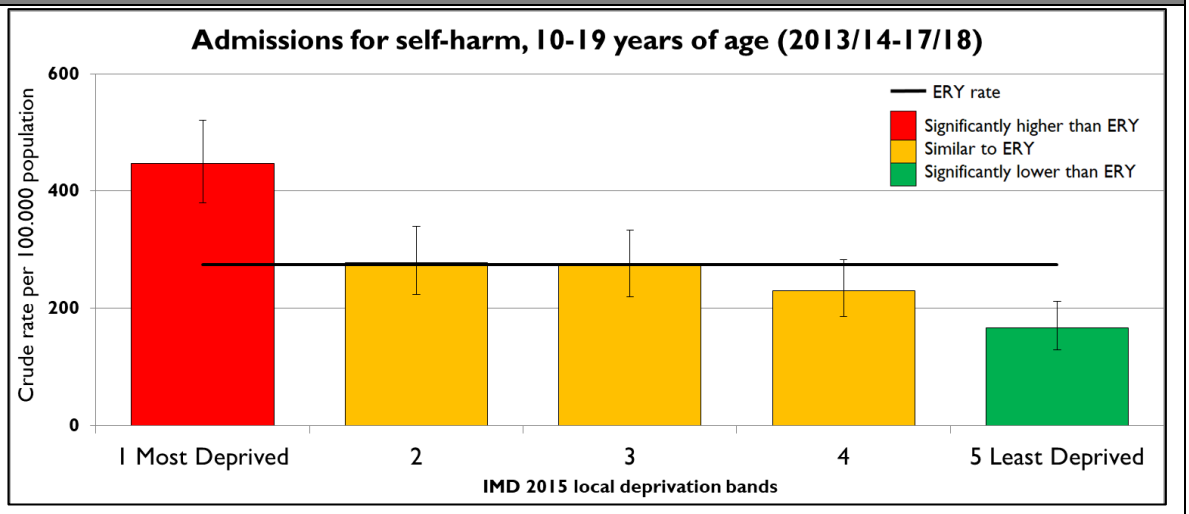


Figure 49: Hospital admissions as a result of self-harm (10-19 years) in ERY wards. Crude rate per 100,000 population. 2013/14-2017/18 (5 years pooled).

Source: NHS Digital*



6.4 Crime:

Crime is an action or omission which constitutes an offense and is punishable by the law. The East Riding has seen a 13% increase in total recorded crime from 2017-2018[114]. Crime and mental health is a massive topic which covers those who commit crimes and the influence their activity has on the mental health of their victims and the wider community. This next section will look at three of the aspects of crime and mental illness; crime and substance misuse, crime and the mental health of victims, and mental health issues in prison.

6.4.1 Crime and substance misuse:

According to research, there is a well-established and complex link between drugs, alcohol and crime. In England, just under 300,000 adults get help for drug and alcohol dependency each year. Most people receiving drug treatment are addicted to heroin or crack cocaine or both and many commit crimes to fund their addiction. One of the biggest influences whether a criminal will reoffend is their use of drugs and alcohol[115].

Crime and poor mental health are also a risk for homeless individuals. See section 4.9 for more information.

6.4.2 Crime and anxiety over safety:

Neighbourhood safety is a determinant of mental health which is important for social cohesion and community resilience. Crime and fear of potential victimisation can negatively impact the health and wellbeing of a population. The potential negative impacts of can include invoking stress and anxiety within the community and cause social isolation, particularly in older individuals[116]. Fear of crime can be a barrier to individual's participation in health-promoting physical and social activities. Public health practitioners are advised to be supportive of fear-reduction initiatives[117].

Victims of crime can commonly develop PTSD following the traumatic event. Research shows that 25% of crime victims (including violent and non-violent crimes) are experience PTSD. Victims of rape are 6.2 times more likely

to develop PTSD than individuals who have not been victims of crime. Victims of crime can also suffer from a wide range of mental health issues such as major depression and severe anxiety[118]. Victims of crime are also more likely to develop substance misuse issues, self-harm or attempt suicide[119].

Evidence suggests those with mental health conditions are more likely to be victims of crime, especially violent crime than the general population[118, 119]. These already vulnerable people are more likely to live in areas of deprivation where the occurrence of crime is higher. An additional concern is the exploitation of vulnerable people with mental health conditions, including substance abuse, being exploited for means such as 'cuckooing' – a form of crime in which drug dealers take over the home of a vulnerable person in order to use it as a base for crime drug dealing. In recent months, there has been an increase in the occurrence of this practice which is concerning to policing and health professionals, as well as a concern for safeguarding those with mental health conditions.

6.4.3 Criminals and mental health in prison:

Around 1 in 4 adults will be diagnosed with mental health illness in their lifetime, and individuals in prison are more likely to suffer from mental health problems than people in the community. Prisoners are less able to manage their mental health because everyday aspects are out of their control and they must follow prison regimes. Many prisoners move in and out of prison, or between different prisons, which makes the job of providing appropriate and personal mental healthcare difficult.

The rates of self-inflicted deaths and self-harm rose significantly from 2012-2016. This suggested that mental health and wellbeing in prison had declined. This concerning increase remains an issue and major mental health concern. In 2016, the Probation Ombudsman found that 70% of prisoners who had taken their own life had previously been identified as having mental health needs[120, 121].

Within the East Riding of Yorkshire County, there are two prisons – HMP Humber and HMP Full Sutton. HMP Humber has a capacity of 1062 and HMP Full Sutton has a capacity of 558. HMP Full Sutton holds some of the most difficult and dangerous criminals in the country[122].

In 2016, six of 17 prisoner deaths within ERY prisons were self-inflicted. The exact number of prisoners who are formally recognised as having existing mental health conditions, or are being treated by prison mental health services is difficult to obtain for the ERY county.

6.4.4 Drug and Alcohol Use:

Drugs and alcohol misuse can lead to criminal activity and result in a custodial sentence. Similarly, those with substance misuse issues can end up in prison. According to the prison reform trust, upon entering prison, substance misuse should be declared and a rehabilitation/detox programme will be initiated[122]. Mandatory drug testing (MDT) can be conducted on remanded or convicted prisoners.

According to Public Health England, over 59,000 adults received treatment for substance misuse problems within secure settings during 2016/17. Almost two-thirds of the treatment adult prisoners received was psychosocial and almost one-third was pharmacological. Of treated adults, 23% received help for opiate misuse, 37% received help for non-opiate misuse and 13% received alcohol-related help[123].

7. Healthy Resilience

Healthy resilience is the ability to 'bounce back' from stress or adversity and is important throughout life. This section looks at key themes which indicate times where resilience is important and how individuals attempt to understand and cope with their health and wellbeing.

7.1 Health Literacy:

Health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. Between 43% and 61% of English working age adults routinely do not understand health information[124]. Examples of the meaning of health literacy are:

- A lady who thought her 'positive' cancer diagnosis was a good thing and could not understand why she was not getting better
- A group of young people who did not know what their waist was
- A young man with diabetes who did not realise there was a connection between what he ate and his ability to self-manage his condition.

Having low levels of health literacy can have profound effects on an individual's health and is disempowering. Low literacy can mean people do not recognise their symptoms as such, do not access healthcare, and do not understand when they need assistance.

Mental health literacy is defined as knowledge and beliefs about mental disorders which aid their recognition, management or prevention[125]. Those identified as having low mental health literacy are more likely to demonstrate unhealthy lifestyle behaviours, such as physical inactivity, smoking and poor diet. In health and social care staff, a lack of mental health literacy can lead to misunderstanding and discrimination toward people living with mental health problems.

Limited health literacy predicts poor diet, smoking and a lack of physical activity independent of risk factors including age, education, ethnicity and income and is associated with an increased risk of morbidity and premature death in older adults, independent of age, socioeconomic position, cognitive function and pre-existing illness. People with long-term conditions including depression are more likely to have limited health literacy[125].

7.2 Diet, Weight and Physical Activity:

7.2.1 Diet

Diet is the food consumed by a person. The food we eat influences our health and wellbeing. Eating well helps us to prevent many conditions such as obesity, high blood pressure, high cholesterol, heart disease and many others. A diet which is well-balanced and rich in fruit and vegetables may be associated with feelings of wellbeing[126]. Put simply, what we eat and drink effects how we feel, think and behave.

The brain like every other organ requires different levels of complex carbohydrates, essential fatty acids, amino acids, vitamins, minerals and water to remain healthy. Although further research is required to fully elucidate the benefits of diet on mental health, it is known a well-balanced diet is beneficial to mental health and wellbeing.

According to an Active Lives survey from Sport England, the Yorkshire and Humber region had significantly lower proportions of the adult population in 2015/16 and 2016/17 who claimed to meet the recommended 5-a-day portions of fruit and vegetables on a typical day (55%) compared to the national proportion (57%).

An unbalanced diet contributes to major physical health issues as well as having influence on the mental health and wellbeing of an individual. The heat map below, obtained from the Global Burden of Disease study (2017) shows the attribution of dietary risks to all causes of ill-health in both sexes and all ages. This chart provokes the consideration that poor diet within the ERY (particularly low vegetables, fruits and fibre) could be causing poor mental health and wellbeing. This chart also demonstrates the potential for further interventions surrounding healthy diet promotion and the benefits on mental and physical health.

Table 9: The attribution of dietary risks to all causes of ill-health in both sexes and all ages[112]. Numbers show the rank of dietary risk contributing to poor health. Dietary risks can contribute to poor physical and mental health.

Source: GBD Study, 2018.

Dietary Risk	England	Y&H	ERY
Low whole grains	1	1	1
Low fruit	2	2	2
Low nuts and seeds	3	3	3
Low vegetables	4	4	4
High sodium	5	5	5
Low omega-3	6	6	6
Low fibre	7	7	7
Low legumes	8	8	8
Low PUFA	10	9	9
High processed meat	9	10	10
Low calcium	11	11	11
High sweetened beverages	12	12	12
High trans fat	13	13	13
Low milk	14	14	14
High red meat	15	15	15

7.2.2 Weight:

There is strong evidence to suggest an association between obesity and poor mental health in teenagers and adults (less evidence for young children). Research has identified a two-way relationship between mental health and weight issues as over- and under-weight individuals have an increased risk of developing mental health issues, and those with mental health issues have an increased risk of developing weight issues (both over- and under-weight)[127, 128]. Weight issues can lead to other health issues, such as arthritis, and cardiovascular disease, which can be detrimental to an individual's mental health.

Obesity in children can have a profound effect on self-esteem and increases the risk of bullying (see section 1.1 for more information). Within ERY, the National Child Measurement Programme (NCMP) reports that reception year and year 6 children are predominantly of a healthy weight (82.7% and 67.9% respectively). The proportion of children in reception year and year 6 who are overweight or obese has decreased significantly in recent years and is significantly better than the national and regional proportions of childhood obesity.

Likewise, in adults weight issues (both overweight and underweight) can cause issues with self-esteem and increase the risk of mental health conditions such as depression and anxiety. 65.3% of adults (18-years and over) within the Yorkshire and the Humber region were classified as overweight or obese in 2016/17. This was significantly higher than the proportion of overweight/obese adults in England (61.3%).

Eating disorders are mood disorders where someone experiences issues with their body weight and shape, and engage in behaviours which will disturb their everyday diet and attitude towards food. The estimated prevalence of eating disorders within ERY (2012) was 6.6% which was the same as the regional (6.6%) and similar to the national (6.7%) prevalence.

7.2.3 Physical Activity:

Physical activity can involve anything which involves moving our bodies (Mind, 2019). Exercise and sport tend to be more specific individual, group or team deliberate activities that we do for fitness or training, fun or competition[129].

Being physically active and exercising can improve self-esteem and mental wellbeing. Through exercise, endorphins (neurochemicals) are released which improve an individual's mood and reduce pain. Due to this chemical response to, it has been recognised regular physical activity and/or exercise reduces stress, anxiety, depression and boosts sleep and self-esteem.

Physical activity and exercise should be encouraged across the life course. Physically activity has also been identified to reduce the risk of dementia[130]. Studies researching the risk of dementia and physical activity have identified the benefits of exercising throughout the life course improves memory, attention and reducing dementia risk.

Within ERY, according to the Sports England survey (2016/17), 68.9% of adults were physically active. This was better than the proportion of physically active adults regionally (64.6%) and nationally (66%).

Considering ERY is a largely rural population (60% of the population live within rural areas), there is unsurprisingly a large volume of outdoor space available for utilisation for exercise. According to research by Natural England (2015-2016), 16.8% of the ERY population use outdoor space for exercise and/or health reasons. This is lower than the regional (17.5%) and national (17.9%) proportions.

7.3 Depression:

Depression is a common mental health problem that causes people to experience low mood, loss of interest or pleasure and feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration[131]. According to QOF data, 8.5% of the ERY population aged 18-years and older are recorded to have depression. This is lower than the regional (10.3%) and national (9.9%) prevalence. Incidence (rate of diagnosis) has increased in ERY consistently since 2013, peaking at an incidence rate of 1.2% in 2017/18. This incidence rate was lower than the regional (1.5%) and national (1.6%).

In the 2016/17 GP patient survey, 12.2% adults reported experiencing depression or anxiety, significantly lower than England average (13.7%); 18.7% people with MSK reported experiencing depression or anxiety, significantly lower than England average (24.1%). In 2017/18, 52.4% social care users reported experiencing depression and anxiety, similar to England average (54.5%).

There are various contributing factors than can lead to depression. These can include biological factors (e.g. genetics or experience of physical illness or injury) and psychological or social factors (experiences dating back to childhood, unemployment, bereavement or life-changing events such as pregnancy). Having a long standing or life-threatening illness, such as heart disease, back pain or cancer, has been associated with an increased risk of depression[131]. Additionally, depression is common in women going through the menopause.

7.4 Anxiety:

Anxiety is a feeling of unease, worry or fear which, when persistent and impacting on daily life may be a sign of an anxiety disorder[132]. Generalised Anxiety Disorder (GAD) is a common type of anxiety disorder and is estimated to impact 5.9% of adults in England. There are different types of anxiety, such as social anxiety, PTSD (see section 10.11), obsessive compulsive disorder (OCD) and panic disorder.

The causes of anxiety are vast and there are many factors which can contribute to the conditions. Factors include biological factors (e.g. genetics, experience of chronic physical illness or injury), psychological or social factors (experiences of trauma or adversity in childhood, struggles with income or poverty, employment status, family and personal relationships and living or work environment).

GAD was the most commonly identified common mental disorder in 2014, with 5.9% of the 17% who report common mental disorders reporting GAD within England[133]. If we use these figures on the East Riding population for 2017, for individuals aged 16+, 49,328 people within ERY suffered from common mental disorders, with 2,910 having GAD.

As per Annual population survey during 2017/18 there were 19.4% adults aged 16 and over reported experiencing high anxiety, similar to England average of 20%. In East Riding, since 2011 till latest period (2017/18) around 18% to 20% adults experiencing high anxiety. Prevalence of smoking in people with anxiety (20.2%) is significantly lower than England average (25.8%).

7.5 Mental Health Act:

The Mental Health Act (MHA) 1983 is the law in England and Wales which was updated in 2007 and tells people with mental health problems what their rights are regarding assessment and treatment in the hospital and in the community, as well as pathways into hospital which can be civil or criminal[134]. In most cases, when people are treated in hospital or another mental health facility, they are voluntary patients. The cases when a person can be detained (also known as sectioned) under the Mental Health Act is when an individual is judged to be a risk to their own safety (i.e. suicidal or aggressive) or a danger to others. The Act is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

Section 136 is part of the Act which can be used by police if they think an individual has a mental illness and needs 'care and control' and taken to a place of safety[135]. Locally, detention under section 136 will see an individual taken to the mental health-based place of safety (136 suite) at Miranda House or the Hull Royal Infirmary where they will receive a Mental Health Act Assessment. Following this, they will either be discharged, admitted to hospital (under a different section of the Mental Health Act), admitted voluntarily or discharged to their GP[136]. In 2018, there were 29,662 detentions under section 136 of the Mental Health Act 1983[137]. This was an increase of 5% from 2017. Locally within ERY, there were 132 section 136'sfrom April 1st 2018 – March 31st 2019.

7.6 Learning Disabilities:

Learning disabilities are conditions which present a reduced intellectual ability and difficulty with everyday activities which affects someone for their whole life[138]. Mental health problems can affect anyone at any time and can be managed with treatment, unlike learning disabilities.

There are many different types of learning disabilities which can be mild, moderate or severe. In all cases, a learning disability is lifelong. It can be difficult to diagnose a mild learning disability as there may not be obvious signs in day-to-day life, but the individual may require support in other areas of their life such as filling in forms[139]. People with severe or profound and multiple learning disabilities will need more care and support with areas such as mobility, personal care and communication.

For parents and family of individuals with learning disabilities, there is concern for their child's wellbeing and future. Parents, family and the individual often face stigma and prejudice which can have effects on the mental health and wellbeing of all involved.

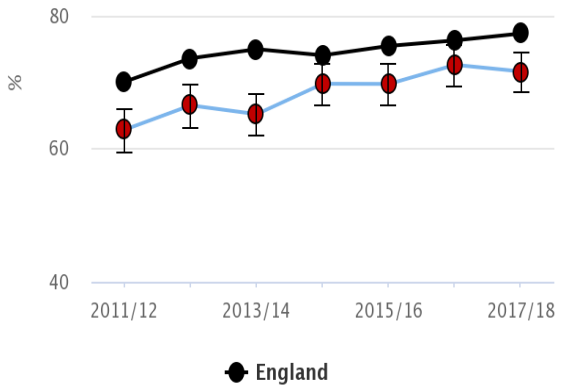
The Government is committed to improving the life chances of people with a learning disability and supporting their families. Government policy is that people with learning disability should lead their lives like any other person, with the same opportunities and responsibilities, and be treated with the same dignity and respect. This means inclusion, particularly for those who are most often excluded, empowering those who receive services to make decisions and shape their own lives

According to QOF figures (2016/17), within ERY, 1% of the population has a learning disability of any kind. This is the same prevalence of learning disability for Yorkshire and Humber, and nationally for England.

According to the Department of Education, in 2017, 6.4% of school aged children (2,920 children) have a learning difficulties. This has increased from 2.5% in 2013. This is a higher than the regional and national levels (5.8% and 5.6% in 2017 respectively).

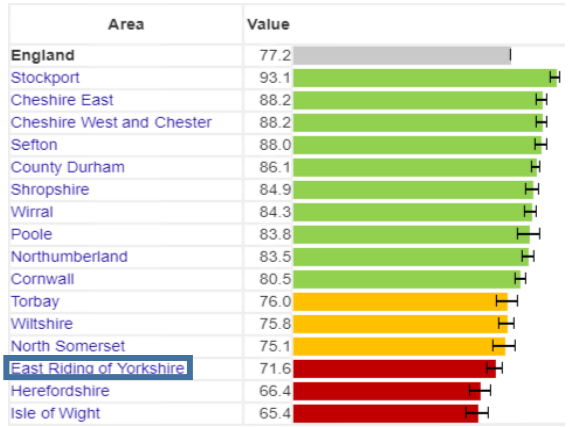
Empowering individuals with learning disabilities to live in stable and appropriate accommodation which meets their support needs is a basic right. Maintaining settled accommodation and providing social care within this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care.

Figure 50: Proportion of adults with a learning disability who live in a stable and appropriate accommodation.



Source: PHE Fingertips, 2019.

Figure 51: Proportion of adults with learning disabilities who live in a stable and appropriate accommodation comparing ERY to CIPFA neighbours.



Source: PHE Fingertips, 2019.

The charts above highlight a need for improved efforts to address relatively low position of ERY in relation to our peers. The relatively low position shows significant improvement is required to increase the proportion of adults with learning disabilities living in stable and appropriate accommodation.

All of us experience challenges around our mental and emotional wellbeing throughout the life course, and this is the same for individuals with learning disabilities. It is estimated between 25-40% of people with learning disabilities also experience mental health problems. Often these go unnoticed or misread as being due to their learning disability and can go unmanaged for a longer period of time.

For children and young people with learning disability, the prevalence rate of a diagnosable psychiatric disorder is 36% compared to 10% of those who do not have a learning disability[140].

The prevalence of dementia is much higher amongst older adults with learning disabilities compared to the general population (21.6% vs 5.7% aged 65+) [141]. People with Down's syndrome are at particularly high risk of developing dementia, with an age of onset 30-40 years younger than the general population[141].

Reported prevalence rates for anxiety and depression amongst people with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general population and higher amongst people with Down's syndrome[141, 142].

Challenging behaviours (aggression, destruction, self-injury and others) are shown by 10-15% of people with learning disabilities, with prevalence highest between ages 20-49[141].

7.7 Risky Behaviour:

Risky behaviour is defined as activities that potentially expose people to harm, or significant risk of harm which will prevent them reaching their potential. Some risky behaviour is normal and part of growing up[143]. Risky behaviour includes use of drugs and alcohol, dangerous behaviour (i.e. riding in cars without seatbelts, drink driving, carrying a weapon), sexual behaviours which may lead to unwanted pregnancies or STIs, smoking, unhealthy diet and low physical activity. Risky behaviour is more prevalent in young adults and men[144].

According to the 2015 YOUth WAY Survey, which investigated the risky behaviour of 15 year olds, 18.5% of survey respondents had 3 or more risky behaviours (including smoking, alcohol use, low physical activity etc.). Applying this proportion to the population of 15 year olds within East Riding in 2017, 298 young people (18.5% of 3810 individuals) could be taking part in risky behaviours.

Research suggests that targeted screening for risky behaviours and mental health concerns among youth in primary care settings can lead to early detection and intervention for emerging or current mental health and psychosocial conditions[145].

7.8 Long-Term Conditions:

Long-term conditions, or chronic conditions, are those that cannot at present be cured, but people with these conditions can be supported to maintain a good quality of life. Long-term conditions are one of the biggest issues facing healthcare today. The longer life expectancy of the population has seen an increase in the support required to maintain a good quality of life. About 26 million people in England have at least one long-term condition (LTCs). There is a massive health inequality regarding LTCs as people living in deprived areas will have health problems 10-15 years earlier than people in affluent areas[146]. This is an issue, as individuals with LTCs are more likely to be unemployed thus meaning their financial situation is worsened by their health.

According to the 2011 Census data, 19.1% of the ERY population were living with a long-term health problem or disability. This was higher than the regional (18.8%) and national (17.6%) proportions. There is evidence that

people with a long-term physical health condition are two-three times more likely to develop mental health conditions, particularly depression and anxiety.

Our physical and mental health are linked and people who live with a long-term physical condition such as diabetes, arthritis or asthma are likely to experience mental health conditions such as depression and anxiety. The incurable nature of chronic conditions have a risk of social isolation, low self-esteem, stigma and discrimination which is a gateway to poor mental health without appropriate support.

More than 15 million people - 30 percent of the UK population - live with one or more long-term conditions according to the Department of Health (2011) and more than 4 million also have a mental health problem. Evidence demonstrates those with a long-term condition are two or three times more likely to develop mental ill-health. People two or more long-term conditions are seven times more likely to experience depression than those without a long-term condition[147]. Since the founding of the NHS in 1948, physical care and mental health care have largely been disconnected. There is an increasing call on healthcare professionals to consider psychological wellbeing when treating the physical symptoms of a condition and vice versa.

The Adult Psychiatric Morbidity Survey (2014) identified that a significant proportion of people have mental health problems that are not diagnosed. According to a Department for Health GP survey, in 2018/19 8.3% of the NHS ERY CCG patient survey respondents were living with long-term mental health problems. This was significantly lower than the national level of 9.9%.

Mental health conditions can be long-term and affect individuals throughout their life. Schizophrenia is a relatively uncommon chronic mental illness which results in substantial disability and a 10% risk of suicide[148]. Mental health conditions such as this carry a high-level of stigma, with representation within the media contributing to social isolation and low self-esteem in individuals with the condition[149].

Like long-term physical conditions such as diabetes, chronic mental health conditions can be managed, through psychiatric services and pharmaceuticals, to maintain a high-level of functionality and good quality of life for the individual. The prevalence rate of schizophrenia within ERY is higher than the prevalence rate for the region and nationally.

7.9 Substance Misuse and Mental Health Issues:

Drug and alcohol misuse is a complex, multifactorial issue. While the number of people with a serious issue is relatively small, the impact an individual's substance misuse has on everybody around them is profound. Substance misuse covers a range of mind-altering substances which can have a severe impact of an individual's functionality and their physical health. Substance misuse is formally defined as the continued misuse of mind-altering substances that severely affects a person's physical and mental health, social situation and responsibilities.

Alcohol dependence in the most common form of substance misuse, but drugs such as heroin, cocaine, crack and cannabis are also included in this category. Most forms of substance abuse give the individual a temporary feeling of wellbeing or false-sense of control but ultimately is damaging to the individuals health.

16.6% of adults in England report drinking to hazardous levels, whilst 12% report levels which indicate probable dependence on alcohol[150]. 3.1% of adults in England show signs of drug dependence. Men are two-times more likely to be dependent on illegal drugs than women[150].

A patient may then present with a mental health disorder and the substance use can go unnoticed, unresolved and increase the risk of further disturbing mental health symptoms. Mental health disorders can also occur as a

result of going through withdrawal from substance use. For example, using substances or ingesting more than the normal units of alcohol per day may induce anxiety and depression, thereby creating confusion between mental health symptoms and substance misuse.

It is report 70% of individuals with mental health disorders who engage in community resources in the UK, also have substance misuse issues. Furthermore, a recent survey in the UK identified that a third of individuals who are at risk of alcohol and drug use disorders, also use mental health services, and those with more severe mental health disorders have been found to be more likely to smoke, and misuse alcohol and other recreational drugs[151]. If a person has mental health problems and use drugs and/or alcohol, they may be described as having a dual diagnosis[151].

If an individual has a dual diagnosis, finding housing can be difficult as housing agencies and trusts often do not accept drug users. As a result of this, poverty, homelessness and crime are common occurrences in those with mental health and substance misuse conditions[152].

See sections 3.6 (poverty), 3.9 (homelessness) and 5.4 (crime) for more information.

Recreational drugs have effects on an individual's mental health as they affect the way they see things, an individual's mood and their behaviour. For some people, long-term substance misuse can lead to long-term mental health problems such as depression or schizophrenia.

7.10 Bereavement:

Losing someone is one of the most difficult times of our lives. Whether death is sudden or expected, bereavement is a process with profound mental and emotional challenges. Dealing with grief is difficult and can affect people in different ways. Although a majority of people regain equilibrium in their mental health after a period of time, a small yet significant proportion of people still have persistent mental health problems such as persistent complex bereavement disorder, PTSD and depression[153]. Around 10% of bereaved people experience these difficulties with higher rates found among specific groups such as parents who have lost a child[154].

Research suggests complicated grief occurs in 7% of bereaved people which is accompanied by depression[155]. Complicated grief causes individuals to enter a state of prolonged grief and is relatively rare. However, the intense sensation of sorrow, pain and rumination felt with this syndrome is felt by all going through grief. Services provided to help individual's overcome their grief are crucial to ensure mental health and wellbeing of the population.

7.11 Vulnerable Groups:

Vulnerability is the degree to which a population, individual or organisation is unable to anticipate, cope with, resist and recover from events. Vulnerable groups are ones which experience a higher risk of poverty and social exclusion than the general population. Ethnic minorities, migrants, disabled people, the homeless, substance users, LGBTQ and elderly people all face difficulties that can lead to inequalities in health and wellbeing. It is important to identify these groups as they may have different mental health needs than the wider population.

7.11.1 Lesbians, Gays, Bisexuals, Transgender and Queer (LGBTQ):

Over the last 5-years, the proportion of the UK population identifying as lesbian, gay or bisexual has increased from 1.5% to 2%. The proportion of the UK population aged 16-years and over identifying as heterosexual or straight has decreased from 94.4% in 2012 to 93.2% in 2017[156].

Due to the increasing number of people identifying themselves as non-heterosexual, it is imperative to account for this population when considering mental health policy decisions.

Research shows that there has been an increasing trend in the mental issues in the LGBTQ community. There is a higher prevalence of poor mental health (including anxiety, depression and stress) in the LGBTQ community compared to heterosexuals[157]. Similarly, a UK national survey showed LGBTQ individuals suffer from significantly poorer health and have worse healthcare experiences especially while communicating with health care professionals[158]. The LGBTQ community has reported an increased association of unhappiness, neurotic, depressive episodes, generalised anxiety disorder, OCD, phobic disorder, probable psychosis, suicidal thoughts and self-harm and increased substance and alcohol misuse[158, 159].

There may be several reasons for this increased prevalence such as institutionalised prejudice, social stress and exclusion, hatred and violence, and often internalised sense of shame about their own sexuality[157]. This perceived discrimination can sometimes prevent LGBTQ individuals seeking medical help which facilitates the downward spiral of vulnerable individual's mental health.

There has been a reported increased substance misuse and self-harm within the LGBTQ community. The risk of alcohol and substance dependence is 1.5 times higher in the LGBTQ community than compared to the general population[158].

Other issues include increased bullying in the younger LGBTQ community affecting their education and social interaction. This has an additional impact on their level of confidence which in turn can affect their level of relationships[159].

Due to the limited amount of knowledge and research available in this field, sometimes policy making can be difficult. Further education and training for the health care providers should be undertaken to help them better understand this problem and make them feel confident in asking the appropriate questions. As reported in the literature, social stress has a big impact on the health of the LGBTQ+ community. Further social awareness and acceptability campaigns should be carried out in the community.

7.11.2 Black and Minority Ethnic:

Different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments. In general, people from BME groups living in the UK are more likely to be diagnosed with a mental health problem, diagnosed and admitted to hospital, experience a poor outcome from treatment, and are more likely to disengage from mainstream mental health services. This leads to social exclusion and a deterioration in their mental health[161].

These notable differences can be explained by a number of factors, predominantly concerning poverty and racism. It may also be due to mainstream mental health services often failing to understand or provide services that are acceptable and accessible to non-white British communities and meet their particular cultural and other needs.

It is likely that mental health problems go unreported and untreated because people in some ethnic minority groups are reluctant to engage with mainstream health services. It is also likely that mental health problems are over-diagnosed in people whose first language is not English.

Irish people living in the UK have a much higher hospital admission rate for mental health problems that any other ethnic group. In particular they have high rates of depression and alcohol problems and are also at a greater risk of suicide. These higher rates may be in part due to social disadvantage among Irish people in the UK, including poor housing and social isolation. Despite these high rates, the particular needs of Irish people are rarely taken into account in planning and delivering mental health services[162].

African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups, but are more likely to be diagnosed with severe mental illness. African-Caribbean individuals are three-five times more likely to be diagnosed and admitted to hospital for schizophrenia. African-Caribbean people are also more likely to enter mental health services via the courts or the police, rather than from primary care which is the main route to treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication rather than being offered talking treatments, and are over-represented in high and medium secure units and prisons. This may be because they are reluctant to engage with services and so are much more ill when they do. It may also be that services use more coercive approaches to treatment for African-Caribbean individuals[162].

The statistics on the numbers of Asian people in the United Kingdom with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognised or not diagnosed in this ethnic group. Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support. Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups. Indian men have a high rate of alcohol-related problems. Research has suggested that Western approaches to mental health treatment are often unsuitable and culturally inappropriate to the needs of Asian communities. Asian people tend to view the individual in a holistic way, as a physical, emotional, mental and spiritual being[161].

There is very little knowledge of the extent of mental health problems in the Chinese community. It has been suggested that the close-knit family structure of the Chinese community provides strong support for its members. While this may be beneficial, it may generate feelings of guilt and shame, resulting in people feeling stigmatised and unable to seek help.

In the East Riding of Yorkshire, according to the 2011 census, 93.9% of the population were born in England, 0.3% of the population was Northern Irish, 0.2% were from the Republic of Ireland, and 0.3% were Asian and 0.1% South African.

7.11.3 Migrants and Refugees:

The term ‘vulnerable migrants’ is defined as people who are seeking asylum, refugees and those with humanitarian protection and their families, separated children, Roma, Gypsies and Travellers, people who are undocumented, refused asylum seekers and those who are trafficked for various forms of forced labour, sexual exploitation and modern slavery[163].

These people have migrated to the UK for a variety of different reasons with different life experiences and backgrounds, making them a very heterogeneous group of people. Often the mental health needs of these individuals is not taken into consideration even though they are the most vulnerable people and most in need for these services.

The mental health of the refugees is directly related to the socio-political context of the refugee experience and the humanitarian efforts that improve these conditions are likely to have positive impacts[164]. There could be a number of reasons for this raised mental health issues such as stress associated before the migration, with the migration and after arrival in their host country.

The language barrier can often be an isolating factor, making migrants and refugees feel lonely and unable to seek help[164]. This facilitates a decline in their mental and emotional wellbeing. To overcome this, we should have resources available, written and oral, in different languages to educate migrants and refugees of their rights and the healthcare system to ensure they do not go without the help they need.

Even though asylum seekers only made up 5% of total immigration in 2018, and with this number decreasing since 2012, substantial effort should be made to provide for their wellbeing once they are here. The problems faced by the vulnerable migrant group is similar to the ones faced by the LGBTQ+ and BME communities with the major difference being their legal status. These groups are often facing the same cultural stereotypical discrimination which leads to social anxiety and poor mental health.

7.11.4 Gypsy and Traveller Communities:

Gypsy and travellers are a minority group within the population. Research indicates due to cultural differences and social stigma surround the Gypsy and Traveller communities, this vulnerable group are less likely to acknowledge mental health problems or access help. Research also identified a high level of stigma surrounding mental health conditions in the Gypsy and Traveller community as negative terminology (i.e. '*psycho'*, '*lunatic', 'loser'* or '*mad'*) and social isolation of those with mental health conditions results in an increase in inequality of Gypsy and Travellers accessing mental health services.

Research identified self-reporting of common mental health disorders is highly prevalent in the community, particularly in the younger generations. Rates of suicide and para-suicide are higher in this community than the wider population[165].

There are three sites within the ERY which gypsy and traveller communities can settle upon and rent pitches from the county council. The sites are located at:

- Woodhill Travellers Site, Woohill Way, Cottingham, HU16 5SX
- Woldgate Travellers Site, Woldgate, Bridlington, YO16 4XE
- Eppleworth Travellers Site, Westfield Road, Skidby, HU16 5YJ

According to the 2012 Gypsy and Traveller Needs Assessment conducted by the East Riding of Yorkshire Council, there was an estimated 488 individuals within this minor community.

7.12 Sexual Health:

Sexual health is a state of physical, mental and social wellbeing in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence[166, 167]. The discussion around sexual health and mental health is considerable with multiple different aspects. This section briefly identifies a few of these aspects.

All people have sexual health needs. A recent study suggests people using mental health services rarely discuss sexual health issues, or related issues such as exploitation or sexual abuse, with their care workers, despite being at a higher risk of experiencing them[168]. Sexual health provision is a complex issue with safeguarding and risk issues being seen as more important to discuss than sexual health promotion. Research has demonstrated mental health staff are aware of the sexual health needs of those with mental health conditions. Particular focus of mental health staff is on risk taking behaviour and sexual dysfunction[169].

There has also been research conducted into the association between depression and sexual risk behaviours, reduced sexual function and increased use of sexual health services[170]. Sexual dysfunction is prevalent amongst patients with common mental disorders such as depression, anxiety and stress[170]. The occurrence of sexual dysfunction can be detrimental to poor mental health and wellbeing.

Sex is a matter of the mind as it is within the brain that sexual arousal and maintenance occurs. Anxiety and depression can strongly affect arousal, causing it difficult to be relaxed to have or enjoy intercourse, or reducing the desire entirely.

Substance misuse can limit sexual interest and behaviours associated with substance misuse can increase the risk of transferring sexually transmitted infections including unprotected sex and transfer of sexually transmitted infections such as HIV. Additionally, addiction or mental health problems may be associated with intentionally seeking risky situations such as having unprotected sex with strangers or escalating levels of violence, humiliation and bodily harm[171].

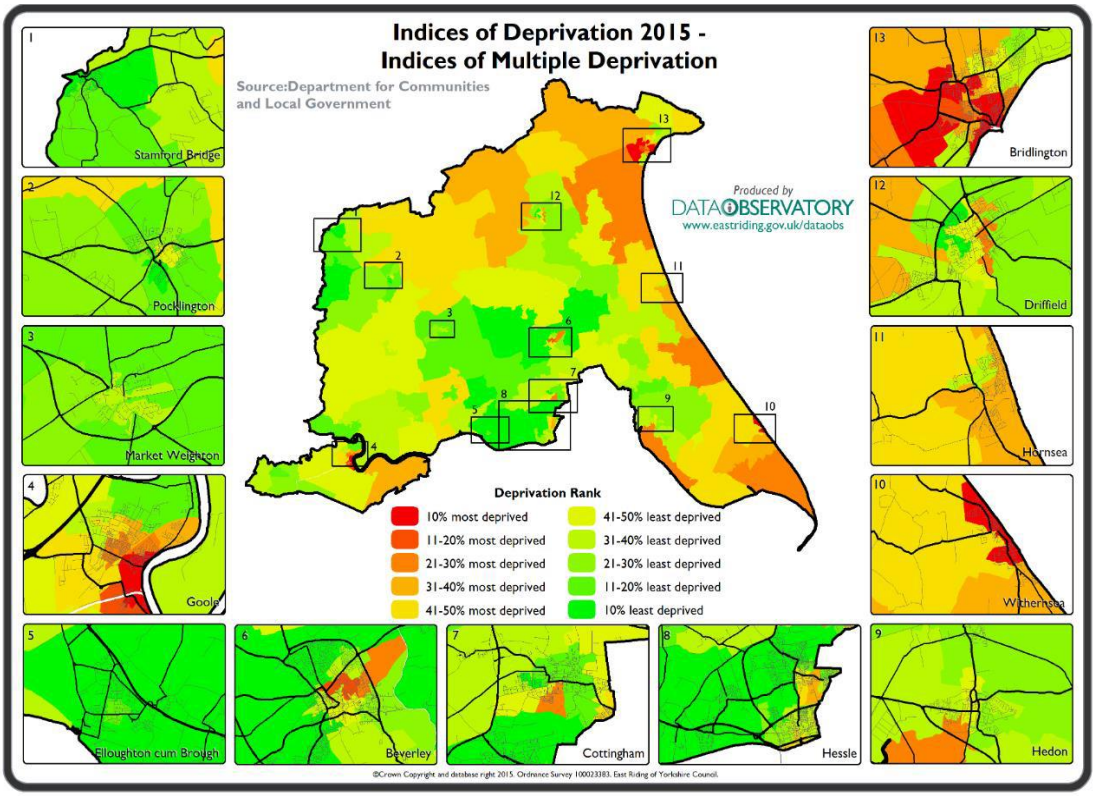
The social stigma of discussing sexual health is also an issue. For individuals with mental health, such as anxiety, discussing sexual health concerns can be daunting and therefore attending clinics or addressing sexual health issues with their partner or a medical professional may be too difficult to discuss.

7.13 Poverty:

Poverty is a multifaceted concept which may include social, economic and political elements. Destitution refers to a complete lack of the means necessary to meet basic personal needs such as food, clothing and shelter.

Overall the ERY is generally considered to be an affluent area, however, there are substantial variations in deprivation levels within the area. The most deprived areas can be found in Bridlington, Goole and South East

Figure 52: Map of the East Riding showing local index of multiple deprivation (IMD).



Holderness. The map below divides the ERY by indices of multiple deprivation (IMD) deciles, with the most deprived areas red and the least deprived areas green.

8. Cross cutting themes

This section looks at key themes which are covered across different aspects of the life course and influence mental health and wellbeing.

8.1 Suicide Prevention:

Suicide prevention is an umbrella term which involves the collective efforts of local citizen organisations, health professionals and other related professionals to reduce the incidence of suicide. Suicide prevention encapsulates direct intervention, psychological treatment, improving coping mechanisms of individuals, reducing suicide prevalence and improving life outcomes following severe mental health.

Nationally there are a growing number of mental health charities and campaigns addressing the stigma surrounding mental health and suicidal thoughts and encouraging individuals who are suffering from suicidal thoughts to seek help. NHS England published the 'Five Year Forward View for Mental Health' in 2016 which has a commitment to reduce suicides by 10% nationally by 2020/21 as well as a chapter dedicated to suicide prevention.

8.1.1 Suicide prevention in ERY:

Within the ERY, there is currently a join real-time surveillance pilot. The pilot is a police-led model which aims to minimise the prevalence of suicide by ensuring postvention support for those affected by suicide, such as family and friends. Real-time suicide surveillance, also known as real time data, is a system that enables a public health team and/or the multi-agency suicide prevention group to consider and agree if interventions are required after a death that has occurred where the circumstances suggest suicide in advance of the coroners' conclusion. Surveillance means immediate help can be provided to those affected by a suspected suicide.

8.2 Smoking:

Smoking is the biggest cause of preventable deaths in England, accounting for nearly 80,000 deaths each year. One in two smokers will die from a smoking-related disease[172]. Most adults are aware of the physical health risks of tobacco but research shows that smoking also affects people's mental health[173]. Within ERY, 10.8% of the population smokes. This is lower than the prevalence nationally (17.2%) and the regional prevalence (18.5%).

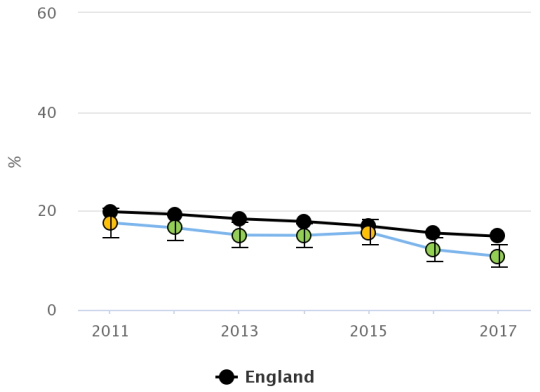
Smoking and addiction is a major issue as individual dependency on nicotine reinforces the habit and continuously increases risk of smoking-related conditions such as lung cancer. Social and psychological factors contribute to keeping people smoking. Many young people experiment with cigarettes, however other factors influence whether someone will go on to become a regular smoker. As young people become adults, they are more likely to smoke if they misuse alcohol or drugs or live in poverty. These factors make it more likely that someone will encounter stress.

Most smokers state they find the habit relaxes them and reduces stress and anxiety[174]. The use of cigarettes for this reason can often lead to further substance misuse (see section 7.3 for more information).

Research into smoking and stress has found that smoking increases anxiety and tension as nicotine addiction causes withdrawal symptoms and increases cravings. Smoking reduces the nicotine withdrawal but does not reduce anxiety.

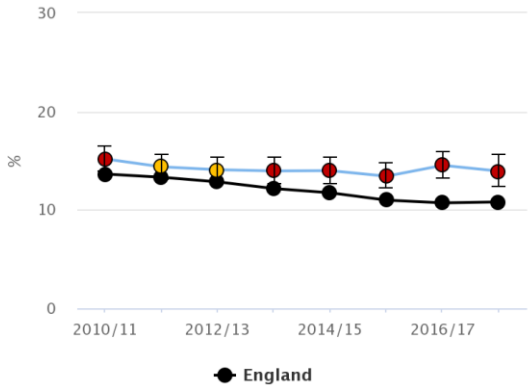
In the UK, smoking rates among adults with depression is two-times higher than adults without depression[174]. People with depression have particular difficulty when they try to quit smoking. Nicotine stimulates the release of dopamine in the brain which triggers positive feelings. In individuals with depression, smoking can be used as a way of temporarily increasing their dopamine supply. However, smoking encourages the brain to switch off its own mechanism for making dopamine in the long run reducing even more the dopamine levels.

Figure 53: Smoking prevalence in adults (18+).



Source: PHE Fingertips, 2019.

Figure 54: Smokers at time of delivery.



Source: PHE Fingertips, 2019.

8.3 Safeguarding:

Safeguarding is the term used to denote measures to protect the health, wellbeing and human rights of individuals which allow people – especially children, young people and vulnerable adults – to live free from abuse, harm and neglect[175].

Safeguarding is the duty of local authorities to protect vulnerable children and adults, including those with mental health and learning disabilities. Any suspicion of abuse or neglect must be investigated by local authorities and reviewed before new protective measures are put into place (which can include removing a child or vulnerable adult from their current location etc.). Safeguarding those with mental health conditions is vital as individuals are often vulnerable, particularly within a care setting. See section 6.7 for more information on learning difficulties.

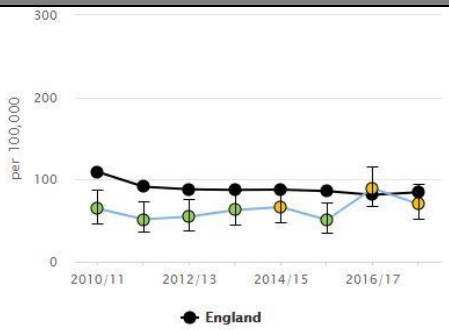
8.4 Hospital Admissions:

Hospital admissions are the formal acceptance by a hospital or other inpatient care facility of a patient who is to be provided with room, board and continuous nursing service in an area of the hospital or facility where patients generally reside at least overnight. A patient can be admitted for a whole host of physical or mental conditions. Admissions can be spontaneous or planned.

The rate of hospital admissions for children and young people with mental health conditions in the ERY is lower than compared to England (figure 55). Compared to other areas in the Y&H region, ERY has the fifth highest rate of mental health related hospital admissions in children and young people (aged 0-17 years) (figure 56).

Compared to its peer comparators, ERY has the second lowest rate of mental health related hospital admissions for children and young people (figure 57).

Figure 55: Children and young people hospital admissions for mental health conditions (0-17 years). Crude rate per 100,000.



Recent trend: ➡

Period	East Riding of Yorkshire					Yorkshire and the Humber region	England
		Count	Value	Lower CI	Upper CI		
2010/11	●	42	64.7	46.6	87.4	73.5	109.4
2011/12	●	33	51.5	35.5	72.3	58.3	91.3
2012/13	●	35	54.8	38.2	76.2	57.9	87.9
2013/14	●	40	63.1	45.0	85.9	62.1	87.4
2014/15	●	42	66.5	47.9	89.9	69.3	87.7
2015/16	●	32	51.0	34.9	72.0	66.3	85.9
2016/17	●	56	89.2	67.4	115.9	58.6	81.5
2017/18	●	44	70.2	51.0	94.3	58.9	84.7

Figure 56: Children and young people hospital admissions for mental health conditions comparing ERY to the Y&H region (0-17 years). Crude rate per 100,000.

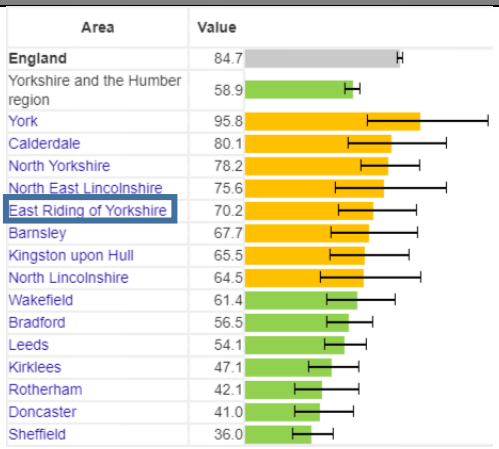
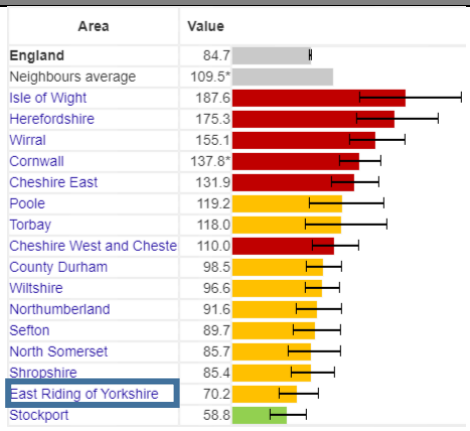


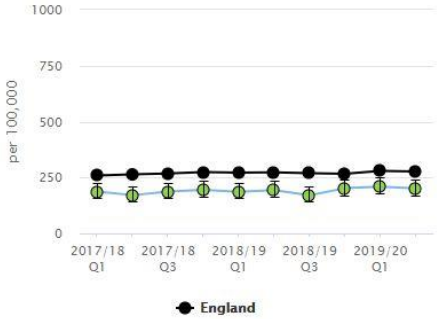
Figure 57: Children and young people hospital admissions for mental health conditions (0-17 years) comparing ERY to peer comparators. Crude rate per 100,000.



Source: PHE Fingertips.

The rate of mental health hospital admissions for the adult population (18 years and older) is significantly lower in the ERY compared to England (figure 58). NHS ERY CCG has the sixth lowest rate of admissions for the region (figure 59) and is average compared to its peer comparators (figure 60).

Figure 58: Mental health hospital admissions for adults (aged 18+). Crude rate per 100,000.



Recent trend: ➡

Period	NHS East Riding Of Yorkshire CCG					North East and Yorkshire (Yorkshire and Humber) NHS region	England
		Count	Value	Lower CI	Upper CI		
2017/18 Q1	●	120	186.7	154.8	223.3	230.5*	259.4
2017/18 Q2	●	110	171.1	140.7	206.3	229.4*	263.7
2017/18 Q3	●	120	186.7*	154.8	223.3	223.3*	268.1
2017/18 Q4	●	125	194.5*	161.9	231.7	234.4*	274.3
2018/19 Q1	●	120	186.4*	154.6	222.9	257.6*	272.2*
2018/19 Q2	●	125	194.2*	161.6	231.4	253.9*	273.5*
2018/19 Q3	●	110	170.9*	140.4	206.0	246.3*	269.4
2018/19 Q4	●	130	202.0*	168.7	239.8	241.6*	267.1*
2019/20 Q1	●	135	208.9*	175.1	247.2	253.9*	279.5
2019/20 Q2	●	130	201.2*	168.1	238.9	260.9*	276.7*

Source: NHS Digital Mental Health Services Data Set monthly reports.

Figure 59: Mental health hospital admissions for adults (aged 18+) comparing ERY to the Y&H region. Crude rate per 100,000.

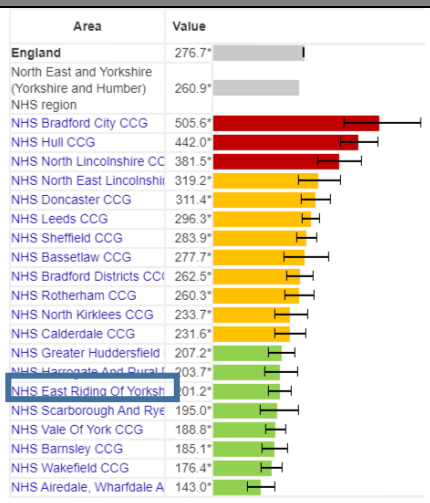
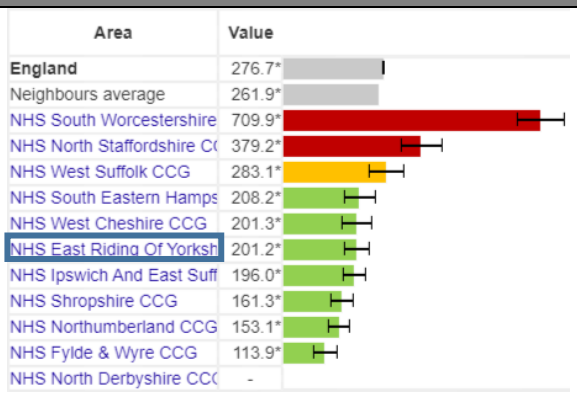


Figure 60: Mental health hospital admissions for adults (aged 18+) comparing ERY to peer comparators. Crude rate per 100,000.



Source: PHE Fingertips.

8.5 Multi-Morbidities:

Although multi-morbidity (presence of multiple chronic conditions) has been researched extensively, there is currently no consensus on its precise definition. The number, type (physical or mental health) and selection criteria for conditions included in multi-morbidity indices vary from one author to another.

Multi-morbidities of physical and mental conditions is estimated to disproportionately affect females more than males. Below is a table of estimates for the prevalence of multi-morbidity within the Yorkshire and Humber region and East Riding of Yorkshire by sex.

Table 10: Estimated prevalence of physical and mental comorbidity by sex using population estimates 2014.
Source: South West Local Knowledge and Intelligence Service, Public Health England, 2019.

Sex	Yorkshire and the Humber	East Riding of Yorkshire
Males	2.9% (77809)	2.8% (4672)
Females	4.9% (134407)	4.7% (8089)

PHE estimates indicate that the prevalence of multi-morbidity of physical and mental conditions increase with age, as demonstrated in the table below.

Table 11: Prevalence of physical and mental multi-morbidities in different age groups, by gender.
Source: Public Health England

	Yorkshire and the Humber					East Riding of Yorkshire				
Age Range	**0-24 years**	**25-44 years**	**45-64 years**	**65-84 years**	**85+**	**0-24 years**	**25-44 years**	**45-64 years**	**65-84 years**	**85+**
Males	1.1% (9441)	4.3% (29027)	13.9% (94761)	39.1% (151798)	61% (25175)	0.5% (216)	1.9% (680)	3.4% (1658)	5.3% (1759)	10.6% (359)
Females	1.4% (11753)	7.5% (51117)	15.9% (109879)	37.6% (167929)	57.1% (45978)	0.7% (275)	4.1% (1470)	5.4% (2724)	7.4% (2760)	13.8% (860)

8.6 Military Personnel and Veterans:

Most British military personnel do not experience mental health problems while in service or afterwards in civilian life. However, military personnel face unique risks in service which if they experience mental health problems can then require specialist treatments and services. A significant minority of service personnel and veterans experience PTSD, depression, anxiety and substance misuse.

Research has identified links between active service and mental health problems in military personnel involved in recent conflicts. Common mental disorders and alcohol misuse were the most frequently reported mental health problems among UK armed forces and personnel. Alcohol use has been identified as substantially higher than in the general population[177, 178].

In the UK, there is an estimated 5 million veterans, and a further 20,000 military personnel on leave each year[179]. Upon discharge from the forces, healthcare is transferred from the military to the NHS. According to the Mental Health Foundation, 0.1% of regular service personnel are discharged annually due to mental health conditions, but some veterans develop problems after leaving the service.

Veterans' mental health problems can be a result of or exacerbated by post-service factors such as difficulty adjusting to civilian life, marital issues, loss of family and social support networks. Younger veterans are at a high risk of suicide in the first two years after leaving the military. Veterans are also vulnerable to social exclusion, homelessness and substance misuse[178].

8.6.1 Military Personnel in ERY:

Within the ERY there is the Normandy Barracks, a driver and transport training facility for military personnel. According to 2011 Census data, there were 784 military personnel living within the ERY either in a personal household or communal establishment.

The ERY has the East Riding Community Covenant which is a statement of mutual support between the civilian community and the local Armed Forces community (which includes military personnel and their family members). This covenant supports the armed forces community working and residing in the ERY and makes it easier to access the help and support available from the Ministry of Defence, the NHS, local government, businesses and the voluntary sector. Health is considered one of the key priorities of the covenant with many services being advertised as readily available to the armed forces community.

Specifically for mental health concerns, the ER Community Covenant encourages those within the forces community to seek help and advice from specialist organisations such as Combat Stress, the East Riding Partnership and the Big Wall. Each of these services specialise in either armed forces mental health or substance misuse issues.

8.7 Serious Mental Illness:

Serious Mental Illness (SMI) is formally defined as a mental, behavioural or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI. SMI typically involve psychosis (when one loses touch with reality), requiring high levels of care, and can require hospitalisation. Two of the main forms of SMI schizophrenia and bipolar disorder.

Schizophrenia is a SMI which affects approximately 1 in 100 people. The condition can alter an individual's perception of reality, their emotions and their behaviours. For more information on schizophrenia, see section 7.10.

Bipolar disorder is an SMI that predominantly affects an individual's moods. It is alternatively known as manic depression as individuals with the condition have episodes of depression (feeling extremely low and lethargic) or mania (feeling high and overactive). These mood swings can vary in length but can last for several weeks (or longer).

8.8 Improving Access to Psychological Therapies:

The Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has since transformed treatment of adult anxiety disorders and depression in England[181]. The service provides evidence-based treatments for those with anxiety and depression, following national NICE guidelines.

An excess of 90,000 people each year access IAPT services and these services are expected to continue to expand in capacity and provision. Referrals to the IAPT service has increased by 3.9% from 2016-17. Recent trends suggest that referrals will continue to increase per annum and cause service capacity issues.

Available information on the IAPT programme is based on the three following elements[182]:

- Outcomes: whether referrals measurably improved following a course of IAPT therapy
- Waiting times: how long referrals waited to be treated by providers of IAPT services
- Activity: i.e. how many referrals were received, treated or ended in the year.

This section looks at the IAPT activity for the NHS ERY CCG and NHS Vale of York CCG compared to England. It is important to consider the IAPT activity for the NHS Vale of York CCG, as areas in the ERY, such as Pocklington, may have residents who seek mental and physical healthcare outside of the NHS ERY CCG area.

8.8.1 IAPT Outcomes:

Across England in 2018/19, 582,556 referrals finished a course of treatment in the year having started treatment, 52.1% of which moved to recovery[182].

For ERY CCG, approximately 54% of referrals finishing a course of treatment in 2018/19 moved to recovery[182]. For Vale of York CCG during the same time period, approximately 48% of referrals finishing a course of treatment moved to recovery[182]. The ERY CCG had a higher rate of recovery than compared to England and the Vale of York CCG in 2018/19.

8.8.2 IAPT Activity:

Across England in 2018/19, there were over 1.6 million new referrals received. For the ERY CCG, there were 13,415 referrals received in the same time period[182]. For the same time period, the NHS Vale of York CCG received 5240 IAPT referrals[182].

During 2018/19, 1.09 million referrals started treatment (some of these referrals may have been received during the 2017/18 time period). Table 10 shows the number of referrals received, entering treatment and finishing course treatment for 2018/19.

Table 12: The number of referrals received, entering treatment and finishing course treatment for 2017/18 by age group.					
	Age Group	**Referrals Received**	**Entered Treatment**	**Finished Course Treatment**	**% Finished Course Treatment**
England	**Under 16**	2,596	1,609	1,153	0.2%
	16-17	31,444	19,737	6,316	1.1%
	18-35	795,315	508,369	262,669	45.1%
	36-64	669,941	484,266	270,907	46.1%
	65+	104,347	78,315	41,511	7.1%
NHS ERY CCG	**Under 16**	-	-	-	-
	16-17	205	85	60	1%
	18-35	5655	2560	2040	39%
	36-64	6355	3205	2690	51%
	65+	1200	620	495	9%
NHS Vale of York CCG	**Under 16**	-	-	-	-
	16-17	50	30	5	0%
	18-35	2545	2005	960	44%
	36-64	2275	1900	1050	48%
	65+	370	295	155	7%

*RAG rating is not significance testing. RAG shows how NHS ERY CCG and NHS Vale of York CCG compare to England.

Source: NHS Digital, 2019.

8.8.3 IAPT Waiting Times:

There are two waiting times of interest for IAPT services; time to first treatment and the time between first and second treatment.

For the time to start first treatment, the average wait for IAPT services across England is 19.6 days. This is significantly less than the average waiting time to first treatment for NHS ERY CCG (24.3 days) and NHS Vale of York (8.2 days) [182].

For the waiting time between first treatment and second treatment session, the average wait time for IAPT services across England is 40.1 day. This is significantly higher than the wait time for the local CCGs. NHS ERY CCG has an average wait time from first to second treatment of 13.5 days, whereas NHS Vale of York CCG has an average wait time of 47.7 days.

8.9 Crisis Care:

A mental health crisis is an emergency that poses a direct and immediate threat to an individual's physical or emotional wellbeing. Crisis care has no specific definition as it is person-centred to ensure individuals receive the specific care they require and that their recovery is manageable for themselves and those around them. Crisis care can be provided by NHS primary and secondary services and can take place within hospitals or within specialised mental health institutions.

Some individuals' may be detained under the Mental Health Act and taken to a place of safety for treatment. For more information on the Mental Health Act, see section 7.6.

8.10 Local Mind Services:

Mind are a nationwide charity who provide advice and support to those experiencing mental health problems[183]. There are around 130 local Minds across England and Wales. There is a local Mind for Hull and ERY with bases in Hull and Bridlington[184]. The local Mind service supports the local community and offers a range of services including therapies, crisis helplines, drop-in services, employment and training schemes and counselling[188].

Recent research by Mind identified that every year across the UK 300,000 people with a long-term mental health problem lose their jobs and the cost of poor mental health to the economy is between £74 billion and £99 billion[185]. Within the local area, over 10,000 people have experienced problems with their mental health for more than 12-months.

8.10.1 Mind work in ERY:

Within ERY, the local Mind offer their services across the county. According to figures from the local Mind, the age ranges of those accessing support increase along with the age range (table 13).

Table 13: Age range of individuals across the ERY accessing the local Mind services.
Source: Hull and East Riding of Yorkshire Mind, 2019.

Age Range:	Number of individuals accessing services:
Under 18	11
18-24	109
25-34	213
35-44	199
45-54	223
55-64	158
65+	90
Unknown	1486
Total	2489

Bereavement services are one of the most common access reasons for the local service. Over the last year, the local Mind has provided bereavement support in approximately 45 areas across the ERY. Support has been provided to families and individuals which aims to help the clients move on and cope in the short and long-term. Case studies from the local Mind describe how one-to-one support is provided to individuals of all ages (children and adults) to help individuals manage their grief.

Another award winning service provided by Mind is the Whole School Approach (WSA). This is a project in only 17 secondary schools across England and Wales in the academic year September 2018-July 2019. Funding from BRIT awards with MasterCard and WH Smiths was distributed to 6 local Minds to run the project with Hull & East Yorkshire (HEY) Mind securing funds to work in 4 East Riding secondary schools.

After research highlighting mental health support in schools is inconsistent with knowledge and time not always readily available, and with young people expressing they want better mental health support in schools, the WSA was developed. The project was designed by pupils, parents, staff and local minds with the aim to educate the school workforce to cope better with life's challenges, manage stress, build supportive relationships and identify when an individual needs extra support.

After an initial survey, a bespoke plan for each school was developed using interventions that address the needs of the whole school workforce (pupils, staff and parents). Interventions included tailored assemblies, workshops, specialist training, awareness raising and 1-1 support. Moving forward, WSA will be working with 5 East Riding schools for the next academic year and 3 of those 5 until July 2023.

Along with organisations like Mind, there are other voluntary community sector organisations within the ERY who provide mental health support. For more information relating to these organisations, see here.

8.11 Local CAMHS Activity:

CAMHS is an NHS based service which covers the local area of Hull and the East Riding. Within CAMHS, sustained increases in demand have been demonstrated through increased referral rates. Referral acceptance rates have also increased, along with conversion rates for young people who subsequently enter treatment.

From July 2018 to June 2019 inclusive, there were 2444 external referrals to ERY CAMHS. Emergency referrals accounted for 84 referrals (3%), routine referrals accounted for 1588 referrals (65%) and there were 772 urgent referrals (32%) during this time period.

Waiting times continue to be a prominent focus of local services. Timely and appropriate support is required to meet and aid the mental health conditions of children and young people. According to the NHS Benchmarking Network 2018 CAMHS project, the average wait time is 13 weeks to start of treatment. Within the ERY, the average waiting time is approximately 6 weeks although the waiting list has increased in 2019 following a marked increase in the number and proportion of referrals accepted by the CAMHS service.

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