# COVID19 Mental Health Needs Assessment Bradford District

# Stage 3 – Final report and recommendations

***July 2020***

## Contents

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## SUMMARY

In April 2020 Bradford District Mental Health Partnership Board requested that the Public Health Department (CBMDC) lead a COVID19 Mental Health Needs Assessment. This document summarise the needs assessment findings. It was undertaken in three stages.

**Stage 1 was a rapid baseline assessment** of mental health disorders, risk & protective factors for Bradford District. This identified groups at particular risk of deteriorating mental well being during COVID lockdown [**chapters 3-5**; a separate report is available on Bradford JSNA site].

**Stage 2 was an analysis of emerging needs.** This gathered intelligence from mental health service providers across statutory and VCS providers (Appendix). It used quantitative mental health service data and Born in Bradford research data, but relies heavily on a May 2020 survey of emerging needs with 41 VCS and statutory services that support well being across Bradford [**chapters 6 and 7**; a separate report is available on Bradford JSNA site].

**Stage 3 includes key findings and recommendations [chapter 9].**

This report summarises needs at a snapshot in time (June 2020). It will be necessary to revisit the data and conversation with providers and their clients over the coming months.

**Key findings**

There are many groups in Bradford District that have an increased risk and prevalence of mental health conditions. Those with long term health conditions, suffering from marginalisation and discrimination, living in relative poverty, with addiction, with existing mental health conditions or learning difficulties, and carers are more likely to see their mental health worsen during the coronavirus pandemic.

Across the country we have seen new mental health risk emerge for front line healthcare workers, those shielding with their families, or pushed into financial difficulty, and across BAME groups and deprived populations that have suffered higher COVID19 death rates.

Our local analysis of the Bradford Population since lockdown has shown us that:

- Fear of coronavirus affects many and is widespread (particularly in BAME groups, the shielded population and some elderly).
- Evidence from previous pandemics and economic crisis suggest that an additional 4,000 people in Bradford District may develop new mental health conditions as a result of the social and health impact of coronavirus, depression being the most

common (with a potential 10% rise in the suicide rate). Post traumatic stress disorder for survivors and front line staff is a real risk.

- It is important not to medicalise normal reactions to the stressful circumstances of COVID-19, as everyone's mental well being will be affected in some way.

**Children and Young people:** Commonly reported issues to the Kooth mental health service for children and young people (CYP) after lockdown were anxiety and stress, uncertainty for the future, fear of contracting COVID-19, feeling overwhelmed by media, and tensions in homes. New Kooth service registrations after lockdown from young females outnumbered males by 4 to 1.

An increase in domestic violence and its impact (within the home environment) has led to a 50% increase in Child Protection notifications for domestic abuse.

**Working age adults:** Key mental health issues for working age adults centre around increased isolation, fear and anxiety related to COVID-19, financial concerns, sleep problems and 'juggling' a new busier home environment. There has been a worrying increase in the complexity of adults presenting at crisis services. Local surveys show that more people describe their mental health as poor since lockdown, with the risk greater for those struggling financially.

There has been no national or local rise in the suicide rate during April-June 2020, although our first response service has seen a sharp rise in out of hours calls (mainly via self referral or from the police).

**Older adults** who appear to be particularly affected include those with cognitive decline/dementia (a quarter of deaths due to covid19 were as in those with dementia). There is a reported increase in self harm associated with dementia, a drop in referrals to memory clinics and a reduction in dementia care planning.

Some families with caring duties have coped well but many report feeling abandoned, with both young and older carers feeling the reduction or suspension of respite care and home visits.

Referrals to bereavement counselling has not increased despite the increased death rate since March (suggesting a potential unmet need for the post lockdown period).

**Mental health services:** During March to May 2020, VCS providers of community mental health services reported reduced capacity in staffing but a rise in demand for services, although 2/3 of organisations reported good continuity of services.

There was a widely reported belief amongst VCS providers that there will be a sudden rise in demand for community and NHS mental health services after lockdown is lifted. This will be

caused by due a combination of those who have waited it out for support, and those with new or worsening symptoms.

There is a particular need to protect the sustainability of our health and social care staff through effective work based well being programmes.

Despite huge disruption, services that support mental well being across the VCS, NHS and statutory sector adapted incredibly quickly during March and April 2020. The switch to digital services has been rapid and innovative, opening new ways to engage with otherwise isolated service users. This new way of working must however take account of individuals either technically, financially or practically (due to their condition) excluded from digital services.

Analysis of NHS mental health service data shows a drop in referrals during April but the switch to telephone/digital support meant that patient contact was maintained for most services. Up until April 2020 there was no increase in appointments for adult mental health services, but an increase in appointments for Child and Adolescent Mental Health Services (although this was an acceleration of a previous increase).

**BAME communities**: Emerging international evidence has highlighted the disproportionate impact of coronavirus deaths on BAME communities. Locally, the 'fear of going out', misinformation (e.g. about deportation, or from home country media), the loss of social support networks, digital language barriers, and lower access to health services are contributory factors to poorer wellbeing.

**Community interventions** delivered through community services & volunteer networks are widely reported to be successful. Phone or video check-ins, or safe face to face support or counselling in open public spaces has supported mental health. In addition, community participation is in itself protective for well being, and such **early interventions are needed to move individuals:**

- **from risk to safety,**
- **from fear to calming,**
- **from loss to connectedness,**
- **from helplessness to self-efficacy, and**
- **from despair to hope.**

In response to these findings a range of recommendations has been framed around the five domains of a **Prevention Concordat for Better Mental Health for Bradford District**, covering:

- Needs assessment
- Partnership
- Translating need onto deliverable commitment
- Defining success measures , and
- Leadership and accountability.

# 1 Structure of the needs assessment

The Mental Health board asked Bradford Public Health Department in April to lead a rapid COVID19 Mental Health Needs Assessment for the District.

The needs assessment was planned in three stages for between April and June 2020, but recognising the impact the COVID will beyond this period certain part of the analysis will need re-visiting.

**Stage 1 – baseline assessment**

To provide a rapid baseline assessment of mental health disorders in Bradford

To identify groups at particular risk of deteriorating mental well being (and key risk factors)

To rapidly review the research and intelligence to help identify key risk factors for poor mental health and wellbeing during COVID-19 and the sub populations that are most likely to be affected

**Stage 2 – emerging needs**

Gather current intelligence and data from mental health service providers across the system (Appendix C).

Use this data to support and inform a mental health outcomes framework

This was presented to the Bradford District Mental Health Board 2nd May.

**Stage 3 – recommendations for preventative and service pathways (by end of June)**

To assess supportive and preventative pathways in Bradford District to meet population mental health needs, and identify any gaps.

# 2 Background

We are already aware of groups across our population that are at risk of poor mental wellbeing and the development of mental health conditions, including anxiety, depression, self harm, psychosis and suicide.

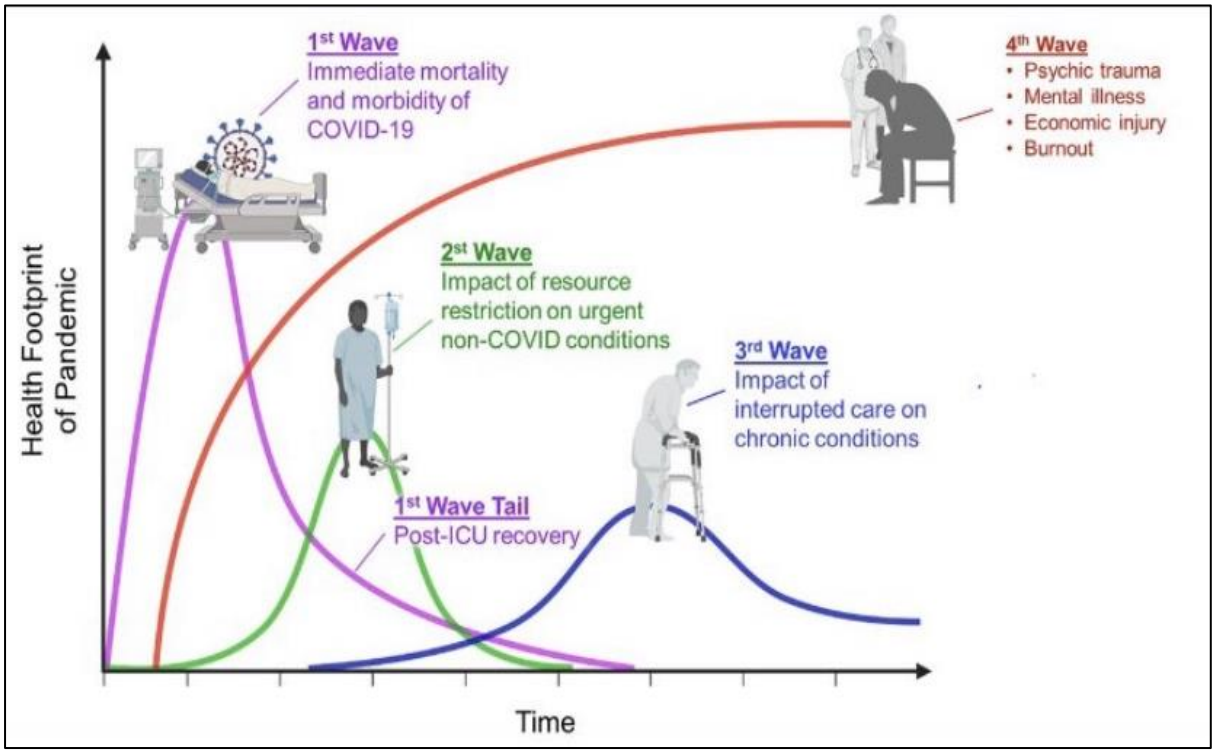
There are many groups in Bradford District that have an increased risk and prevalence of mental health conditions. Those with long term health conditions, suffering from marginalisation and discrimination, living in relative poverty, with addiction, with existing mental health conditions or learning difficulties, and carers are more likely to see their mental health worsen during the coronavirus pandemic.

Across the country we have seen new mental health risk emerge for front line healthcare workers, those shielding with their families, or pushed into financial difficulty, and across BAME groups and deprived populations that have suffer higher COVID19 death rates.

During the COVID pandemic and lock down restrictions mental health is likely to be significantly challenged due to increased isolation and financial strain as well as increased levels of bereavement and traumatic experiences.

## 2.1 Four waves of coronavirus

**Figure 1 - Four waves of coronavirus – 4th wave – psychological trauma, mental health and social/economic impact**



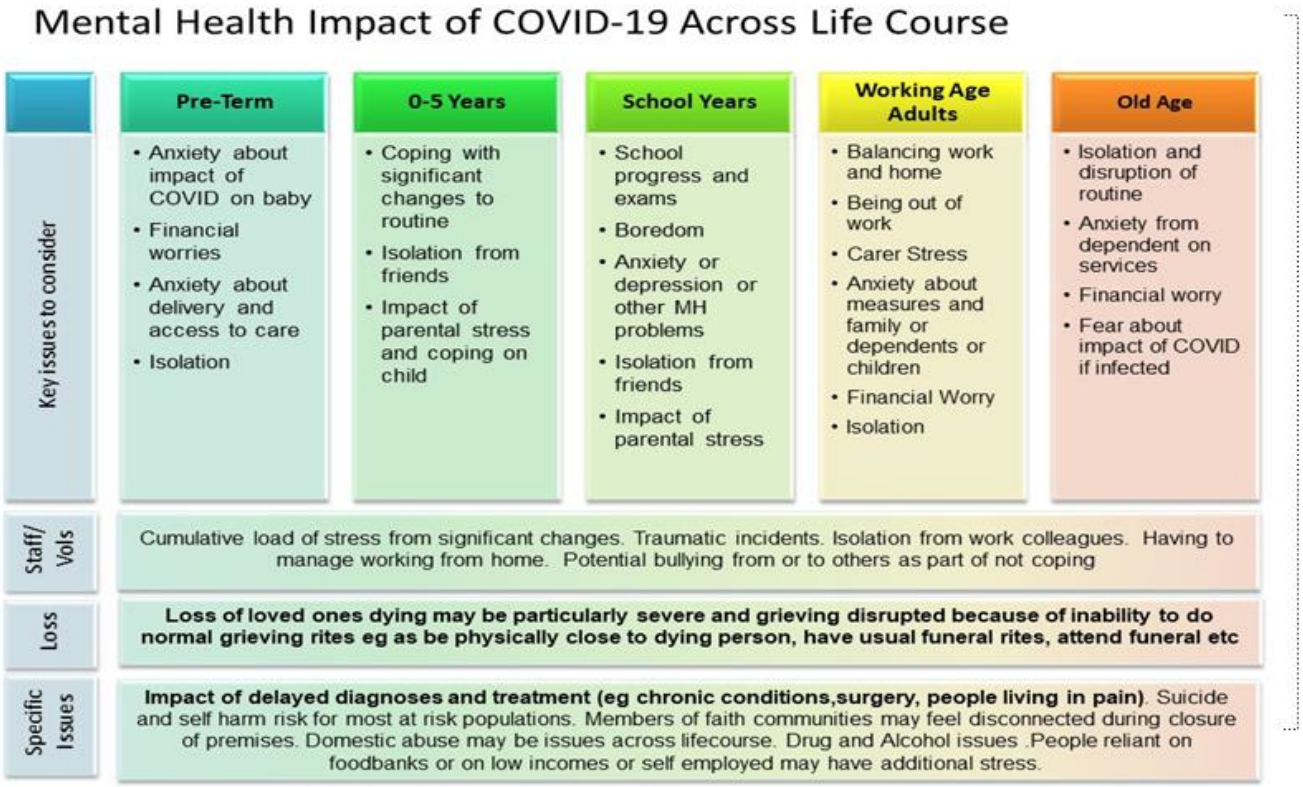
*Victor Tseng [https://twitter.com/vectorsting/status/1244671755781898241]*

Since March 2020 the Bradford District Health and Care system has been understandably focussed on a rapid operational response to the coronavirus pandemic, with additional large scale mobilisation of community support and networks across the VCS and other statutory bodies. This has straddled the NHS and social care systems (for both physical and mental health). Initially this was to meet the immediate mortality and morbidity associated with covid19 (1st wave ) with a growing focus now on non-covid related healthcare (2nd wave) and longer term chronic conditions whose treatment may have been interrupted (3rd wave). Since March Bradford Mental Health partnership arrangements have rapidly identified and expanded a broad mental well being strategy to meet the mental health impact of the 4th wave of COVID19 (Figure 1). This needs assessment looks at the March to June period to consider the emerging 4th wave and longer term considerations.

## 2.2 COVID19 impact across the life course

We need to take a life course approach to identifying the impacts and groups vulnerable to Coronavirus (Figure 2). This covers increased isolation and loneliness which will affect children and young people separated from their friends and support networks. It will affect furloughed staff and increasing isolation of those already at risk due to disabilities, long term conditions or existing mental health conditions.

**Figure 2**




## 2.3 High profile events and pandemics

Our approach needs to learn from evidence about how communities respond to major events such as pandemics and natural disasters. This requires an approach that recognises sudden and long term impact on individuals, communities, and societal mental well being. Both risk and protective/resilience factors needs to be recognised.

Research shows that there will be a pronounced psychological and behavioural impact on communities if two or more of the following four characteristics are present:
**(1) large numbers of injuries and/or deaths**
(2) widespread destruction and property damage,
**(3) disruption of social support and on-going economic problems**
(4) intentional human causation

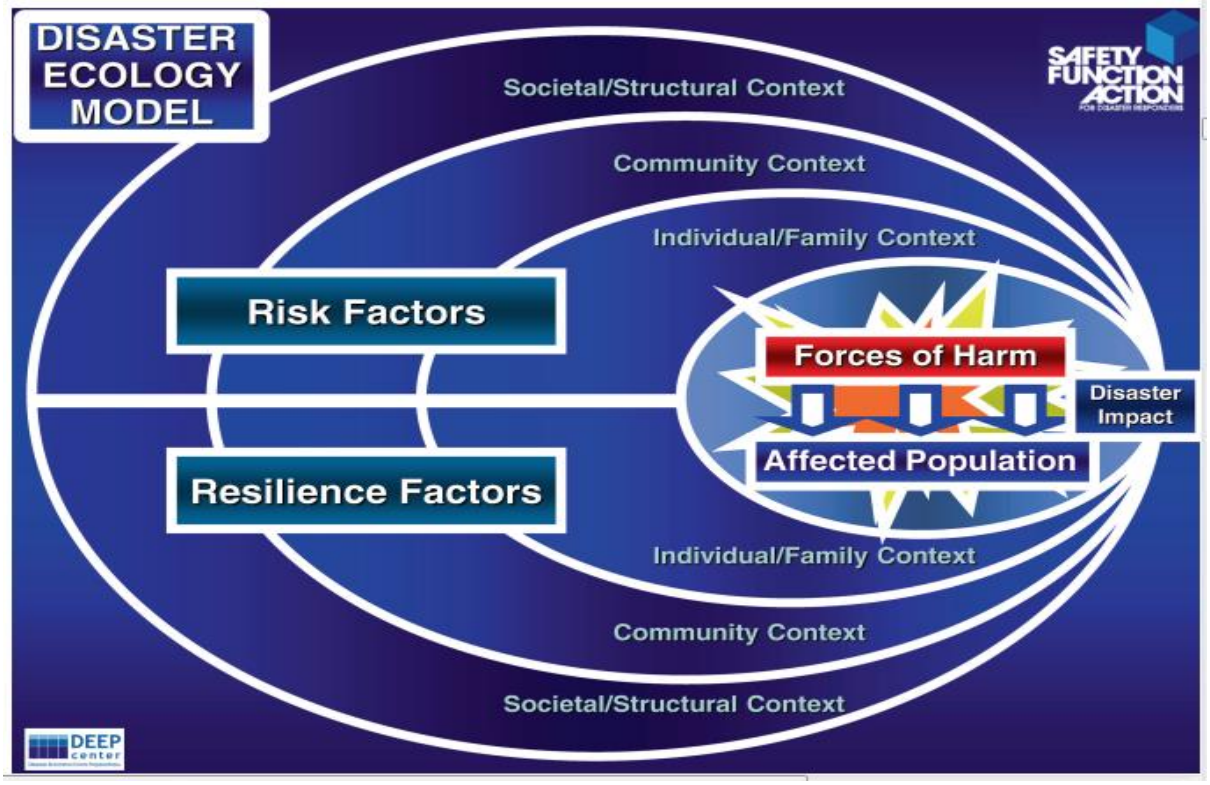
*(1) and (3) present already due to COVID19*

One of the major aims of early post-disaster intervention is to re-establish a sense of safety and calm, and draw on community assets to maximise resilience in communities (Figure 3). A range of interventions are required to support coping skills and ameliorate psychopathological presentations.

Effective early intervention should move individuals:
(1) from risk to safety,
(2) from fear to calming,
(3) from loss to connectedness,
(4) from helplessness to self-efficacy, and
(5) from despair to hope.

It is important we do not pathologies normal reactions to stress caused directly by coronavirus infection or indirectly by fear of it. In literature, most disaster-exposed individuals are minimally affected by adversities and are frequently able to adapt to their circumstances. Bradford District has a population of 530,000, however, so there will also be a significant proportion of the population either directly or indirectly affected.

**Figure 3**




*Shultz et al. (2007). Psychological Impacts of Natural Disasters.*

## 2.4 Suicide risk

Suicide is a tragic outcome of poor mental health and individual crisis. The consequences go far beyond the loss of individual life, as suicide impacts acutely on close family and friends. The negative impact can be compared to ripples in a pond spreading outwards to wider social networks and communities. A recent paper indicated that many of the emerging consequences of the coronavirus pandemic are known risk factors for suicide (Gunnel, 2020), so our policy response must address this.

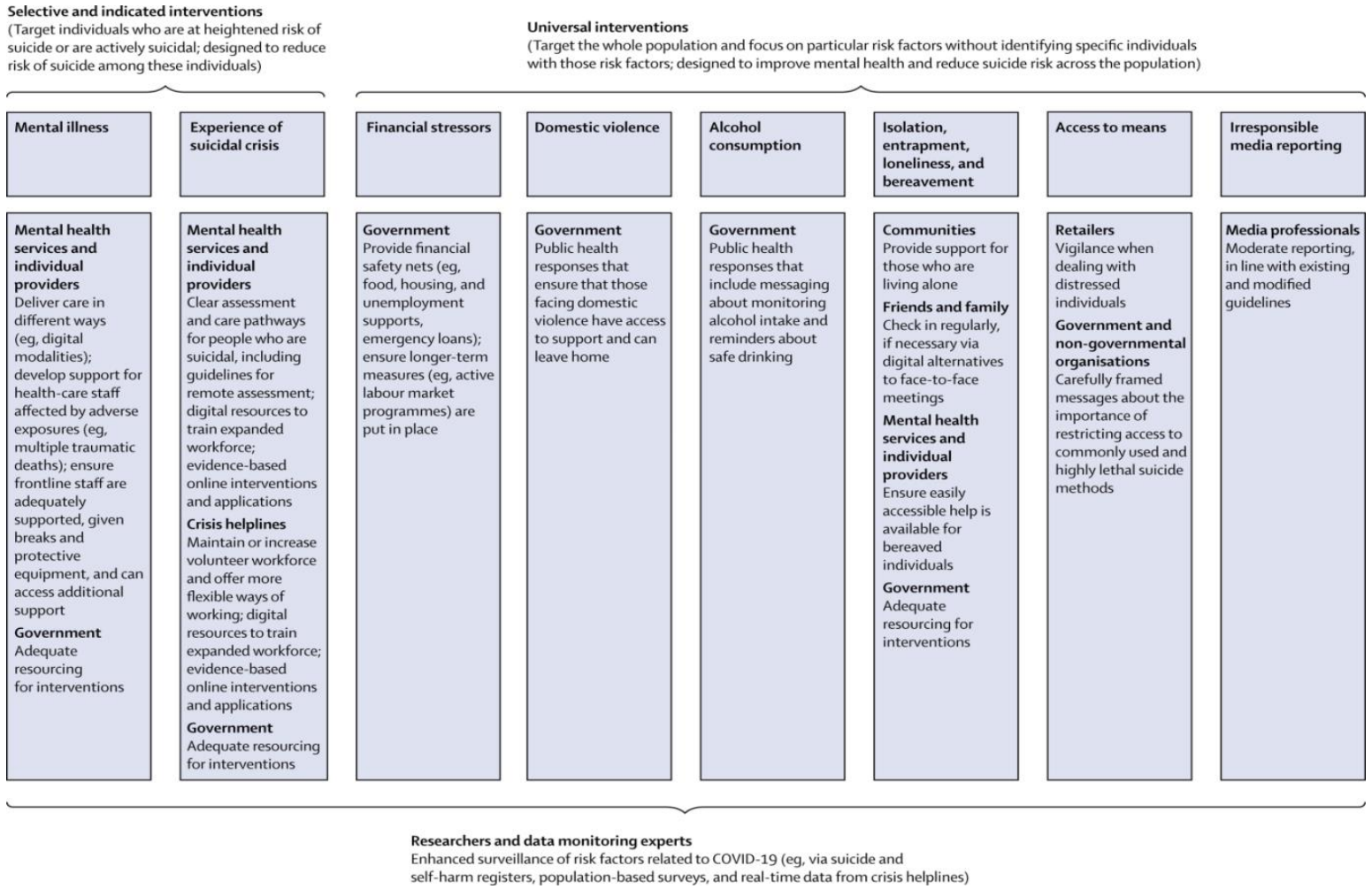
**There are various potential drivers of increased suicide during the coronavirus crisis. These include increased stigma towards individuals with COVID-19 but also an exacerbation of pre–existing risk factors such as psychiatric disorders, domestic violence, financial stressors, alcohol use and increasing isolation (Figure 4).**

The adverse effects of the pandemic on people with mental illness may also be exacerbated by fear, self-isolation, and physical distancing (worsening existing symptoms and leading to other developing new mental health problems). The consequences of increased pressure on mental health services are already being felt and the mental health of frontline healthcare workers required particular attention.

A range of selective and universal interventions are required to combat suicide risk, needed across mental health service and community support services and networks. Mental health services need to develop clear remote assessment and care pathways for people who are suicidal, and staff training to support new ways of working. Helplines also require support to increase their volunteer workforce, offer flexible methods of working and adequate training.

Finally a comprehensive response to emerging suicide risk needs to be informed by enhanced surveillance of both suicides themselves and COVID-19-related risk factors that contribute to suicidal behaviours.

## Figure 4: Public health responses to mitigating suicide risk associated with the COVID-19 pandemic




Gunnell et al. (2020). Suicide risk and prevention during the COVID-19 pandemic. Lancet Psychiatry. DOI:https://doi.org/10.1016/S2215-0366(20)30171-1

# 3 Groups most affected by COVID-19

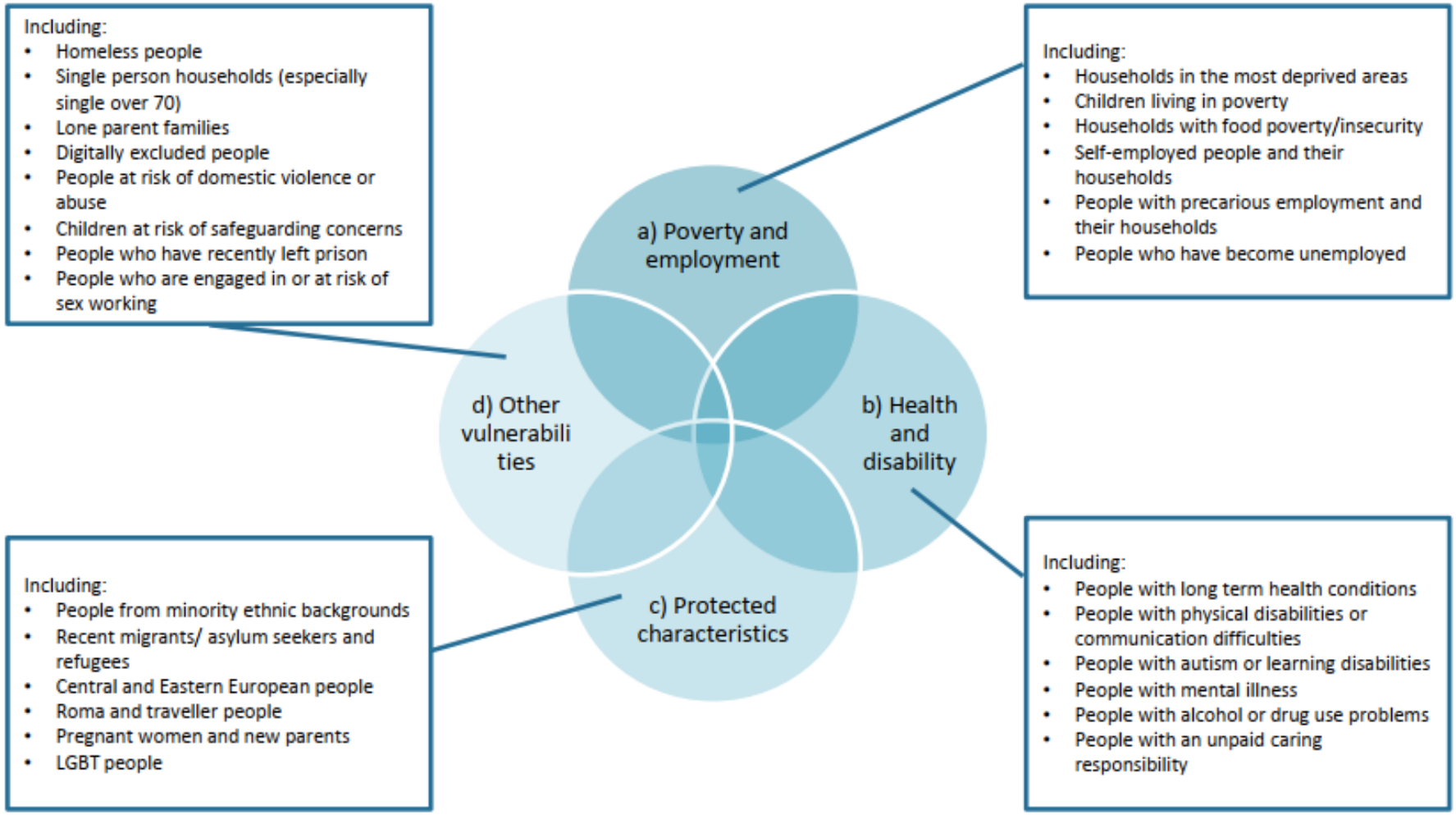
Based on knowledge of risk and protective factors for mental health, and baseline levels of mental health across the district, we might be able to highlight communities that are particularly at risk of deterioration in their mental health during this period. This is likely to be those populations that:

A) Already have high levels of poor wellbeing and mental health
B) Are more exposed to risk factors for poor mental health during coronavirus
C) Are less able to maintain participation in protective factors for wellbeing.

The groups whose mental health is most likely to be impacted by COVID19 are varied.

| |
|---|
| COVID-19 patients, plus close family and friends (50% risk of depression/PTSD) |
| Front line health and social care staff (at risk of PTSD) |
| Black, Asian and Minority Ethnic groups (higher underlying health risk/economically marginalised/crowded households) |
| Groups at high risk of unemployment, low income or loss of financial support (29,000 self-employed ) (18,000 children in poverty) |
| Young persons, especially with poor support mechanisms in place (15,600 with diagnosable mental health disorder) |
| Patients with a history of mental illness/autism/dementia (80,000/4,500/4,300 adults) |
| High risk group (adults with long-term conditions) and clinically high risk shielded adults/children (16,000 people on shielded list) |
| Elderly (8,900 with common mental health disorders; plus socially isolated) |
| Carers (any age) (approx 50,000 carers) |
| Groups at increased risk of abuse (children in need 12,900) |
| Socially isolated members of society (homeless, language or cultural barriers, disability) |
| Those with a past history of trauma or substance use (14,000 alcohol related admissions p.a) |
| Pregnant and postnatal women (and partners) (600-900 post natal depression p.a) |

# Which population groups are most vulnerable to indirect impacts of COVID-19?



# 4 Baseline assessment (Stage 1)

A full baseline assessment of mental health in Bradford District, the risk and protective factors for COVID19 and initial emerging initial evidence of impact are contained with in a more complete report (Appendix A), but summarised below.

**Risk and protective factors**

| Risk factors | Protective factors |
|---|---|
| Substance misuse/alcohol | Good quality antenatal/postnatal care |
| Deprivation | Early years (family experience/nurturing) |
| Fuel and food poverty | Good quality education |
| Poor housing | Regular income |
| Loneliness/Social isolation | Community participation |
| Stressful/uncertain work | Meaning, purpose and spirituality |
| Previous mental disorder | Positive relationships |
| Physical ill health | Physical activity |
| Debt/Unemployment | Access to green space |
| Domestic abuse | Good physical health |
| Bereavement | |

*There are also likely longer-term impacts related to:*

- Medium to long term economic downturn including further unemployment, loss of business, homelessness, ingrained poverty, suicide.
- Ongoing distress due to bereavement
- PTSD (from 1 year after an event) particularly for health and social care workers exposed to prolonged COVID care and suffering, and for members of the public having lost family members in particularly tragic circumstances.
- On-going depression and anxiety triggered by the initial COVID response.

- Worsening and untreated issues with addiction, for example online gambling, alcohol and drugs.
- Health-related anxiety due to delayed treatment or diagnosis (egg for cancer)

## 4.1 Baseline mental health disorders

This section outlines baseline levels of diagnosed mental health disorders in Bradford, mostly drawing upon data from 2017-2019. Local data to indicate socio-economic inequalities across these mental disorders (for example, by socio-economic status, or ethnicity) are not available and these rates therefore represent averages across all age groups.

**Table 1: Mental health disorders in Bradford populations across the life course** (Data source: PHE Fingertips: Mental health, dementia and neurology unless otherwise stated)

| Population group | Mental health condition/ situation | Estimated count | Estimated frequency (prevalence / incidence/ count) | Notes |
|---|---|---|---|---|
| **Pregnancy and perinatal period** | Postpartum psychosis | 12 | n/a | 2017/2018. Estimated number of women. |
| | Severe depressive illness in perinatal period | 174 | n/a | 2017/2018. Estimated number of women. |
| | Mild- moderate depressive illness and anxiety in perinatal period | 580-870 (lower-upper estimate) | n/a | 2017/2018. Estimated number of women. |
| **Children and young people (CYP)** | Mental disorders (total) | 15,600 | | 2017/2018. Estimated numbers of CYP with mental disorders. (5-17 years) |
| | Emotional disorders (anxiety disorders and depression) | Estimated 3,492 based on ONS populations | 3.8% | Estimated prevalence, aged 5-16 years. 2015 data. |
| | Hospital admissions as a result of self-harm. | | 581.4/ 100,000 | 2018/19 data. 10-24 years. |
| | Percentage of looked after | 106 | 32.3% | 2018/19 data. |

| | | | | |
|---|---|---|---|---|
| | children whose emotional wellbeing is a cause for concern | | | |
| | Autism | 1,128 | 10.9/ 1000 | Children with autism known to schools 2018 in Bradford district |
| | Learning disability | 6,958 | 7.0% | Pupils with Learning Disability: % of school aged pupils (2017)<br>2nd highest in YH. Significantly higher than YH (5.8%) and England (5.6%) |
| **Working age adults 16-64 years** | Psychosis (new cases) | | 26.8/100,000 | 2011 data. Estimated incidence from modelling data, via Fingertips |
| **Adults (all ages) ≥16 years** | Common mental disorder (CMD) prevalence | Estimated 79,493 based on ONS populations | 19.5% | 2017 data. CMD= any depression or anxiety. Estimated prevalence in PHE fingertips based on data from the APMS. |
| | Depression | 50,305 person | 11.4% | 2018/19 prevalence age 18+ district estimate |
| | Serious mental illness (SMI) | 6,069 persons | 1% | SMI includes major depressive disorder, schizophrenia and bipolar disorder. 2018/19 prevalence QOF. District estimate. |
| | Autism | 4505 – (ONS 2018 population estimates) | 11/1000 (95% CI 3–19/1000) | National estimate. Data source: Adult Psychiatric Morbidity Survey |

| | | | | |
|---|---|---|---|---|
| | | | | (2007) and Intellectual Disability Case Register study (IDCR) (2010) combined. |
| | Suicide | Average 38 deaths per year | 8.1/100,000 115over three year period. | Data from BD JSNA: 2016-18period. |
| **Adults (all ages) ≥18 years** | Learning disability – adults receiving long term support from the LA | 1510 | 3.82 per 1000 | 2018/19 data Rate similar to YH (3.63) and significantly higher than England (3.42) |
| **Older population ≥65 years** | Common mental disorder (CMD) prevalence | Estimated 8,928 based on ONS populations | 11.4% | 2017 data. CMD= any depression or anxiety |
| | Dementia | 4,280 | 5.01% | Prevalence. 2019 data. |
| **Whole population** | Learning disability (QoF) | 3,811 | 0.6% | 2018/19 QoF data – Same as YH proportion |
| | Emergency hospital admissions for intentional self harm | | 266.2/ 100,000 | 2018/2019 data |

## 4.2 Baseline assessment of mental health risk and protective factors

Certain risk factors are known to be associated with poor mental health. Appendix A goes into risk and protective factors for poor wellbeing in more detail, taken from the Bradford JSNA which represents a slightly broader range of factors.

**Table 2a: Risk factors for mental health in Bradford** (Data source: PHE Fingertips: Mental health, dementia and neurology)

| Population group | Risk factor for poor mental health | Estimated total numbers | Prevalence, or figure | Notes (NB: To add dates) |
|---|---|---|---|---|
| Children and | Low birth weight | 277 | 4.16% | 2018 data. Highest rate |

| | | | | |
|---|---|---|---|---|
| young people (CYP) | (%) | | | of low birth rate in Y&H. Significantly higher than Y&H: 3.14%, England: 2.86%. |
| | Overweight and obesity (%) | 1,451<br><br><br>2,773 | Reception: 21.8%.<br><br>Year 6: 38.3% | 2018/19 data. Reception age, increasing. Y&H: 23.7% England: 22.6%.<br><br>Year 6: increasing, highest in Y&H. England: 34.3% |
| | Children in low income families (%) | 34,745 | 23.8% | 2016 data. Significantly higher than Y&H (19.5%) and England (17%) |
| Working age adults 16-64 years | Employment deprivation | | 0.162 | 2015 data. Proportion of working age population who can't work due to unemployment, sickness, disability or caring responsibilities. Bradford in worst third of Y&H. England: 0.119 Higher figures show greater deprivation |
| Adults (all ages) ≥18 years | Overweight and obesity (%) | Estimated 243,028 based on ONS populations | 61.5% | 2017/18 data. 18 years and older. Adult overweight and obesity- similar to England average (62%). Lower than Y&H (64.1%), not significantly so. |
| Whole population | Fuel poverty (% of households) (2017) | 27,767 households | 13.5% | Highest in Y&H. Y&H: 10.6% England:10.9% |
| | Statutory homelessness (priority need) | 116 | 0.6/1000 households. | 2017/18 data. Households in temporary accommodation, per 1000 total households. |

| | | | | |
|---|---|---|---|---|
| | | | | Increasing. Significantly higher than Y&H (0.4/1000). England: 3.4/1000. |
| | Violent crime | 28,190 offences | 52.7/1000 population. | 2018/2019 data. Violent offences per 1000 population. Second worst in Y&H. Significantly higher than Y&H: 36.9/1000 and England 27.8/1000. |
| | Domestic abuse related incidents and crimes | | 38.9/ 1000 | 2018/19data. Similar to several other regions in Y&H. |
| | Admission episodes for alcohol related conditions | 13,869 admissions | 3,035/ 100, 000 | 2018/19data. Bradford rate is second highest in Y&H. |
| | | | | |

**Table 2b: Protective factors for mental health in Bradford** (Data source: PHE Fingertips: Mental health, dementia and neurology)

| **Population group** | **Protective factor for poor mental health** | **Estimated total numbers** | **Prevalence, or figure.** | **Notes** |
|---|---|---|---|---|
| Working age adults 16-64 years | Employment | 213,400 | 66.0% | 2018/19 data. 16-64 yrs in employment Lowest rate in Y&H. Y&H: 73.7%, England: 75.6% |
| Adults (all ages) ≥19 years | Physical activity | Estimated 240,166 based on ONS populations | 61.9% | 2017/2018 data. ≥19 years doing at least 150 MIE minutes physical activity per week. Y&H: 64%. England: 66.3% |
| Whole population | Housing quality: indoor living environment. | | IMD score of 35.7. | Proportion of homes failing to meet standards on fitness for habitation, disrepair, modern facilities and thermal comfort. |

| | | | | |
|---|---|---|---|---|
| | | | | Bradford has the poorest score in Y&H. England: 22.1 Higher scores indicate greater deprivation. |

# 5 The projected mental health impact of COVID 19

**Emerging evidence of the impact of coronavirus in the UK**

In a recent position paper outlining mental health research priorities during COVID-19 (Holmes et al, 2020) the authors theorised that the likely consequences of COVID-19 would be to increase social isolation and loneliness. These symptoms of poor mental health are themselves strongly associated with further mental health problems including anxiety, depression, self-harm and suicide attempts (Elovainio, 2017; Matthews, 2019). They suggest that tracking loneliness and intervening early on risks and buffers for this symptom would be an important priority.

Two surveys conducted by the UK Academy of Medical Sciences and the research charity 'MQ: Transforming Mental Health' inform the position (one with people with lived experience of mental health, and the other representative sample of the general population). Those with previous experience of mental health issues expressed concerns about **social isolation, increased feelings of anxiety and depression** and particular concerns about exacerbation of pre-existing MH issues. There were also **reported difficulties in accessing MH services** and support during the coronavirus pandemic. Concerns over the effect of COVID on the mental health of children and older people were also expressed (Holmes et al, 2020).

Elovainio M. et al. (2017). **Contribution of risk factors to excess mortality in isolated and lonely individuals: an analysis of data from the UK Biobank cohort study.** Lancet Public Health. **2**: e260-e266.

Matthews T., et al. (2019). **Lonely young adults in modern Britain: findings from an epidemiological cohort study.** Psychol Med. **49**: 268-277.

Holmes et al. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. Lancet Psychiatry. DOI:https://doi.org/10.1016/S2215-0366(20)30168-1

Further recent surveys within the UK expand on these findings. The 'Life Under Lockdown' survey (Ipsos Mori and Kings College London) found that nearly half of participants had felt more anxious or depressed than normal as a result of COVID. Younger people were more likely to find it very difficult to cope (42% of 16-24 year olds stated they were finding it extremely difficult to cope, compared to 15% overall). There appeared to be a financial impact already- 22% were either very likely or certain to experience difficulty affording basic

essential and housing costs or had already experienced this. 16% of workers had already lost their jobs or were certain/ very likely to.

Experience from previous economic crisis and pandemics have resulted in serious mental health impacts on population. The Centre for Mental Health has forecasted that the health and economic impact of COVID19 may lead to an additional 500,000 people in the UK with mental health conditions (Figure 5).

**Figure 5 – Forecasted (estimated) impact of COVID19**

| Issue | Effect | Potential local impact |
|---|---|---|
| Rise in debt once temporary measures cease (local data) | Universal credit claims (Bradford) | 7,600 increase (44% up from March to April) |
| Financial crash (2008) (CMH) | UK 500,000 more MH problems | equates to 4,000 for Bradford District |
| Hong Kong SARS 2003, Financial crash (CMH) | 7-10% national rise in suicides | 3-4 deaths per year Bradford District (but hides spectrum of suicdal behaviour) |
| SARS 2003 patients (CMH) | 12 months later (20-25% PTSD; 60% depressive disorder) | Potnetial impact on 1,300 known COVID cases (end of May) |
| Current H&SC covid staff (BMJ) | Anxiety (50%), sleep issues (30%), burnout | impact on 3,700 H&SC staff already COVID tested |
| Bereavement (CMH) | 7% of close relatives have complex reaction | impact on 473 known COVID deaths (end of May) |

# 6 Emerging needs (stage 2)

During May 2020 a short survey was sent to providers of mental health and well being services (VCS and statutory) across the District covering the nature of their services, service delivery and access issues and insight from service users. The Bradford Mental Health Provider Forum was used as the network for distribution, and Public Health completed a thematic analysis to identify emerging themes. **This survey provides a snap shot up to May 2020 and we are planning to repeat the survey at regular intervals to maintain an overview of mental health needs in or communities.**

Forty-one organisations responded to the survey, covering a range of services including befriending, counselling, psychotherapy, bereavement support, services for patients with cancer, carers, and peer support groups. There were also more specific services for people with serious mental illness or autism, individuals and families who have experienced trauma or abuse, and services aimed towards members of the BAME community, deprived communities and refugee and asylum seekers (see Appendix C for a full list of responders).

## 6.1 Delivery and capacity

Where information on capacity was recorded 50% reported a reduced staff capacity in some respect. Not many organisations quantified the extent of this reduced capacity, but where they did it ranged from 20 to 40%. The reasons for a reduced capacity included; staff sickness, concern over working in a home environment, volunteers needing to shield and volunteers struggling with their own mental health. There is difficulty in rapidly replacing volunteers where organisations require quite a lot of training, or the ability to work with certain communities where knowledge of the local language is helpful. Despite half of the organisations reporting a reduced capacity, just three stated they did not have capacity to cope with the current demand.

The survey of VCS mental health providers was not a quantitative analysis of demand but services were concerned of a sudden rise in demand for face to face services (or remote) as isolation due to distancing measures and financial insecurity wears on. Also that those with serious pre-existing mental health and social problems (e.g. addiction or experiencing domestic or sexual violence) may reach crisis suddenly and without early interventions.

All providers where applicable reported adapting their service provision to adhere to social distancing guidelines. All organisations were still making themselves available to their service users via telephone, webchat, text, video and sometimes with provision of online tools or support mechanisms to service users. Some providers are adjusting their operating hours to increase access, some are re-deploying staff from one area to another to meet demand. There are excellent examples of proactive work to increase frequency of contact with some service users with the highest needs and this has resulted in good engagement of case-loads. Some have provided practical resources to home settings where face to face sessions are not possible (for example, craft and cooking equipment as well as self-help packs). However, complete transfer of services to remote methods has not been possible for some organisations based on the nature of the service they provide, or the groups that they work with. For this reason, some organisations are currently providing an amber ‘rag rating’ for their service.

**Services were asked to 'rag rate' their organisation based on:**

- Green – Service continuity not significantly affected.
- Amber – Some issues/concerns with service delivery due to staffing capacity /client presentations etc.
- Red – Significant difficulty in delivering services.

Current self-reported RAG rating of organisations in the MHPF survey, May 2020 (n=30)

| Rag Rating | n(%) |
|---|---|
| Green | 18(60%) |
| Green/Amber | 2(7%) |
| Amber | 9(30%) |
| Amber/Red | 1(3%) |

**there were 11 organisations which did not have a RAG rating recorded. However, ten of these were not asked*

Some provider organisations report that demand has increased (see gaps and needs section). In others, demand has gone down, despite expectations that it would increase (for example bereavement services, some services aimed at young people). This may be due to lack of awareness that services remain open, or it may be that service users are not able to engage, or not comfortable to engage remotely. Monitoring future demand and capacity going forward will therefore be important.

## 6.2 Children and Young People

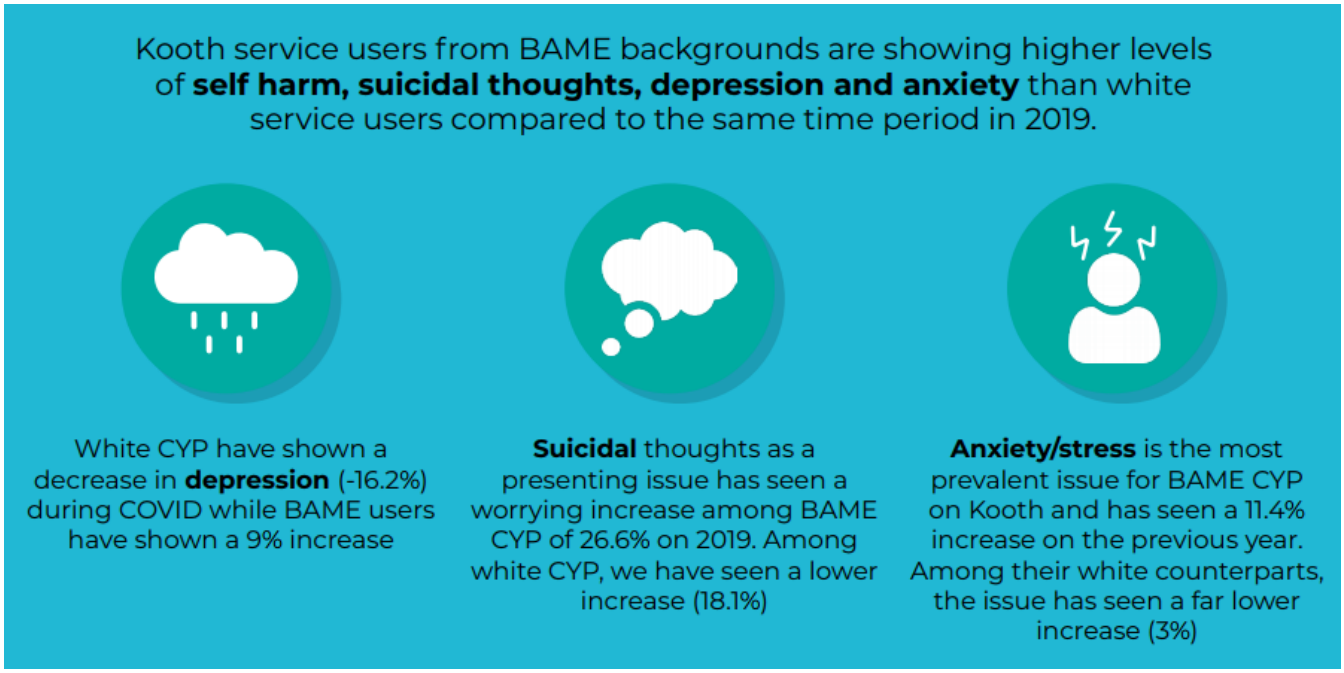
The perinatal mental health service saw an increase in appointments during the early stages in April 2020 but reports lower access from areas of high deprivation and in the Central area of Bradford, representing an area of unmet need for the service. Midwifery face to face contact has reduced due to social distancing during COVID19 (with a potential impact on nurse/patient relationships).

Nationally the Kooth mental health support service for children and young people has reported an increase in numbers of CYP reporting certain risk factors of poor mental health (Figure 7 - national data to June 11$^{th}$). The increases have been greatest for those presenting with sleep issues, school/college worries and autistic spectrum disorder.

**Figure 7 - Kooth (digital mental health service for children and young peoples mental) – national data (June 2020)**


The biggest <u>national</u> increases in mental health problems in these data is for young people from BAME groups (national data to June 11th) (Figure 8).

**Figure 8 - Kooth service for BAME children and young peoples – national data (June 2020)**



**Locally our Bradford Kooth service data shows**

The number of monthly new registration for Bradford Kooth has fallen since the start of lockdown. The number of new registration from BAME communities has remained stable (between 30% and 40% of the total)

Although the number of logins remained similar after lockdown (Figure 9), the number of unique users has fallen by 25% (Figure 10).

The service provides a range of mental health support options across the teenage years from 11 to 19 years (Figure 11).

New registrations after lockdown from females outnumbered males by 4 to 1.

**Figure 9: Number of new logins with Bradford Kooth by month (pre and post lockdown)**

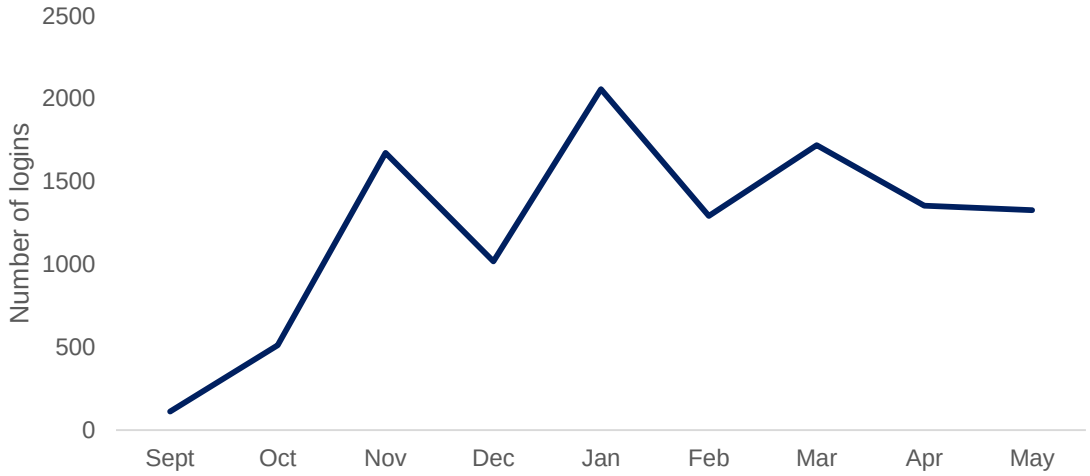



**Figure 10: New registrations with Bradford Kooth by month (pre and post lockdown)**

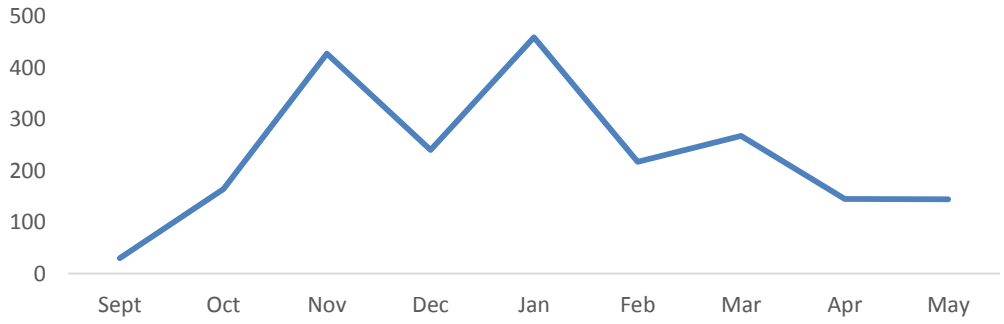
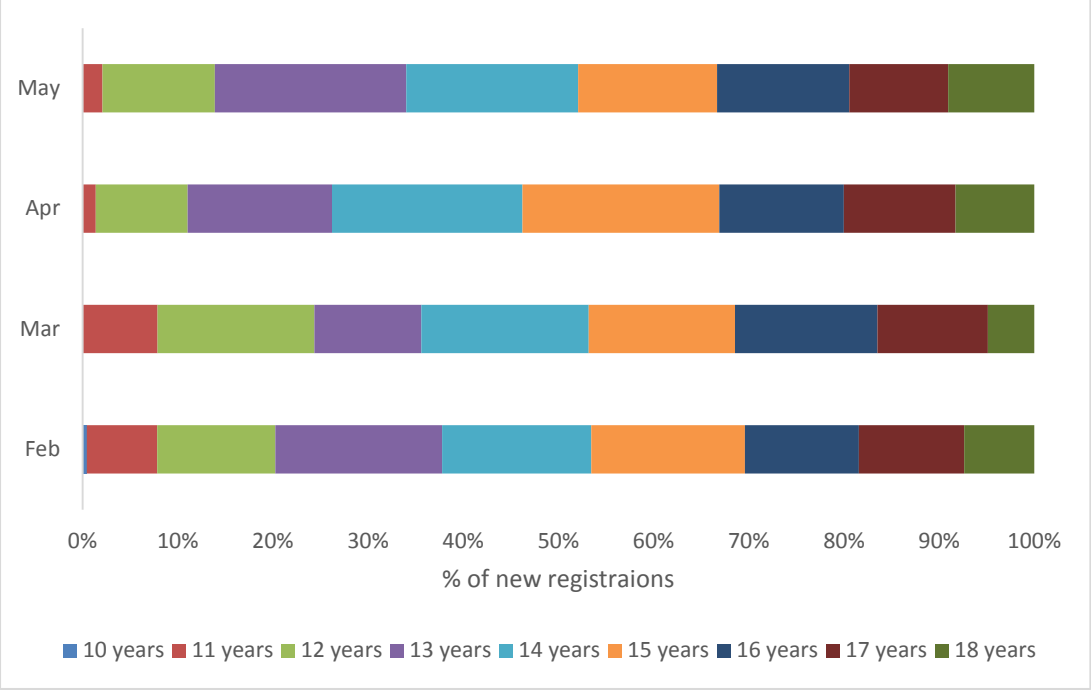


**Figure 11: New registrations for the Bradford Kooth service (pre and post lockdown)**




The main issues reported for CYP in the VCS provider survey were:

- Anxiety and stress, uncertainty for the future, fear of contracting COVID-19, feeling overwhelmed by media, feeling low and tensions in homes. Some reported concerns over domestic violence. Specific anxieties also relate to worrying about the future, school, and personal/family safety.
- Issues related to school closure were also expressed, including concern over exams, boredom, frustration, lack of routine and increased use of gaming to cope.
- However <14 years not feeling as comfortable/ able to engage remotely.

Exposure to domestic violence and concerns around this issue (within the home environment) have led to a 50% increase in Child Protection notifications for domestic abuse.

Self-harm (suicidal ideation) are being reported as issues from local crisis services with young people attending crisis services reporting a worsened mental health due to lockdown.

## Born in Bradford Survey data

A Born in Bradford analysis of vulnerabilities for children from their previous surveys (2016-2019; 15,641 children, aged 7-10 years old) showed a range of vulnerabilities and protective factors for mental health.

Home, family and family relationships: 13% don't have a garden and almost a third say there is no park near their home where they can play; 7% never play in a park [risk factors: lack of green space and exercise]

Material resources: 17.5% say they don't have a computer, laptop or tablet with internet access at home. Over 14% of children say they don't have three meals a day. One quarter of children say they worry about how much money their family has all of the time [risk factors poverty, digital exclusion, lack of access to home schooling/education]

Friends and school: The majority of children like school a lot, but 13% say they do not like school. 14% say they don't have many friends; 11% say they are bullied all of the time and 41% are bullied some of the time [school is a protective factor for some (currently lost due to COVID), where as returning to bullying may be a risk factor for others]

Self reported wellbeing: Most children are happy all or some of the time, but 4% say they are never happy and 5.5% report being sad all the time. [no comparative data during COVID]

*Coronavirus Scientific Advisory Group. BIHR. Born in Bradford pre-COVID-19 Child Wellbeing Survey. June 2020. https://www.bradfordresearch.nhs.uk/findings-and-resources/*

### A recent review of the role of school to reduce health inequalities in CYP concluded:

**"The worst consequences of this COVID shutdown are experienced by the most vulnerable children who already rely on school for educational, nutritional, and health needs (due to socioeconomic disadvantages or disabilities). In addition to the possible lack of parental support at home, major inequalities arise in the access to digital learning resources. The COVID-19 crisis gives us the opportunity to re-assess what type of school we want for the future."**

**"Teachers should act as health promoters for their students from a young age, by actively fostering healthy habits (physical activity, good personal hygiene, and balanced diet) and raising awareness of the consequences of risky behaviours"**

The worst consequences of COVID19 shutdown are experienced by the most vulnerable children who already rely on school for educational, nutritional, and health needs due to their socioeconomic disadvantages or disabilities. In addition, the possible lack of parental support at home means inequalities in access to digital learning resources. The COVID-19 crisis gives us the opportunity to re-assess what type of school we want for the future, and there is a strong role for the Local Authority in supporting teachers and schools to achieve this ambition.

Rethinking the role of the school after COVID-19. 2020. Lancet Public Health. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30124-9/fulltext?dgcid=raven_jbs_etoc_email

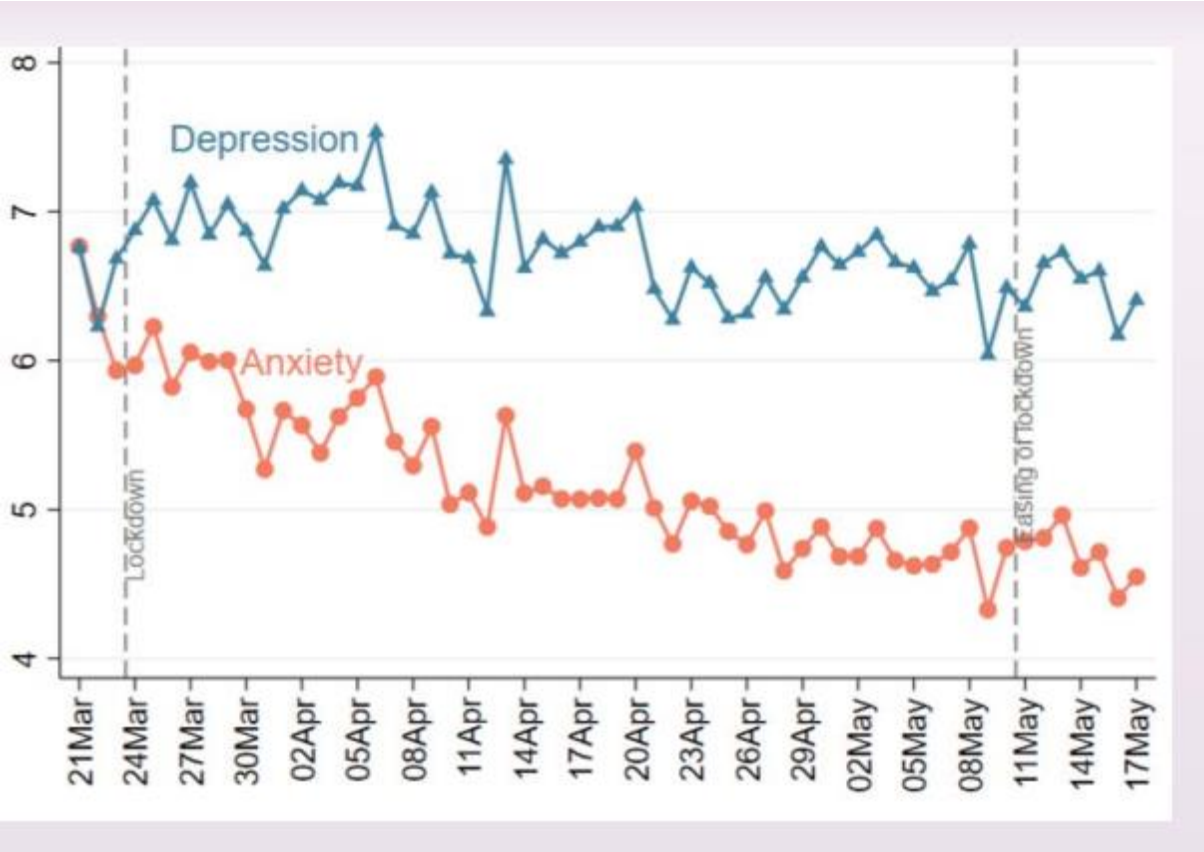
## 6.3 Working age adults

**The national picture is mixed. National surveys show an increase in access to online support (main reasons being the new work culture ("juggling"), sleep and the health of others as major causes of anxiety. However there is no corresponding national increase in reported anxiety and depression from national surveys undertaken by the University of Manchester (Figure 12).**

During COVID19 people in low income households are more likely to experience financial insecurity, reduced work hours, have long term health conditions, live in crowded households, no internet access (for other opportunities) - all mental health risk factors. Nationally, a third of people with mental health problems are cutting back on essentials (food, heating, missing debt repayments). There is a potential systemic rise in debt once temporary financial measures are lifted.

Our local survey results show that many provider organisations reported their service users to be struggling with **increased isolation**, fear and anxiety related to COVID-19, in addition to existing depression and risk factors such as financial concern. Indirect health related anxiety has also been expressed (for example, those with a diagnosis of cancer). Although not reported in this survey, feedback from the national online mental health service for adults (Quell) has indicated that parental mental health has significantly increased during lockdown, following the increased pressure that families are experiencing at home (juggling home schooling, home working or worklessness, and other family commitments).

**Figure 12: University College London social survey of anxiety and depression**




[L Appleby presentation to West Yorkshire Suicide Prevention advisory Network, June 20]

There was an initial dip in referrals in the lead up to lockdown which then increased in April and May. Data suggests an increase in **crisis presentations** in Safer Spaces of 50-70%. This may be partly accounted for by an increase in capacity to take referrals and previously unmet need. Symptoms include increased self-harm, alcohol use, and suicidal ideation/planning. For a few with longstanding mental illness, symptoms of psychosis are worsening. Lockdown may also increase risk due to individuals feeling trapped and controlled.

Results from a rapid survey of 800 families involved with the **Born in Bradford research** data study paints a picture of multiple and increasing risk during coronavirus during April and May 2020.

**Living circumstances**

**2 in 5** families lived in overcrowded homes.

**1 in 4** families live in poor quality housing

**1 in 4** reported living with someone clinically vulnerable

**1 in 3** households had self isolated at some time (often to protect a vulnerable person)

**Mental Health**: From validated MH assessment tools (PHQ-8 and GAD-7).
Compared to before the pandemic, more people had poor mental health during lockdown.
**2 in 5 respondents had depression**
**2 in 5 respondents had anxiety.**
The risk of becoming depressed was higher for those who were struggling financially, and for White British respondents

**Money**
**1 in 3** families are worried about the job security of the main earner
**1 in 4** are worried about paying the rent/mortgage
**1 in 4** couldn't afford to buy the food they needed.
**1 in 10** had severe financial and food insecurities (skipping meals)
**67%** of self-employed and not working are worse off than before Covid
**49%** of main earners who are furloughed are worse off now
**2 in 5** who smoked or drank alcohol reported smoking/drinking more during lockdown.
**1/2** of respondents reported doing less exercise during lockdown
**2 in 5** participants reported worrying about their health most or all of the time (associated with clinically vulnerable person in house).
**16%** of children who were eligible for a school place during lockdown took this up (fears child might catch the virus)

*Coronavirus Scientific Advisory Group. BIHR. When will it end? Will it end?" Findings of the First 1000 Participants in the Born in Bradford Covid-19 Parents Survey. June 2020.*
*https://www.bradfordresearch.nhs.uk/findings-and-resources/*

### COVID19 and financial difficulties

Nationally, nearly two in five (38%) people with experience of mental health problems report that their income has dropped as a direct result of the pandemic. Symptoms of common mental health problems make adjusting to an income drop even harder, reducing the ability to plan and problem-solve. Anxiety and difficulties communicating can lead to trouble in accessing help. This was reflected in survey of providers who report financial insecurity (due to reduced, uncertain, or lost work) is impacting on their service user's mental health.

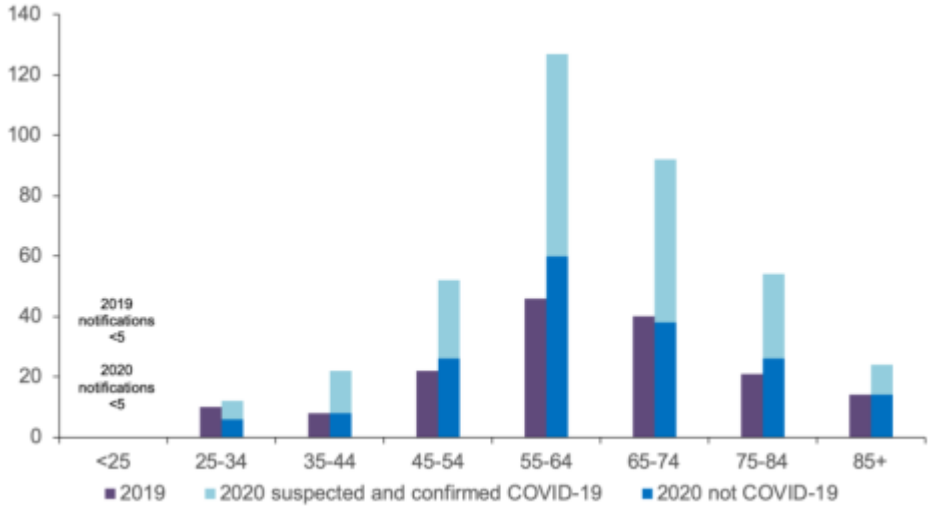

INCOME IN CRISIS. How the pandemic has affected the living standards of people with mental health problems. Money and Mental Health Policy Institute. 2020

**Suicide:** There has been no nationally reported rise in suicides (June 2020). Local data shows 10 suicides (as of 26th June) during March, April and June in Bradford District. Our local suicide audit shows an average of 40 per year (10 per quarter) so there appears to be no statistical local rise in suicides since the start of COVID19 lockdown. However there is an increased risk of suicide in people with severe mental illness (whose support services may have been disrupted) and a reported increase in financial stressors (a suicide risk for men in particular) and reports of domestic violence (risk for women).

Service providers report that living alone has been associated with crisis presentation (and alcohol/self harm/suicidal ideation) with police involvement in these cases at safer spaces (Sanctuary and Haven). Our first response service (crisis and out of hours service) has seen a sharp rise in out of hours calls (mainly via self referral or from the police). Nationally, charities that support LGBT report an increase in people contacting support services (Hero charity suicide prevention service 44% increase compared to the first 3 months of the year). Those from the LGBGQ community have a higher risk of suicide than the rest of the population

### Learning difficulties

There is growing evidence that they are at increased risk of mortality from COVID-19. The CQC analysed deaths among people with learning disabilities (some of whom may have also be autistic) and found that between 10/4/20 and 15/5/20 there was a 134% increase in number of death notifications (excess 221 deaths in a 5 week period).




## 6.4 Older people and dementia

Older adults have a higher prevalence of underlying health conditions which directly impacts the associated risk of COVID-19. This increased vulnerability has led to many service users feeling fearful and anxious when it comes to going outside for essential items including groceries and prescriptions.

Seven providers with older adults as their specific target population responded to the survey.

- All providers stated isolation and loneliness were leading to poor mental health of their service users. Other potential risk factors included; uncertainty over the future and the news having a main sole focus on COVID -19.
- Older adults which appear to be particularly affected include; those with cognitive decline/dementia, those who live alone or in retirement flats as they have been confined to their flats and not able to use the communal areas, the BAME community, those with a terminal illness, those waiting for a medical procedure which has been postponed and those who are deaf or hard of hearing.

- One provider noted that older adults experiencing cognitive decline/dementia are more confused, angry and frustrated while in quarantine/lockdown. Those with a terminal illness have higher anxiety as they feel as though time is slipping away.
- An increase low mood in service users was observed in three providers and an increase in depression was also observed in three providers. One provider noted an increase in suicidal thoughts in their elderly service users. Especially those who have been recently bereaved.

## Dementia

A quarter of people who died in the first two months of the COVID pandemic in England and Wales had dementia (over 8,500 people in March and April 2020), with dementia the most common pre-existing condition for coronavirus deaths. A quarter of deaths locally included dementia as the primary condition March-May. Older people may also have a higher dehydration and nutrition risk due to frailty.

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinapril2020

Key concerns across the District that impact on the mental well being of people with dementia and their carers are:

A significant increase in self harm has been reported in people with dementia in recent months.

A significant drop in referrals for memory clinics, creating a potential backlog after lockdown and delay in assessment.

A rise of 15% in antipsychotic drug use for people with dementia during lockdown (combined total for care home and home living). The use of antipsychotics should be reserved for severe symptoms that have failed to respond adequately to non pharmacological management and are not recommended as a first line treatment.

The register of people with dementia is decreasing in numbers and there has been a drop in there number of referral to memory clinics. Delays in packages of care can therefore be an additional stress if financial assessment is not happening (needed before provision starts).

Extended support work in homes and advanced care planning has ceased or not progressed for many patients.

Helpline providers report desperation from isolated carers. Some services are back on line which has opened up some contact again for carers and patients who are desperate to talk to someone. Some carers are coping with on-going abuse, with less support than prior to lock-down, and the lack of day services is causing a huge strain.

The fear of patients of being admitted to a home has caused some not to due to a perceived and real risk (particularly early in the pandemic), although lockdown principles and infection control are now robust in care homes.

The Alzheimer's society have recommended that local leadership (LA, CCG and partners) put in place an action to address the impact of social isolation on people living with dementia and their carers, including:

- a focus on sufficient PPE for care staff
- short breaks for informal carers to be re-instated as soon as possible
- care plans should be reviewed (with emergency arrangements in place)
- appropriate measures to support contact between residents and their loved ones
- adequate staffing for clinical support in care and domiciliary services for end-of-life care.
- local analysis has also highlighted the need for a strong virtual training offer for care home staff (including a focus on under-nutrition and hydration, building on the emergency dietetic service put in place during COVID10).

*Alzheimer's society. Dementia and COVID-19: Social Contact. June 2020.*

## 6.5 Carers

Carers groups report a lack of respite services (which was an existing issue for many) has been care due to COVID19 lockdown.

Carers from BAME communities have added stress due to the increased risk of COVID19 mortality (highest in the Bangladeshi group). Young carers report that the lack of protected 'me time' (felt throughout the carer community but felt particularly felt by many young carers) has drastically reduced, impacting on their mental health.

Older carers face barriers not accessing digital resources.

Some families with caring duties have coped well but many report feeling abandoned (not listened to) and overwhelmed due to additional responsibilities during COVID19 (many are also now having to home school). The Alzheimer's society locally report the high risk of carers mental health deteriorating due to being further socially isolated with the person they care for. The requests for

face to face visits and services rather than phone calls is high for this group of carers, with common concerns about what happens after lockdown ends but whilst COVID is still circulating.

## 6.6 Bereavement

**There has been no reported increases in people accessing these services locally.**

Two service providers for bereavement counselling have reported that referrals have not increased despite around 400 deaths due to COVID-19 locally. It is not known whether there is an awareness gap in these services being available, although the bereavement pathway is being strengthened with West Yorkshire Partnership Involvement. Some service users may have chosen to delay help until face to face services re-open. However, bereavement remains an important risk factor for poor mental health, and continued support of this group is important

## 6.7 Black, Asian and Minority Ethnic groups

Emerging international evidence has highlighted the disproportionate impact of coronavirus on BAME communities. An analysis by Public Health England showed that (after accounting for the effect of sex, age, deprivation and region) people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. Those of Chinese, Indian, Pakistani, other Asian, Caribbean and other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.

A further analysis by the Institute for Fiscal Studies found that after controlling for age and geography, Bangladeshi hospital fatalities are twice those of the white British group, Pakistani deaths are 2.9 times as high and black African deaths 3.7 times as high. There may also be increased risk of COVID infection due to multi-generational households (particular in South Asian communities). Some ethnic minorities are also more economically vulnerable to the current crisis and men from minority groups are more likely to be affected by the shutdown. This work also showed that certain common professions (e.g. service sector, restaurant, health sector industries) have seen higher death rates from coronavirus. South Asian communities are also at higher risk of serious complications from COVID19 due to pre-disposition to (or pre-existing long term conditions) such as diabetes and heart disease (often with earlier age of onset).

Beyond the data: Understanding the impact of COVID-19 on BAME groups. PHE. 2020. https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities

Analysis of COVID death data for Bradford District has shown a strong correlation between deprivation and deaths from COVID 19. The Bradford Institute for Health research has analysed hospital data for COVID 19 patients between February and mid-June 2020.

The risk of dying in those patients testing positive for COVID was similar in Pakistani origin patients in Bradford compared to White British patients (no statistical difference). Analysis will continue as further data is reviewed.

The mortality rate in those testing positive for COVID-19 was significantly lower in South Asian origin (21.9%) compared to White British patients (40.8%). However, South Asian patients are significantly younger than White British patients (average 56 vs 73 years). More white British men have tested positive than women (men have a higher COVID mortality rate), whereas the number of cases for South Asian patients are around the same in men and women. There are some caveats to this analysis as it uses outcomes from hospitalized patients classified as COVID deaths, rather than using community data and all cause mortality data. In addition, deaths in BAME communities are being compared against a background population white British population that has high deprivation and long term condition rates.

In terms of mental health further indirect impacts of COVID19 are detrimental to mental health. Firstly, isolation due to heightened and perceived fear of coronavirus. This can be exacerbated by language barriers that hinder access to culturally specific and tailored public health and safety messaging.

During lockdown there was also a loss of multi-generational childcare support (which compounds financial insecurity and family disruption (this affects all groups).

The breakdown of face to face community networks during lockdown also means the grieving process and personal support (so important to well being) has greatly reduced. This has also disrupted the community worker in many settings. A lack of multi-language information on mental health websites both providing advice and directing to mainstream mental health service provision is a commonly reported theme from providers.

There are several examples of ‘fake news’ circulating currently (e.g. incorrect threats of deportation if COVID infected) which may impact on communities’ ability to seek help when needed and follow safe practices to avoid infection. This is particularly difficult for asylum

seekers and other marginalised groups who may not speak English, and whose community networks, vital to remain informed, may have weakened. Within the Central and Eastern European community temporary work is reportedly drying up. There are issues within the Roma community being reported due to language barriers to accessing services, being unaware services are open, fear and confusion due to mixed messages on COVID19

Across different BAME groups there were reports of families getting their COVID using public health messages from TV and radio of their home country or country of origin. These messages may differ significantly from the UK and run counter to current social distancing or testing guidelines.

The national PHE report made the following recommendations to address the excess burden of COVID on some BAME group which address reducing health inequalities both within the BAME population and in society as a whole:

- Producing culturally sensitive education and prevention campaigns to rebuild trust and help communities' access services.
- Targeting ethnic minority groups with culturally sensitive health messages, and
- Ensuring that Covid-19 recovery strategies actively address inequalities to create long-term change.

## 6.8 Face to face v digital access

**For digital and remote access there are**

**Technical barriers – Can't access to due lack of knowledge, training, broadband or hardware**

**Acceptability barriers - Don't like this type of service due to specific needs, preferences or past experiences (and waiting for face to face service to resume which may result in increased risk of crisis, isolation or gap in treatment)**

**Practical barriers - Not effective or practical for complex cases (trauma), behavioural difficulties, some serious mental illness**

**Is was a widely held belief amongst providers that due to these barriers there will be huge surge in demand for face to face mental health services as lockdown eases.**

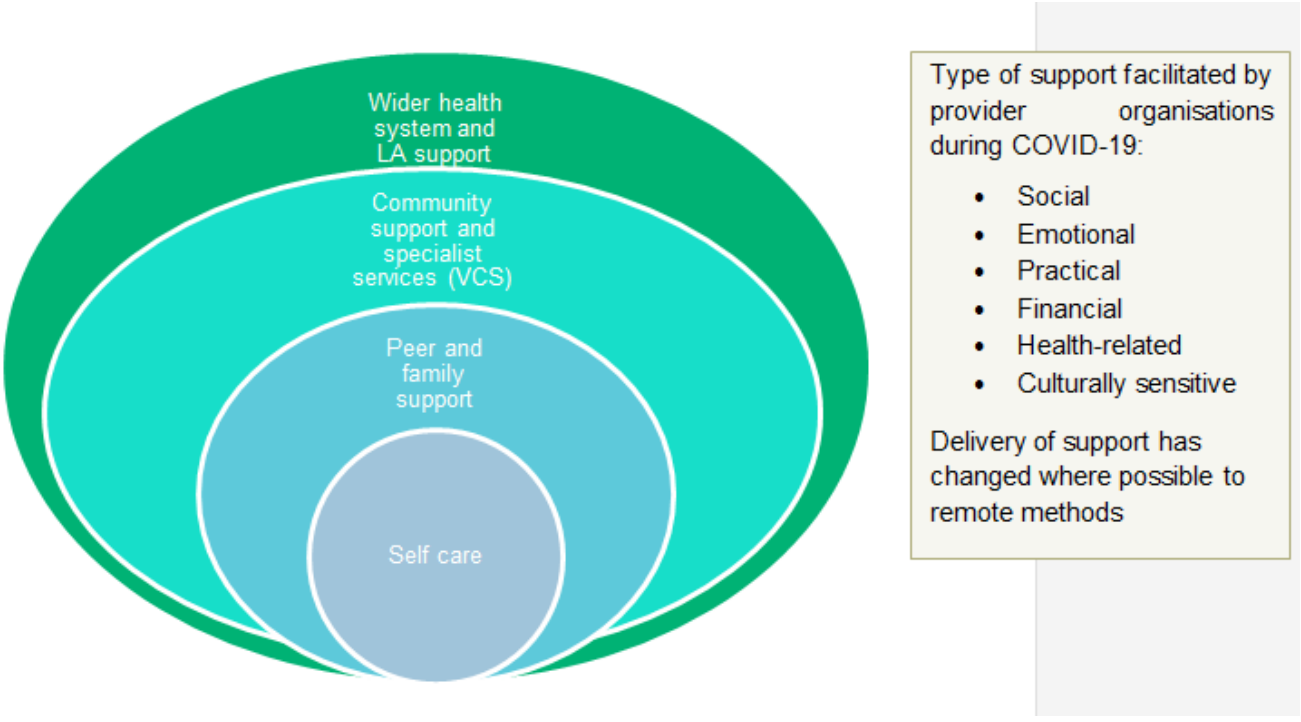
**Remote provision** of services through telephone or online methods has been successful for mainstream and specialist services (across VCS providers and within Kooth services for CYP). The switch to digital ways of working have opened new opportunities for engagement.

Regular telephone check-ins with service users have also been welcomed by many and some have asked for more support to be provided through virtual groups, including peer support. However, some groups are missing out on remote service delivery during lockdown as they do not have access to online devices, are unsure how to use the digital platforms, or cannot afford phone data.

Over halve of all providers in the survey stated some difficultly to effectively deliver face to face services via remote methods. Some people may not be comfortable discussing certain issues over the phone or online (and it may not be possible for some to do this confidentially). Some people are choosing to wait for the return to face to face services rather than use digital versions- as has been seen in some referred for bereavement counselling. Providers felt that face to face interventions are still needed and the only effective option for some groups, including those with more complex cases, behavioural difficulties, experiences of trauma, SMI and young children who are unable to take part in online support work.

Community intervention delivered through service and volunteer driven support networks have been widely reported to be successful during lockdown (Figure 13), having a huge impact on the well being of the recipients. Simple phone or video check-ins, or safe meetings in open public spaces increase the supportive effect of "me time", hearing a "familiar voice", supporting also self-care and signposting to further sources of support. Examples such as the 'Garden gate' scheme for children and young people and ambassador schemes in Central/Eastern European communities have been cited.

**Figure 13: Type of support facilitated or delivered by provider organisations**



## 6.9 Safeguarding

Some services have raised concerns that the lack of current face to face work makes it more difficult to pick up safeguarding concerns. Under lockdown conditions there are a lack of opportunities to disclose information due to school closures, reduced access to GPs, lack of access to friends and support workers. Concerns have also been raised about a likely increase in online abuse as some (especially young people) spend more time online. Some survivors of sexual abuse are facing controlling behaviour in lockdown and are unable to access services remotely.

## 6.10 Staff well being

**The sustainability of mental health and well being support services depends on our workforce.**

Some providers mention staff wellbeing as a possible concern going forwards. Many staff have adapted well to remote working, however for some services this type of work involves discussing sensitive and potentially upsetting issues in their home environment, without the normal support structure of work around them. Some report significant fatigue from online and remote working, and the mental health of frontline health workers was another issue that was highlighted. Although VCS staff numbers were stable (May 2020) there was a reported drop in in volunteers (who are difficult to replace quickly)

Within the VCS sector most services report good adaption to remote working with some staff adapting well and others some missing work support structure. Others in non clinical roles report fatigue from online and remote working (system problem).

National evidence about health and social care workforce is clearly showing higher stress and anxiety levels (50% increases), insomnia (30% increase ). Risk factors fro worsening mental health in H&SC staff are younger age of staff,  those with dependents, and those with a COVID affected or at risk family. Previous research has also shown the impact of burnout due to prolonged stressful working conditions can occur up to 2 years after the event and be associated with increased smoking and drinking.

Another concept that has been reported is “moral injury” where by care staff feel a sense of helplessness due to healthcare demand, guilt at not being able to do enough or their initial lack of PPE putting their own family at risk, ultimately leading to mental health problems (particularly reported in intensive care staff).

## 6.11 Emerging needs

Providers rapidly changed working practices during March and April to continue supporting service users. The change in delivery of care to largely remote work has meant, however, that some groups are not able to receive the level of care they would have done prior to COVID, or that some groups have new needs that are not necessarily being met. A summary o emerging needs is listed below.

### Groups where gaps in mental health support during COVID-19 has been highlighted

- **Children and young people** (particularly <14 years in age or developmentally) have been mentioned as not feeling comfortable or able to engage with services remotely.
- Groups with **no or little digital access**, including some older populations and those with limited finances, some BAME communities and Asylum seekers.
- Groups whose **first language is not English**- awareness, access and use of services may be limited
- **LGBTQ+ communities** with no family support or safe place to go during isolation.
- Individuals or families with **experience of domestic or sexual abuse** (difficult to make contact, difficult to work in the way that is urgently needed)
- **Carers** (parent & unpaid carers) struggling with lack of respite care; from BAME communities (with added stress around infection risk and decreased access to social support through wider family and worship).
- **People suffering bereavement.** Referrals are down, despite an expected increase. Some bereaved doo not want remote support, increasing isolation and mental health risk.
- Some **patients with cancer or a terminal illness**
- Some people with **complex/serious SMI (**experiencing a worsening of symptoms)
- **People living in poverty** – may lack online devices, not be able to afford phones and credit and with existing health and mental health issues.
- **BAME groups** have a number of risk factors which increase their need for support, including language barriers, infection risk, exclusion, living arrangements, financial insecurity. Additional needs for **asylum seekers and refugees** (access remote support, other vulnerabilities (e.g. trafficking, re-triggering of past trauma), lack of any social support to access.
- It is difficult to engage over the phone with elderly people with **dementia**

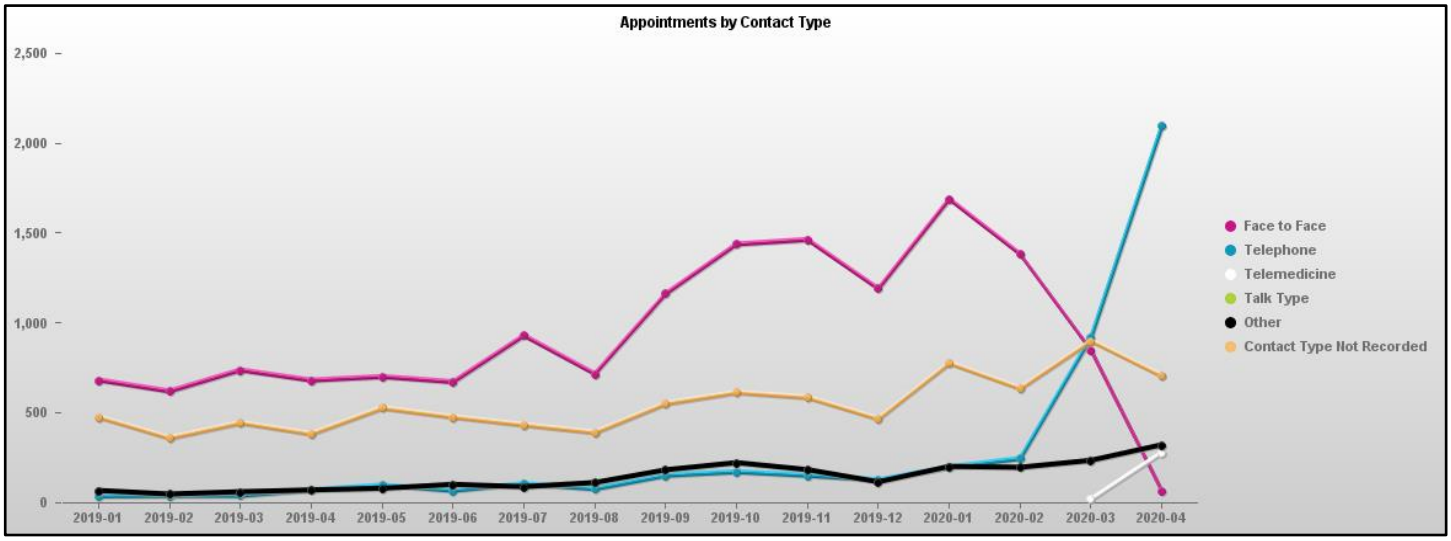
# 7 Mental Health service data (NHS)

**Data has been analysed for NHS mental health services delivered by Bradford District Care Trust, up until and including April 2020. So this provides some early signs of changes in demand and acuity of mental health service and how it is being delivered.**

The main patterns of service provision during April 202 (compared to the previous 12 months) are summarised below. There was:

- a large fall (usually at least 50%) in referrals to mental health services during April 2020. This was seen in CYP and adults, and further and regular follow up analysis is needed from May 2020 onwards.
- an initial Increase in BDCT re-admissions in April.
- an increase in appointments for CAMHS (75% increase) (Figure 14), eating disorders (79%) and Looked after children services (50%) although this was an acceleration of increases in the previous few months, and an increase in appointments to the peri-natal mental health team (109%). A rapid switch to telephone from face to face appointments was observed in April 2020.

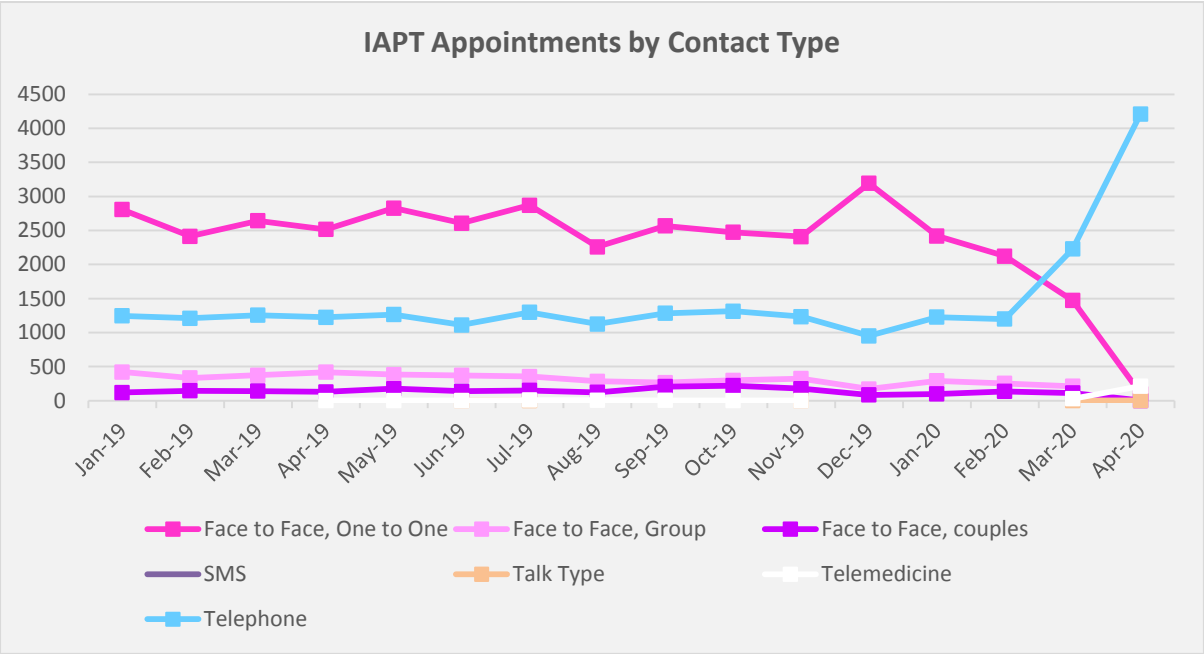
**Figure 14: Total appointments for CAMHS (2019/2020 by month)**




## Psychological therapies (IAPT)

- There was little change in total adult appointments for IAPT (psychological therapies increased 7%) and for common mental health problems, although a rapid switch to telephone appointments (Figure 15).

**Figure 15**




- a fall in community mental health team (50% down), integrated home treatment team (35% down) and learning disability appointments, as may be expected of services that rely on home visits.
- an increase in appointments for older people mental health conditions (27% increase).
- Where data was available, we looked for analysis of changing trends by gender or ethnic group. This did not reveal any marked increases by gender or ethnicity that were different to the patterns described above.

## Psychiatric liaison

*BRI Trust data*

The average number of monthly assessments decreased by 36% in April 2020 compared to April 2019. The proportion of total assessments that were completed in HDU/CDU decreased post lockdown from 20% in the pre lockdown period to 8% post lockdown.

The reason for attending was relatively similar pre and post lockdown with the largest differences seen for a decrease in presentation for deliberate self-harm /Suicidal/Alcohol and an increase seen in social reasons.

*Airedale Trust data*

The average number of assessments per month (April & May 2020 data available) fell by 29% compared to the same period in 2019.

Although there appears to be an increase in the proportion of individuals with a known previous involvement with MH services there was also an increase observed in those with no history, this observed difference is likely due to better data entry post lockdown, with an average of 12% missing pre lockdown.

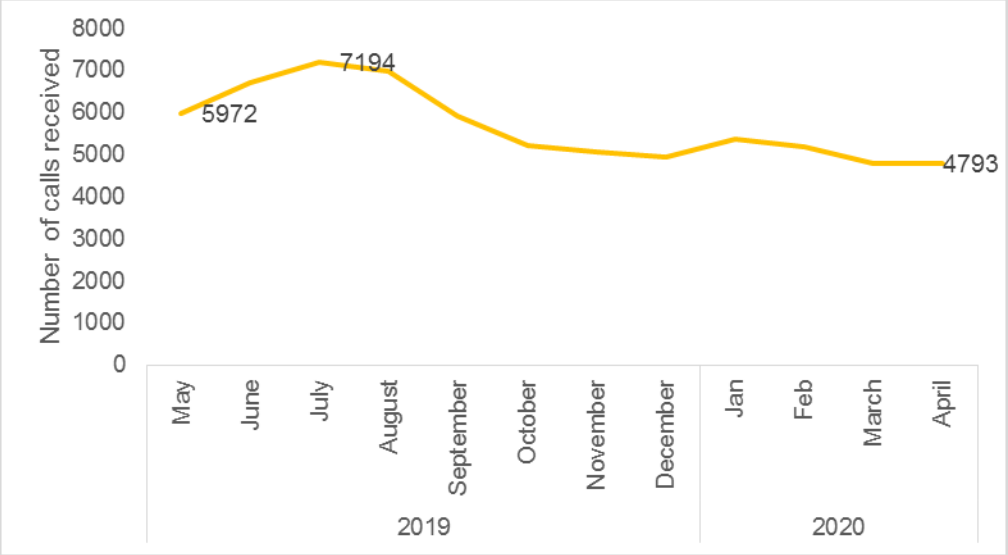
The reasons for attending remained similar with the biggest difference again seen in a decrease in presentation for DSH/Suicidal/Alcohol.

## First response Service

**The First Response Service saw a 48% increase in telephone triage activity <u>out of hours</u> during April with much of this increase accounted for by police referral and self-referral (suggesting unmet assessment within specialist services during this time)**.

The total number of calls to First response did not change significantly pre and post COVID19 lockdown in March (Figure 16).

**Figure 16 Total calls received by First Response (May 2019 – April 2020)**



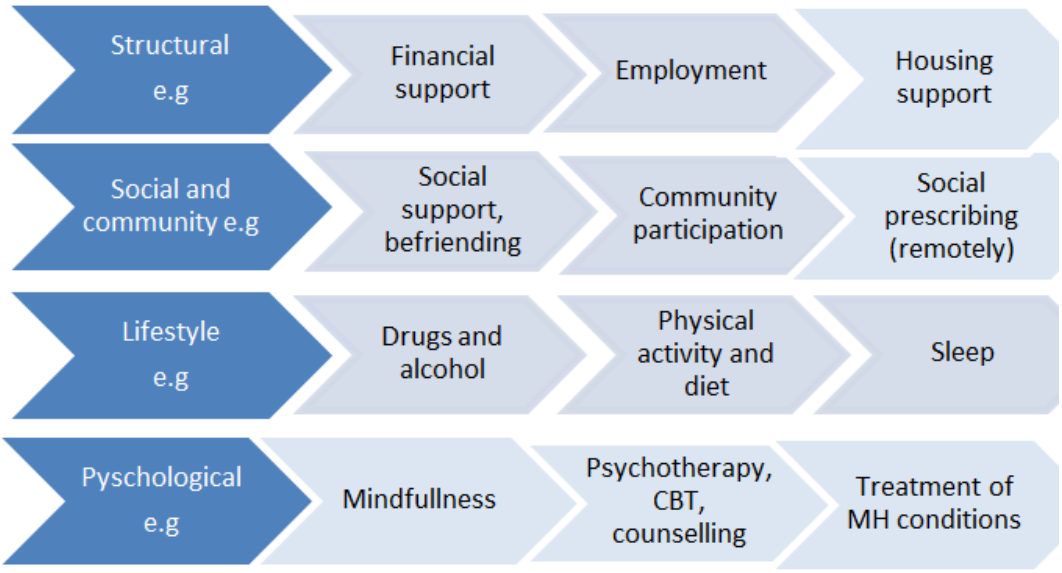
# 8 Governance for local response

The Bradford District Mental Health partnership board includes partners from statutory and community providers, with various sub groups leading on specific mental health issues. A Mental Health Provider Forum, made up of many VCS and statutory organisations that deliver mental health support services, provides a valuable feedback mechanism between communities and commissioners. Since March 2020 the focus of this partnership structure has been on:

1. **Service continuity:** To maintain safe continuity of crucial services with a view to ensuring people can stay well, get well, and can access timely crisis support when needed.
2. **Spotlight areas:** To ensure we have a focussed approach for vulnerable groups and emerging service areas of need, e.g. bereavement and postvention support. Linking to wider work on support for 'vulnerable people'.
3. **Communications:** A coordinated approach to communication with providers, public and staff to ensure they have key messages, insight, support and link with Silver command communications plan.

This governance structure has enabled local partnerships and services to develop a structural, community based, lifestyle related and psychological service response to improve mental well being (Figure 17). It will be the responsibility of Mental Health partnership board to lead the work of taking forward recommendations in the next chapter, but implementation will be a shared responsibility of many organisations.

**Figure 17 – whole system response**



# 9 Key findings and recommendations

## 9.1 Key findings

**Key findings**

There are many groups in Bradford District that have an increased risk and prevalence of mental health conditions. Those with long term health conditions, suffering from marginalisation and discrimination, living in relative poverty, with addiction, with existing mental health conditions or learning difficulties, and carers are more likely to see their mental health worsen during the coronavirus pandemic.

Across the country we have seen new mental health risk emerge for front line healthcare workers, those shielding with their families, or pushed into financial difficulty, and across BAME groups and deprived populations that have suffered higher COVID19 death rates.

Our local analysis of the Bradford Population since lockdown has shown us that:

- Fear of coronavirus affects many and is widespread (particularly in BAME groups, the shielded population and some elderly).
- Evidence from previous pandemics and economic crisis suggest that an additional 4,000 people in Bradford District may develop new mental health conditions as a result of the social and health impact of coronavirus, depression being the most common (with a potential 10% rise in the suicide rate). Post traumatic stress disorder for survivors and front line staff is a real risk.
- It is important not to medicalise normal reactions to the stressful circumstances of COVID-19, as everyone's mental well being will be affected in some way.

**Children and Young people:** Commonly reported issues to the Kooth mental health service for children and young people (CYP) after lockdown were anxiety and stress, uncertainty for the future, fear of contracting COVID-19, feeling overwhelmed by media, and tensions in homes. New Kooth service registrations after lockdown from young females outnumbered males by 4 to 1.

An increase in domestic violence and its impact (within the home environment) has led to a 50% increase in Child Protection notifications for domestic abuse.

**Working age adults:** Key mental health issues for working age adults centre around increased isolation, fear and anxiety related to COVID-19, financial concerns, sleep problems and 'juggling' a new busier home environment. There has been a worrying increase in the complexity of adults presenting at crisis services. Local surveys show that

more people describe their mental health as poor since lockdown, with the risk greater for those struggling financially.

There has been no national or local rise in the suicide rate during April-June 2020, although our first response service has seen a sharp rise in out of hours calls (mainly via self referral or from the police).

**Older adults** who appear to be particularly affected include those with cognitive decline/dementia (a quarter of deaths due to covid19 were as in those with dementia). There is a reported increase in self harm associated with dementia, a drop in referrals to memory clinics and a reduction in dementia care planning.

Some families with caring duties have coped well but many report feeling abandoned, with both young and older carers feeling the reduction or suspension of respite care and home visits.

Referrals to bereavement counselling has not increased despite the increased death rate since March (suggesting a potential unmet need for the post lockdown period).

**Mental health services**

National surveys found that 80% of people with severe mental illness said their mental health had got much worse as a result of the pandemic with 40% getting less support from mental health services.

During March to May 2020, VCS providers of community mental health services reported reduced capacity in staffing but a rise in demand for services, although 2/3 of organisations reported good continuity of services.

There was a widely reported belief amongst VCS providers that there will be a sudden rise in demand for community and NHS mental health services after lockdown is lifted. This will be caused by due a combination of those who have waited it out for support, and those with new or worsening symptoms.

There is a particular need to protect the sustainability of our health and social care staff through effective work based well being programmes.

Despite huge disruption, services that support mental well being across the VCS, NHS and statutory sector adapted incredibly quickly during March and April 2020. The switch to digital services has been rapid and innovative, opening new ways to engage with otherwise isolated service users. This new way of working must however take account of individuals either technically, financially or practically (due to their condition) excluded from digital services.

Analysis of NHS mental health service data shows a drop in referrals during April but the switch to telephone/digital support meant that patient contact was maintained for most services. Up until April 2020 there was no increase in appointments for adult mental health services, but an increase in appointments for Child and Adolescent Mental Health Services (although this was an acceleration of a previous increase).

**BAME communities**: Emerging international evidence has highlighted the disproportionate impact of coronavirus deaths on BAME communities. Locally, the 'fear of going out', misinformation (e.g. about deportation, or from home country media), the loss of social support networks, digital language barriers, and lower access to health services are contributory factors to poorer wellbeing.

**Community interventions** delivered through community services and volunteer networks are widely reported to be successful. Phone or video check-ins, or safe face to face support or counselling in open public spaces has supported mental health. In addition, community participation is in itself protective for well being, and such early interventions are needed to move individuals:

- from risk to safety,
- from fear to calming,
- from loss to connectedness,
- from helplessness to self-efficacy, and
- from despair to hope.

In response to these findings a range of recommendations has been framed around the five domains of a **Prevention Concordat for Better Mental Health for Bradford District**, covering:

- Needs assessment
- Partnership
- Translating need onto deliverable commitment
- Defining success measures , and
- Leadership and accountability.

## 9.2 Recommendations

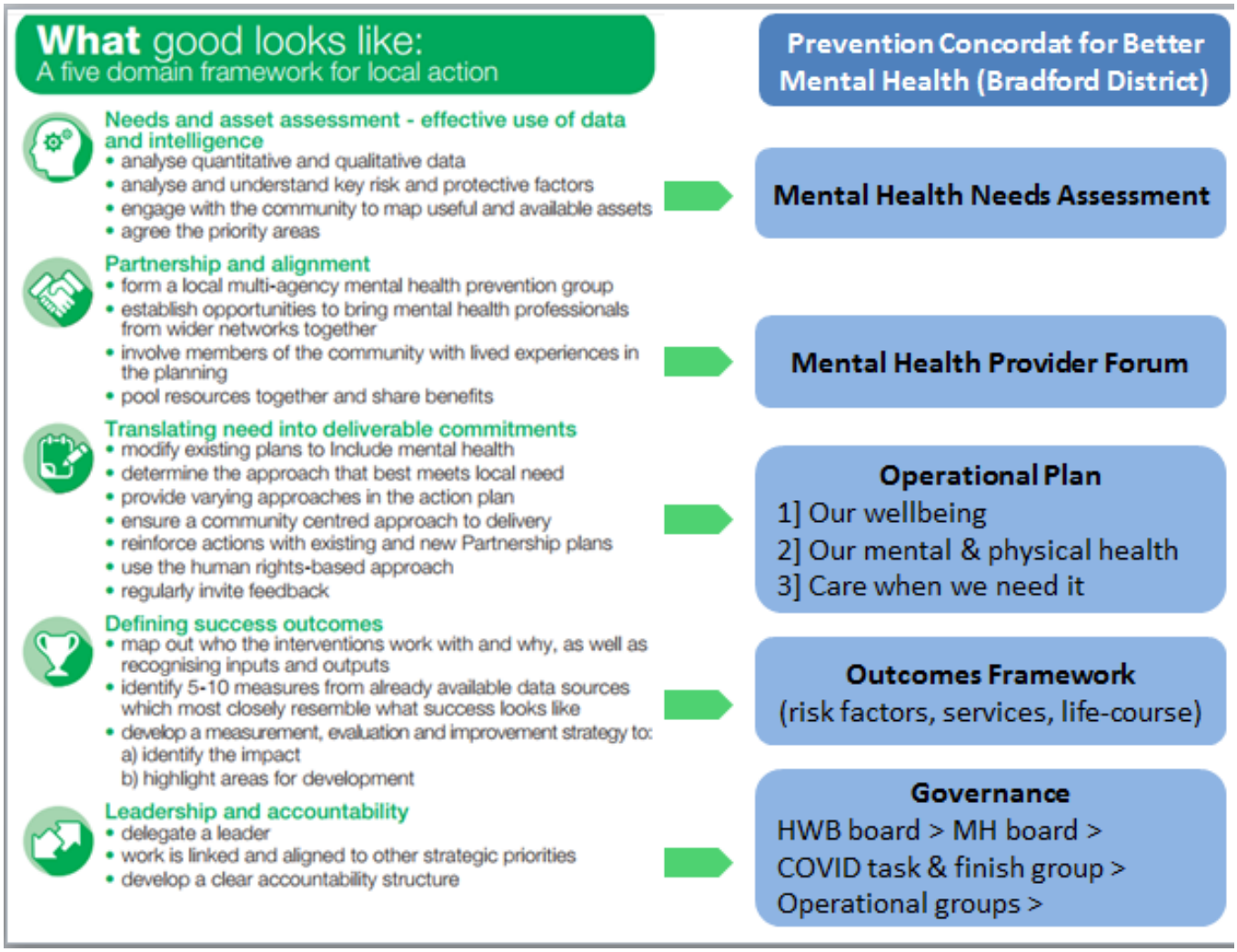
### 9.2.1 OVERARCHING RECOMMENDATION

**The Mental Health Partnership Board (with its partners) should develop and sign a Prevention Concordat for Better Mental Health for Bradford District, using the 5 domain model below.**

**This should cover:**

- **the agreed partnership approach and commitment between board partners;**
- **<u>early interventions to support mental well being and resilience across the population;</u>**
- **a renewed focus on prevention of poor mental health in CYP and BAME communities;**
- **and integrated partnership working for commissioning and service development.**

**Suggested structure for a Prevention Concordat for Better Mental Health in Bradford District**




### 9.2.2 NEEDS ASSESSMENT

**Share the results of this needs assessment widely across strategic groups managing COVID response and recovery, including health and social care, mental health, VCS and economic partnerships.**

Specific areas for further analysis that this work has highlighted are:

- To investigate the support of smaller VCS organisations who support the mental well-being of provide to BAME communities
- Review of First Response and Guideline pathway for appropriate triaging of mental health
- A deep dive into the impact of 3 months of lock down on crisis care, psychotic disorders and increasing complexity of children and adults presenting with mental health issues.

- Analysis of perinatal mental health service data (with a view to identifying areas and ethnic groups with unmet need; and suitable interventions for those not meeting the threshold for service).
- Ensure quality ethnicity data collection and recording (along with age, gender, location and outcomes) as part of routine NHS, social care and VCS data collection systems (mandated within contracts).
- Further our understanding of the COVID impact of wider determinants on poor mental health (in particular financial issues, discrimination & racism, fear of COVID19, poor access to services, and culturally specific service provision across the life-course).
- BDCT may want to use the IAPT (access to psychological therapies) forecasting demand tool to support medium term service planning for this service.

### 9.2.3 PARTNERSHIP AND ALIGNMENT

**Support community based well being services (on the ground) to sustain and support networks that require face to face contact in communities to deliver early interventions.**

Hold single issue forums to develop and share best practice for:

- Supporting mental health during financial insecurity
- Digital inclusion for mental health
- Supporting the mental health of BAME communities
- Early interventions and crisis support for children
- Psychosis and acuity

Continue the community mental health survey (repeating at regular intervals) in partnership with the Mental Health Provider Forum.

Ensure that commissioning processes and new investment in mental well being contribute to the 'left shift' approach to reducing risk factors for mental health, and strengthening protective factors (co-produced though the MHPF, and within BAWC Community Partnership frameworks).

Early identification of staffing issues within mental well being services (via partnership discussion) with a focus on flexibility for re-deployment, skills share and joint training.

### 9.2.4 TRANSLATING NEED INTO DELIVERABLE COMMITMENTS

***Mental well being services***

**Safe re-introduction of face to face services, prioritised based on level of need and risk with a guidance and support package for VCS organisations.**

**Develop a face to face and digital offer (using a blended approach) with available support by age and background.** This needs to take account of the technical, financial and practical barriers to accessing help digitally (for families and carers).

**Commission a mental health support line for adults (similar in model to the CYP Kooth service).** Emerging issues to take to focus in are the new work culture, sleep, fear of COVID, financial problems, family issues, domestic violence, alcohol and suicidal ideation).

**For support after crisis, develop a standard discharge offer from A&E and crisis services** (e.g after overdose, suicide attempts, self harm, psychosis) including basic information on services, community handover and follow up. BDCT may want to consider shortening the window to follow up post discharge to support suicide prevention.

**Agree a set of best practice guidelines for identifying safeguarding concerns during remote or digital contact.**

**Pursue closer integration of mental health support and treatment within physical health programmes of work** (due to raised risk, stress and anxiety related to COVID19 for those with long term conditions particularly in deprived areas and with high BAME populations).

**Implement the recommendations of the Alzheimer's society COVID report** to address the impact of social isolation on people living with dementia and their carers, and specific improvement to the care pathways.

***Employers***

**Develop a mental health support programme for employers (co-produced with the business sector).** This may include basic information for 'back to work' well being, targeted

work for high risk occupations providing essential public services, and a pathway to longer term mental health issues due to work related stress or redundancy. This will need to pay particular attention to:

- Longer term mental health issues (e.g PTSD) for staff directly exposed to prolonged care around COVID.
- Occupational health support for VCS organisation without well developed occupational health support.

**Expand the networked training offer for basic mental health training**. To increase knowledge, confidence and appropriate referral; leadership for mental health within organisations; and access to training led by a representative workforce.

***Test and trace***

**Tailor information and community messaging appropriately within the local test and trace programme to address mental health issues.** This should address the fear of COVID in BAME groups, and inequalities in infection rates in deprived and BAME groups.

***Communities***

**Strengthen long term partnerships between healthcare, LA planning and communities to ensure plans take account of mental health can be promoted through protective environments** (mental health risks due to over-crowded housing & poor access to green spaces have been highlighted during lockdown).

**Support interventions to target those most at risk of social isolation**. This requires an approach across the age profile that combines safe community based befriending and drop-in / phone-in schemes, with focus on reducing language barriers for digital programmes. **The Council's COVID Household Plan needs to be promoted again prior to winter to support household resilience.**

**Ensure the bereavement directory of resources is widely shared (and reflects diversity across the population).**

***Children and Young People***

**Use the role of the Local Authority in supporting schools in fostering healthy habits, good emotional health; and reducing inequalities in digital learning.**

**Continue to develop a range of mental health support options for children and young people through NHS services, online help, school, community and family settings, by implementing the recommendations of the independent system review by the Centre for Mental Health.** These support options need to actively break down barriers with hard to reach Children and Young People.

**Build on positive development of community face to face or telephone support (e.g. "check-in", youth services garden gate schemes, community ambassador schemes).**

**Adopt the current Adverse Childhood Experiences (ACEs) strategy from Better Start Bradford and CBMDC Public Health as a key preventive workstream for mental health.**

***BAME communities***

**Produce culturally sensitive education and prevention campaigns to rebuild trust and support for communities to access services during disruption caused by COVID.** These need to target ethnic minority groups with culturally sensitive health messages, and build on the cultural & spiritual services delivered by communities.

**Develop safety messages within a communications plan to reduce fear of COVID (culturally specific and using behavioural change theory).**

***Financial issues***

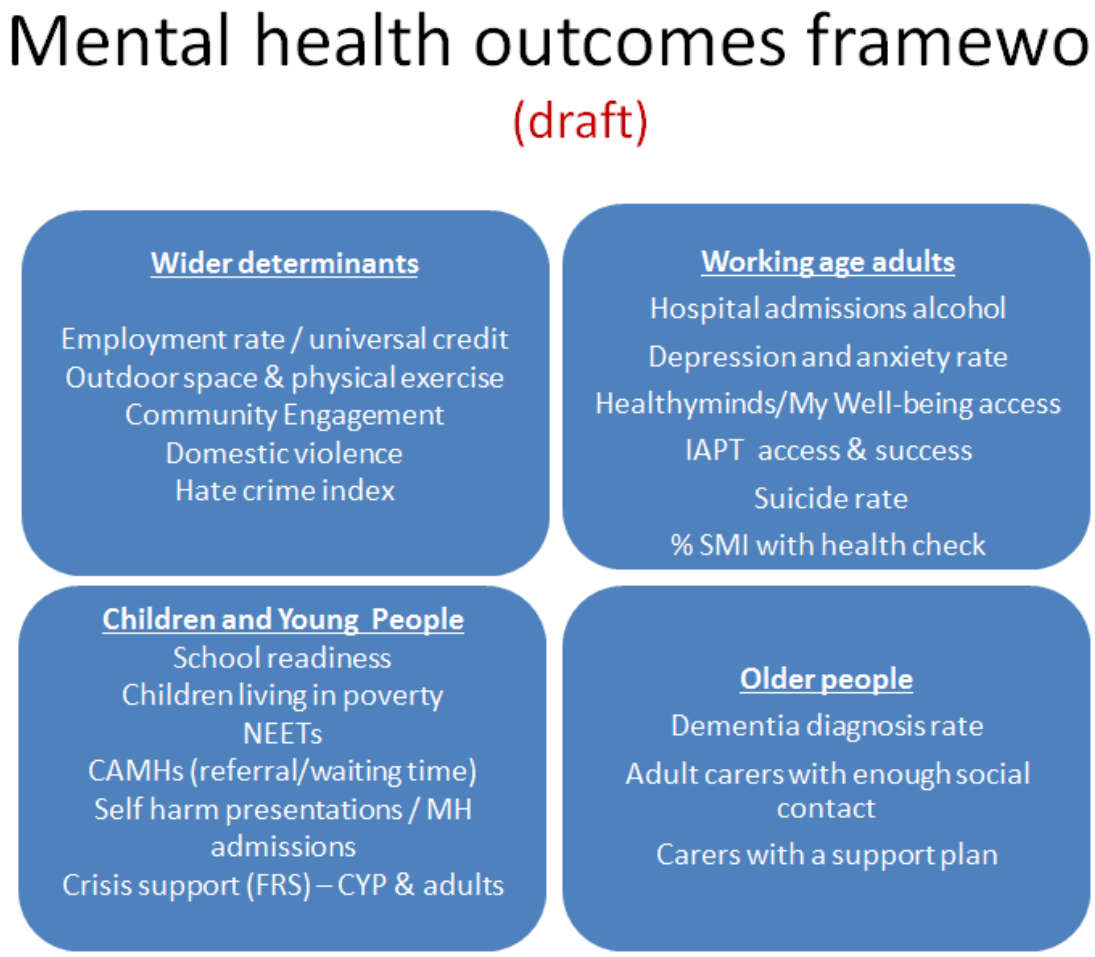
**Develop widely accessible dual advice services for financial support and advice (with mental well-being), to support interventions that reduce poverty improve well being**. The Local authority and other creditors could:

- increase support before council tax enforcement activity begins
- ensure collections departments equip staff with the knowledge and guidance to support people with mental health problems (see Money and Mental health)

### 9.2.5 DEFINING SUCCESS MEASURES

**Agree a mental health outcomes framework (linked to a data dashboard) to regularly update the Mental health board partners on key success measures.**

*A draft set of indicators is presented below. Analytical capacity needs to be agreed between the CCG , LA and BDCT.*




*Data needs to be ideally a mixture of outcome data (may only be available annually and from surveys) and service data (that is more timely and may be service activity data). Some indicators, e.g. poverty, may be a good proxy indicator for other sub-indicators, e.g. domestic violence, children in need. Some indicators may be a good barometer of other indicators, e.g. suicide is a reflection of a spectrum of needs covering self-harm, suicidal ideation and the timely availability if crisis care and resolution.*

### 9.2.6 LEADERSHIP AND ACCOUNTABILITY

**Use the Prevention Concordat for Better Mental Health (5 domains framework) as an evaluation framework to review the effectiveness of mental health partnership, and continuing relevance of this agreement.**

**All partners should understand their role in the success of the concordat and in delivering assurance to the Health and Well Being Board.**

**Ensure that the Covid-19 mental health recovery strategy actively addresses inequalities in mental well being to create long-term change.** This needs to address the risk factors of poor mental experienced more in deprived communities (covering poor housing, alcohol or drug problems, poverty or debt, unemployment, gambling, discrimination or stigma), domestic violence, covid infection and bereavement, social isolation and loneliness)

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## Acknowledgement

**We would like to thanks and acknowledge many professionals in the VCS and statutory sector who, during an extremely busy and stressful period for many, provided essential intelligence for this report (Appendix C).**

## Appendix A - Mental Health Needs Assessment - Stage 1 Baseline assessment (May 2020)

See: COVID Mental Health Needs Assessment - Stage 1 Baseline assessment - May 2020

https://jsna.bradford.gov.uk/Mental%20wellbeing.asp

## Appendix B - Mental Health Needs Assessment - Stage 2 Emerging Needs (June 2020)

See: COVID Mental Health Needs Assessment - Stage 2 Emerging Needs - Findings from the MHPF survey - June 2020

https://jsna.bradford.gov.uk/Mental%20wellbeing.asp

# 10 Appendix C – Contributors

Mental Health Provider Forum
Bradford District Care Trust cider
Barnardo's
Bradford Bereavement
Bradford Counselling Service
Bradford Rape Crisis
Cancer Support Yorkshire
Carers resource
Children's Trauma Therapy Service Family Action
Cruse Bereavement
Domestic Abuse & Sexual Violence
Family Action
Girlington
Horton Housing
Kooth
Making Space Carers
Making Space
Cellar trust
Mind in Bradford- MAST
Mind Extended access
Refugee action –solace
Relate Bradford
Relate Keighley and Craven
Roshni Ghar
Community Companions
Guide Line and wellbeing MIB
Sanctuary MIB
SMILE
Sharing voices MHPF
The Brathay Trust
Tower Hurst
Yorkshire MESMAC Counselling
Yorkshire MESMAC Peer support
Bradford Deaf community association
Citizens advice Bradford
Community works
Good neighbourhood project
Healthy lifestyle solutions
Men's shed Project
Ravenscliffe
Sangat
Specialist Autism Services
St John's day centre
Bradford District Dementia Strategy Group
Bradford Airedale Wharfedale Craven CCG
Bradford Local Authority
Airedale, Wharfedale, Craven Hub
West Yorkshire Police
Better Start Bradford
Bradford Institute for Health research
*Coronavirus Scientific Advisory Group*