COVID-19 ADULT MENTAL HEALTH NEEDS ASSESSMENT FOR PLYMOUTH 2021

CONTENTS

1. EXECUTIVE SUMMARY

Good mental health is a state of wellbeing in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively and make a contribution to their community. The COVID-19 pandemic and the control measures to reduce transmission are having profound health, economic and social consequences, which will impact on our mental health and wellbeing now and into the future.

The population of Plymouth in 2017 was 263,070. Deprivation levels in Plymouth are higher than average and there are wide variations across the city.

Livewell South West are commissioned by NHS Devon Clinical Commissioning Group to deliver all specialist mental health services within Plymouth, including inpatient psychiatric units and Community Mental Health Teams. Plymouth City Council commission mental health services, which support people with lower levels of need. There are also community sector and private organisations that are part of the Plymouth Mental Health Network.

Mental health and wellbeing pre-COVID

The prevalence of common mental disorders in Plymouth was 18.2%, which was significantly worse than the average in England. In Plymouth the proportion of adults with a low life satisfaction score was 4.0%, with a low worthwhile score was 3.8%, with a low happiness score was 7.7% and with a high anxiety score was 22.2%. These measures of self-reported wellbeing were in line with national rates. Emergency hospital admissions for deliberate self-harm was significantly higher than in England but the local suicide rate was similar to the national average. In Plymouth, people with serious mental illnesses are 2.7 times more likely to die before the age of 75 than the rest of the population. This is significantly better than the England average, but shows the adverse health outcomes experienced by this group.

Mental health and wellbeing during COVID-19

Nationally, population level mental health and wellbeing worsened at the start of the pandemic. This was followed by a recovery in the summer of 2020, but not to pre-pandemic baselines. More recent evidence suggests a further decline in population mental health in the winter of 2020/21. There is no evidence of changes in rates of self-harm or suicide since the start of the pandemic. The total number of GP diagnoses of depression decreased in the pandemic but GP diagnoses of depression as a proportion of all GP diagnoses has increased.

The mental health and wellbeing of certain groups have been disproportionately affected by the pandemic. These groups include: young adults, females, certain ethnic minorities, adults living with children, adults with pre-existing mental and physical health conditions, adults who were recommended to shield, older adults with multiple co-morbidities, adults who are socially isolated, adults with low household income or low relative socio-economic position, adults who experienced a loss of income, adults with financial worries, carers and frontline health and care staff.

Future mental health need

It is too early to see the full extent of the pandemic on mental health. When applied to Plymouth, a national model forecasts that over 43,000 adults in Plymouth will have a new

need for mental health services due to the pandemic. Almost two thirds of this this increase need will be in those who already have mental health conditions.

The pandemic is likely to adversely affect the risk and protective factors for mental health. Risk factors include deprivation and inequality, unemployment and poor working conditions, poverty and financial insecurity, poor housing and homelessness, crime and violence and alcohol consumption. Protective factors include community wellbeing and social capital, physical activity and use of outdoor space.

Perspectives of mental health providers in Plymouth

Discussion with a range of providers in Plymouth found there was a rapid move to digital provision in the pandemic and some were often managing a higher level of need remotely than they felt equipped to. In some cases, demand seemed to increase, whereas it had reduced in others. Most providers felt able to meet the demand, but there were signs of increasing challenges, including staff wellbeing and retention, engaging meaningfully with clients, transitions between services, uncertainty about the future and meeting increasing needs and demand. Providers' thoughts on service and system improvements have informed the recommendations.

Conclusions

The pandemic has negatively impacted mental health nationally and locally. Certain groups have been more affected, many of which were at higher risk before the pandemic. Consequently, the pandemic may worsen health inequalities. Local intelligence suggests that there has not been a sudden substantial increase in demand for services. However, mental health is complex and multi-factorial. Individuals have different challenges and resources, and these have been affected in different ways. Therefore, a predicted increase in mental health needs will more likely occur gradually, and in time become difficult to manage in the system.

Recommendations

The overriding recommendation of this health needs assessment is that key organisations within the Health and Care system in Plymouth should sign and work together to meet the commitments of the Public Health England Prevention Concordat for Better Mental Health.

This preventative, or public mental health approach attempts to build the resources and resilience of individuals and communities so that they can face the challenges in their lives in order to prevent the onset, development and escalation of mental health problems. It will strengthen the protective factors for good mental health and reduce the risk factors at an individual and community level. Prevention activities are cost-effective and will impact positively on the NHS and social care system. More targeted interventions will help reduce mental health inequalities and improvement to mental health services will improve the lives of those who have developed mental health issues.

The individual recommendations are framed around the domains of the PHE Prevention Concordat for Better Mental Health, which are understanding local needs and assets, working together, taking action for prevention and promotion including reducing health inequalities, defining success and measuring outcomes, and leadership and direction.

2. INTRODUCTION

2.1 COVID-19 AND MENTAL HEATLH AND WELLBEING

The COVID-19 pandemic and the control measures to reduce transmission have impacted on almost all aspects of our lives. These measures have been in place in some form for over a year in the United Kingdom (UK). The pandemic and the control measures have profound health, economic and social consequences, all of which will impact on our mental health and wellbeing now and into the future. Moreover, these impacts are experienced differently by different groups. There is a risk that the pandemic may increase and entrench mental health inequalities that existed and were widening before the pandemic. It is crucial that we increase our knowledge of the broad impacts of the pandemic on mental health and wellbeing and the population groups that are more greatly affected. This will enable the mental health needs of our population and the hardest hit groups to be recognised and monitored so that appropriate support can be provided to mitigate the impact.

2.2 AIM

To bring together what is known nationally and locally about the impact of the COVID-19 pandemic on mental health and wellbeing needs in adults; and to make recommendations to the local system to improve the mental health of the population.

2.3 OBJECTIVES

1. To outline the baseline mental health and wellbeing profile of Plymouth adults prior to COVID-19 pandemic.
2. To review the emerging evidence to describe the impact of COVID-19 on mental health and identify groups that are more greatly affected.
3. To assess how the pandemic may affect future mental health needs.
4. To gather current intelligence, data and changes to service provision from mental health service providers across the local system.
5. To identify current and potential future gaps in service provision in Plymouth.
6. To provide evidence-based recommendations to promote wellbeing and prevent mental illness during COVID-19 and prepare the system to cope with changes in mental health need as a result of COVID-19.

2.4 SCOPE AND LIMITATIONS

The scope of this needs assessment is limited because of time and resource constraints during the pandemic. Therefore, this needs assessment will specifically address the mental health needs of adults in Plymouth in relation to the COVID-19 pandemic. Dementia is not included in this.

The evidence presented has been brought together from what was available between November 2020 and May 2021. New evidence will emerge, and the situation of the pandemic will change after this time period, which then may supersede some of the findings in this report.

Furthermore, due to the rapid nature of the work and the regular emergence of new evidence this needs assessment cannot be exhaustive. There will inevitably be some gaps, which should not be taken as deliberate omissions.

2.5 METHODS

- The baseline mental health and wellbeing profile of Plymouth adults prior to COVID-19 pandemic was outlined by reviewing data from the previous mental health needs assessment together with the information from Public Health England's (PHE) mental health and wellbeing joint strategic needs assessment (JSNA) [1].
- The PHE COVID-19 mental health surveillance report was used as the main source of evidence for the impacts of COVID-19 on mental health and the groups that are more greatly affected [2].
- The potential future mental health need as a result of the pandemic was assessed using nationally available modelling data. In addition, evidence relating to the impact of the pandemic on the wider determinants of mental health (as outlined in the PHE mental health JSNA) was reviewed.
- An open discussion with ten mangers of mental health and related services was held to gather intelligence on the impacts of the pandemic on providers and their services. These ten services were chosen to provide a range of perspectives from different services around the city.

3. PLYMOUTH PROFILE

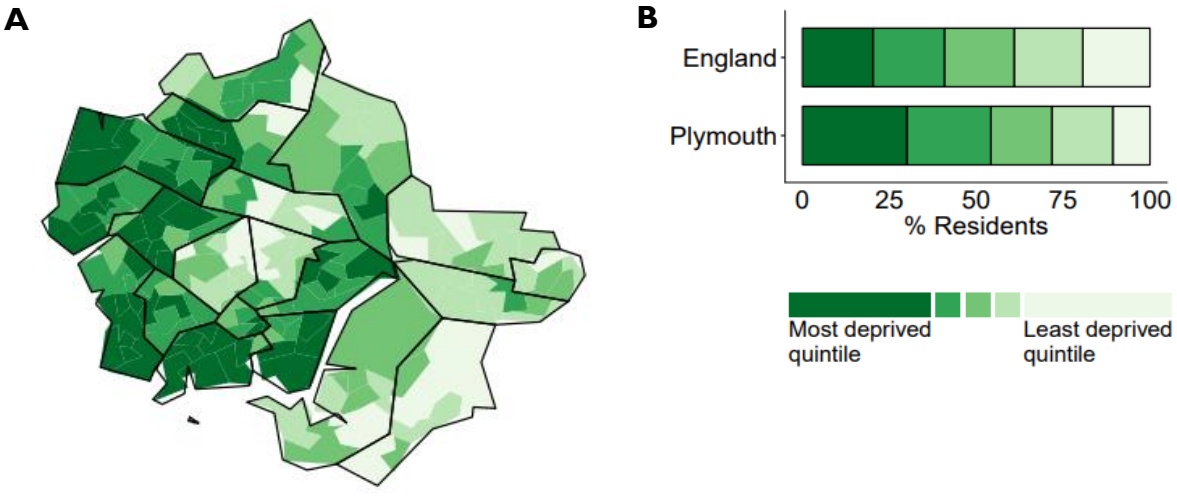
Understanding the population of Plymouth is fundamental to providing mental health services and support in the city. 263,070 people are estimated to live in Plymouth according to the Office for National Statistics (ONS) mid-year estimate 2017. The population of Plymouth is expected to grow to around 274,300 by 2034, a projected increase of 4.3 per cent. The proportion of the population aged 65 and over is expected to increase from 17.9 per cent in 2016 to 22.7 per cent in 2034. There is a projected 32.7 per cent increase in the number of people aged 65 or over between 2016 and 2034 in Plymouth [3].

A growing and overall ageing population presents a number of challenges, which include additional demands on the provision of services.

Plymouth is divided into 39 neighbourhoods, which are grouped to form 20 electoral wards. There is a longstanding awareness of the deprivation that exists in Plymouth. Inequalities occur both geographically across the city, and within and across communities.

Figure 1 shows levels of deprivation in Plymouth using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015) shown by lower super output area (LSOA).

Figure 1: (A) Map of Plymouth showing 2017 electoral wards (bold lines) and lower super output areas by deprivation.
(B) Graph showing proportion of Plymouth residents living in the five deprivation quintiles, compared to England.
Darker green areas indicate higher areas of deprivation.



Lines represent electoral wards (2017). Quintiles shown for 2011 based lower super output areas (LSOAs). Contains OS data © Crown Copyright and database rights 2018. Contains public sector information licensed under the Open Government Licence v3.0

Source: PHE Plymouth Health Profile 2018

This figure shows that many LSOAs in Plymouth are in the most deprived quintile nationally and that there is a greater level of deprivation in Plymouth compared to the England average. Furthermore, the map highlights the wide variation across the city.

Further information on the population, deprivation and demographics of Plymouth can be found in the Plymouth Report 2019:
https://www.plymouth.gov.uk/publichealth/factsandfiguresjointstrategicneedsassessment/plymouthreport

Area profiles for each neighbourhood and ward are found on the Plymouth JSNA website:
https://www.plymouth.gov.uk/publichealth/factsandfiguresjointstrategicneedsassessment

4. MENTAL HEALTH AND WELLBEING

Good mental health is more than just the absence of mental disorders or disabilities but is an integral and essential component of good health.

Mental health is a state of wellbeing in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.

Wellbeing is a difficult concept to describe and define and may mean different things to different people. A useful definition of wellbeing is the balance point between an individual's and community's resource pool and challenges faced [4]. Stable wellbeing is when individuals or communities have the psychological, social and physical resources they need to meet particular psychological, social and/or physical challenges. When there are more challenges than resources, the balance is lost and their wellbeing is impaired, and vice-versa.

Mental health and wellbeing are fundamental to our collective and individual ability as human to think, portray emotion, interact with each other, earn a living and enjoy life.

Good mental health and wellbeing is strongly influenced by the conditions in which people are born, grow, live, work and age. Promoting mental wellbeing and supporting mental ill health is essential not only for individuals and their families, but to society as a whole. In the UK:

- One in four people will experience mental illness in their lifetime.
- One in six people experience mental illness at any one time.
- 75% of mental health conditions in adult life (excluding dementia) start by the age of 24.
- Mental ill health is estimated to cost the UK economy £105 billion a year in health care and loss of productivity costs [5].

Within the population there are also significant avoidable inequalities in mental health problems that exist between groups. The Public Health England JSNA characterises these by personal characteristics, environmental factors experienced and groups across the life course [1]:

Personal characteristics:

- Black and ethnic minority groups
- People living with physical disabilities
- People living with learning difficulties
- People with alcohol and/or drug dependence
- Prison population, offenders and victims of crime
- LGBT (lesbian, gay, bisexual and transgender) people
- Carers
- People with sensory impairment
- Homeless people

- Refugees, asylum seekers and stateless person

Environmental factors experienced:

- Deprivation and inequality
- Poverty and financial insecurity
- Poor housing and homelessness
- Unemployment and poor working conditions
- Exposure to crime, safety and violence
- Poor community wellbeing and social capital

Groups across the life course:

- Women who are pregnant or have a child aged under 12 months
- Children living at socio-economic disadvantage
- Children with parents who have mental health or substance misuse problems
- Children who are looked after
- Adults with a history of violence or abuse
- People with poor physical health
- Older people living in care homes
- Isolated older people

5. MENTAL HEALTH AND WELLBEING PRE-COVID

5.1 MENTAL HEALTH NEED AND OUTCOMES

The estimated prevalence of common mental disorders in Plymouth in 2017 was 18.2 per cent, which is significantly worse than the England average of 16.9 per cent.

The annual population survey is a national survey which asks about self-reported wellbeing. Comparing Plymouth to the national average between April 2019 and March 2020 [1]:

- 4.0% of people in Plymouth reported a low satisfaction score, which statistically similar to the England average of 4.7%.
- 3.8% of people in Plymouth reported a low worthwhile score, which is the same as the rate in England.
- 7.7% of Plymouth residents reported a low happiness score, which is statistically similar to this figure in England (8.7%).
- 22.2% of Plymouth residents had a high anxiety score. This was similar to the England average of 21.9%.

The directly standardised rate of emergency hospital admissions for intentional self-harm in Plymouth in 2019/20 (financial year) were 244.0 per 100,000, which is significantly above the England average of 192.6 per 100,000.

The directly standardised suicide rate in Plymouth between 2017 and 2019 was 11.7 per 100,000, which is statistically similar to the England rate of 10.1. The suicide rate in males and females in Plymouth over this time period was also similar to the England average.

Individuals with serious mental illness have a higher rate of physical health conditions and poorer health outcomes. In the UK, people living with a serious mental health condition die 12-13 years younger than other people. In England, people living with a serious mental health condition are about 3.5 times as likely to die before the age of 75 than adults without serious mental illness. In Plymouth, this excess risk of premature mortality under the age of 75 is about 2.7 [1]. This is significantly better than in England overall, but still highlights the inequalities experienced by those with poor mental health.

These baseline (pre-pandemic) mental health statistics and outcomes in Plymouth are summarised in Table 1:

Table 1: Summary of baseline mental health indicators in Plymouth prior to the COVID-19 pandemic

Indicator	Plymouth	Comparison to England
Prevalence of common mental disorders (2017)	18.2 %	Significantly worse
Low life satisfaction score (2019/20)	4.0%	Statistically similar
Low worthwhile score (2019/20)	3.8%	Statistically similar
Low happiness score (2019/20)	7.7%	Statistically similar
High anxiety score (2019/20)	22.2%	Statistically similar
Emergency hospital admissions for intentional self-harm (2019/20)	244.0 per 100,000	Significantly worse
Suicide rate (2017-2019)	11.7 per 100,000	Statistically similar
Excess under 75 mortality rate in adults with serious mental illness (2015-2017)	269.9%	Significantly better

5.2 MENTAL HEATLH SERVICES

There are a wide range of mental health services in Plymouth from acute care for mental health crises through to community and mental health promotion services. Many of these are commissioned by the NHS and the local authority. There is also a wide array of non-commissioned services in the private and voluntary and community sector.

NHS commissioned services:

Plymouth is part of the NHS Devon Clinical Commissioning Group (CCG). Livewell South West are commissioned to provide health and social care services in Plymouth and deliver all specialist mental health services within Plymouth, including:

- An adult inpatient unit (Glenbourne).
- Places of Safety for Adults and Children/Young people in Plymouth.
- A home treatment team that aim to keep people who are acutely mentally unwell out of hospital and living in the community. Access is 24 hours a day and 7 days a week. This service also manages admissions the inpatient Glenbourne Unit.
- Psychiatric Liaison Service within Derriford Hospital. This is nurse led with consultant support.
- Plym Bridge House, a tier 4 tertiary unit that supports 12 to 18 year olds with serious mental ill-health. The Child and Adolescent Mental Health Service (CAMHS) is also run by Livewell SouthWest.
- Community Mental Health Teams.
- A new First Response Unit, which was set up in May 2020. This service is staffed by mental health professionals and provides advice, support and signposting to over 18s in Plymouth experiencing a mental health crisis. This service operates 24 hours a day and seven days a week.

Local authority commissioned services

Plymouth City Council commission a number of mental health services including:

- Colebrook support services, which support people to live independently in the community.
- Colebrook Headspace, an out-of-hours service for people who feel that they are approaching a mental health crisis.
- Rethink Plymouth: a mental health charity.
- Devon Mind, a mental health charity.
- Wolseley Trust, a business and Community Economic Development Trust that provides a social prescribing service.
- Elder Tree Befriending for socially isolated and vulnerable older people
- Advice Plymouth, which provides advice and information relating to personal management and finances.

Non-commissioned services

There is a vibrant network of voluntary and community sector and private organisations that provide support for mental health and wellbeing in Plymouth.

The Plymouth Mental Health Network (www.plymouthmhn.org) brings this community together by supporting providers with a local network. This allows providers at all levels to share information and ideas, and work collaboratively to support people in Plymouth with their mental health.

6. MENTAL HEALTH AND WELLBEING DURING COVID-19

6.1 CURRENT NATIONAL EVIDENCE

PHE COVID-19 mental health and wellbeing surveillance (last reviewed 5 May 2021, website last updated 8 April 2021 to include data up to 15 February 2021) [2] presents close to real time intelligence on the mental health and wellbeing of the population of England during the COVID-19 pandemic COVID-19: mental health and wellbeing surveillance report - GOV.UK (www.gov.uk).There are two main categories of information included in this report:

- Weekly data from the UCL COVID-19 Social Study and ONS Coronavirus and the Social Impact on Great Britain.
- Academic research.

The strengths of this data are that it is updated regularly and aims to provide close to real time evidence. The report also collects data from a range of sources and methods (such as validated surveys and self-reported data) and triangulates this to give higher confidence in the conclusions. However, the evidence is new research, some of which is ongoing and unpublished and so may not have been peer reviewed. With the published research there is a delay between data collection and publication because of the time needed to clean and analyse it. The weekly data is more immediate, however, it is difficult to draw conclusions because the data has not been analysed to control for confounding factors or identify potential biases. The time frame from the start of the pandemic to having available published research is short meaning that it is likely that new evidence will emerge in future relating to the mental health impacts of COVID-19. It is therefore important to regularly review the evidence.

Mental distress:

The average mental distress (measured using a standard validated questionnaire – GHQ-12) was 8% higher in April 2020, than it was between 2017 and 2019 [2].

The proportion of adults who reported clinically significant psychological distress changed from:

- 20.7% in 2019
- 29.5% in April 2020
- 21.4% in July 2020
- 21.5% in September 2020

Anxiety:

Two sources of weekly data using different samples and measurement (UCL COVID-19 Social Study and ONS Coronavirus and the Social Impacts on Great Britain (up to 22 February 2021) show pattern of higher anxiety than baseline at the start of the pandemic. This gradually reduced and levelled off in the summer of 2020 at above pre-pandemic levels. Average levels of anxiety then increased through the autumn of 2020 and winter of 2020/21 but not up to the high levels seen during the first lockdown [2], [6], [7].

This data is supported by early academic literature, indicating that anxiety levels increased at the start of the first lockdown but decreased thereafter [2]. Trends seen in the weekly data after September 2020 are not yet covered in the academic literature.

Low income, loss of income, pre-existing health condition, young age, living with children, high perceived risk of infection and being female were all associated with anxiety [8], [9].

Depression:

The UCL COVID-19 weekly data shows levels of depression were high at the start of the first lockdown, before reducing and levelling off above best available pre-pandemic baseline [6]. There is also some suggestion of increasing depression since August 2020 but not to levels seen in April 2020.

The academic literature is mixed and only currently covers up to September 2020. Some studies have found an increase in average depressive symptoms since the pandemic started, whereas others have found no difference. During the first national lockdown women, younger adults, people with lower educational attainment, people from lower-income households, people with pre-existing mental health conditions, caregivers (formal and informal), people who lost formal help, and people living alone reported higher depressive symptoms than the overall population. Groups that reported higher levels of depression in the pandemic, correlate to risk groups from before the pandemic. These groups have also shown faster recover during the pandemic than lower risk groups [2].

Life satisfaction:

Two sources of weekly data using different samples and measurement (UCL COVID-19 Social Study and ONS Coronavirus and the Social Impacts on Great Britain) show life satisfaction at the start of the pandemic was significantly lower than baseline. This improved between April and September 2020, before decreasing almost to levels seen at the start of pandemic between October 2020 and February 2021. There are early indications of improvements after this. [6], [7].

Increases in rates of low life satisfaction occurred in all age groups but it was more common in younger adults than older adults. Older adults who were shielding were found to have a lower life satisfaction during the pandemic [2].

Loneliness:

Two sources of weekly data using different samples and measurement (UCL COVID-19 Social Study and ONS Coronavirus and the Social Impacts on Great Britain) are not consistent in their figures for population loneliness. UCL data shows there has been almost no changes in loneliness rates between April 2020 and February 2021 [6]. However, ONS data indicates that loneliness levels were around pre-pandemic rates between April 2020 and October 2020 but have increased thereafter. [7].

Academic literature indicates that overall self-reported levels of loneliness were relatively stable. However, those who were most lonely before the pandemic reported increases in loneliness and those who were least lonely reported decreases. Young adults, women, people with lower education, people with low income, people who are economically inactive, people with an existing mental health condition, people living alone, and urban

residents were more likely to report being lonely during the pandemic. These groups are almost identical to those at increased risk pre-lockdown, but their risk increased in the pandemic. Older people with multiple health conditions, or who were shielding were also shown to be particularly affected by loneliness [2].

Thoughts of death/self-harm, self-reported self-harm and suicide:

Population level rates of self-harm have not increased during the pandemic [10]. However, there is some evidence that a significant proportion of UK adults may be at risk for self-arm thoughts and behaviours [11]. The largest risk factors for self-harm thoughts and behaviours were experiencing abuse and financial worries.

Another study found that frequency of self-harm and thoughts of suicide/self-harm was higher among women, BAME groups and people experiencing socioeconomic disadvantage, unemployment, disability, chronic physical illnesses, mental disorders and those who had had a COVID-19 diagnosis [12].

An ongoing meta-analysis with no geographical limits found 28 studies (half of which were research letters of pre-prints) that met their inclusion criteria. It found that so far no studies have found changes in suicide, self-harm, or attempted suicide and suicidal thoughts associated with the pandemic [13]. Similarly, a study in England found between April and October 2020 found no change in suicide rates compared to 2019 [14].

However, previous epidemics, such as SARS in 2003 were associated with a rise in deaths by suicide [15]. There was also an increase in suicides associated with the 2008 financial crisis in Europe and North America [16]. It may therefore be possible that it is too early to see any changes in suicides as a result of pandemic currently.

GROUPS DISPROPORTIONATELY AFFECTED

Overall, the national picture is of higher levels of psychological distress than prior to the pandemic. There has been some recovery since the start of lockdown, but the available evidence suggests this is not generally to pre-pandemic levels. However, disproportionate changes in the mental wellbeing of certain groups may not be evident from looking at data for the whole population. The evidence is still emerging, and the picture may change as time goes on. Box 1 summarises the groups that current evidence suggests have been at higher risk of mental ill health since the start of the pandemic.

Box 1: Groups at risk of mental ill health since the start of the COVID-19 pandemic.

- Young adults
- Females
- Black, Asian and Minority Ethnic (BAME) men
- Adults living with children, in particular lone mothers
- Adults with pre-existing mental health conditions
- Adults with pre-existing physical health conditions
- Older adults who were recommended to shield
- Older adults with multi-comorbidities
- Adults who are socially isolated
- Adults with low household income or relative socio-economic position
- Adults who experienced loss of income, especially the self-employed
- Adults with financial worries
- Carers (formal and informal)
- Frontline health and care staff

Many of these are groups that before the pandemic were at higher risk of mental health problems, demonstrating the potential of the pandemic to increase mental health inequalities.

Young adults and women

Broadly, young adults (between 18 and 34, depending on study) and women have been more likely to report worse mental health, wellbeing, life satisfaction and loneliness during pandemic than adults and older men, respectively. This is a similar pattern to before the pandemic, but differences may have increased. Women and young adults seemed to experience a faster recovery between April and September, which has reduced some of the differences seen earlier in the pandemic [2].

Women were more likely to have made larger adjustments to manage demands of work, home and childcare during lockdown than men and these adjustments are associated with increased distress. The disproportionate impact of the pandemic on employment and financial security may also go some way to explain the increased risk of poor mental health in these groups [2].

Adults living with children

There is evidence that adults living with children have been more likely to report worse mental health than adults living without children since the pandemic, with lone mothers being particularly vulnerable [2].

Ethnicity

The relationship between mental health wellbeing and ethnicity during the pandemic is unclear due to limited evidence, small sample sizes and confounding factors, such as income and employment. Data suggests that men and women from BAME groups reported a similar

deterioration in mental health during the pandemic to each other. For men this change was larger than in White British men, but the reduction in mental health for women from BAME groups was similar to that of White British Women [2].

People with pre-existing mental health problems

Those with pre-existing mental health problems have reported higher levels of anxiety, depression and loneliness than adults without pre-existing mental health conditions, however, the evidence does not suggest that the gap has changed between these groups since the start of the pandemic [2]. There is also evidence that people with a diagnosed psychiatric disorder have been more likely to be infected, hospitalised and die from COVID-19 than those without a psychiatric disorder [17].

Adults with pre-existing physical health conditions

Some studies have found that adults with long-term physical health conditions have reported worse depressive symptoms than adults without long-term physical health conditions. Specific conditions have also been identified as risk factors for poorer mental health, including asthma and some cancers. Older adults with multi-morbidities reported higher levels of depression and loneliness than older adults without multi-morbidities. A qualitative study found that mental distress may be due to fear and anxiety around the consequences of catching COVID-19, the impact of shielding/isolation, the experience of access to healthcare and uncertainty about the future [2].

Older adults who were recommended to shield or with multi-morbidities

This group were more likely to report higher levels of depression, anxiety and loneliness in June and July 2020 than people of a similar age but not recommended to shield. Rates were particularly high in those who strictly complied with shielding guidance [2].

Adults who are socially isolated

More frequent face-to-face or phone/video contact, as well as higher perceived social support, were associated with lower levels of depressive symptoms [2].

Adults with low household income or relative socioeconomic position

Adults with low household income or relative socioeconomic position was associated with increased symptoms of anxiety, depression and loneliness [8] [18] [19] [20]. Adverse experiences such as COVID-19 illness, financial difficulties or difficulty accessing food or medicine, were having a larger impact on mental health and wellbeing in adults in a lower socioeconomic position [21].

Adults who experienced loss of income and financial worries

Adults not in employment were more likely to report worse and increasing loneliness than those in work [20] [21]. Adults who experienced loss of income early in lockdown reported higher levels of anxiety [8] and mental distress [22]. Having some paid work or continued

connection to a job during the pandemic is associated with better mental health than not having any work [23].

Health and care workers

Data from previous pandemics indicate that the mental health of health and social care workers is negatively impacted [24]. Evidence so far in this pandemic is mixed. The PHE surveillance report comments on a number of studies which show worse mental health in key workers, however, some studies show no difference to the general population or even better mental health. Staff working in intensive care units were found to have high rates of probable Post Traumatic Stress Disorder. However, many respondents reported good wellbeing.

The picture is similarly mixed for informal carers. Between April and September 2020, they experienced higher rates of depressive and anxiety symptoms than non-carers, but they also had a higher sense of life being worthwhile.

The evidence to date does not cover the entirely of the pandemic. Academic research provides evidence up to the autumn of 2020 and the less robust weekly data up to February 2021. Since these dates there have been lockdowns beginning in November 2020 and January 2021 following a significant rise in COVID-19 cases. Since March there has been lower case rates and therefore easing of restrictions, according to the government roadmap (COVID-19 Response - Spring 2021 (Summary) - GOV.UK (www.gov.uk)). These fluctuations in the case rates and national restrictions are likely to have affected mental health in both directions. Mental health in the lockdown may have worsened but improved again following the increased ability to socialise and work as the restrictions are eased. This would reflect the changes that were seen in the first national lockdown and easing of restrictions in the summer of 2020. Reports such as this will therefore struggle to keep up with the rapid changes in our society. This highlights the importance of referring to the most up to date evidence presented on the PHE COVID-19: mental health and wellbeing surveillance report COVID-19: mental health and wellbeing surveillance report - GOV.UK (www.gov.uk).

6.2 NATIONAL CHANGES IN DEMAND FOR MENTAL HEATLH SERVICES

The PHE COVID-19 mental health surveillance report provides national data on the use of telephone and online services that support mental health [2].

- Anxiety UK, a charity for those affected by anxiety-based conditions, had a rapid rise in cases during the first lockdown, peaking in May and June 2020. This was followed by a decrease in the summer of 2020 and a steady rate of calls towards the end of 2020, which was higher than in 2019. Calls at the start of 2021 looked to have increased again.
- Mind, which provides advice and support to people experiencing a mental health problem, initially saw a decrease in demand at the start of the first lockdown. This was followed by a gradually increasing demand by calls, texts and emails up to October 2020, where demand has since steadied. Mind also reported that the length of calls after the start of the pandemic is generally longer when compared to pre-COVID.
- Togetherall is an online community for people who are stressed, anxious or feeling low. There was an increase in logins during the first lockdown in spring 2020. Logins then decreased to pre-pandemic levels over the summer of 2020, before rising again to first lockdown levels through the autumn of 2020 and winter of 2020/21.
- Kooth PLC provides digital mental health care for young people, adults, students and businesses. Adult weekly logins rose and fell modestly with the first lockdown and easing the spring and summer of 2020. Logins then increased again from September 2020 to February 2021 to levels higher than seen in the first lockdown (despite a significant dip over Christmas and New Year).
- Rethink Mental Illness is a charity that provides numerous mental health services. Calls to its advice service have been stable throughout the pandemic, except for one week of high demand in August 2020.
- Citizens Advice give independent advice on benefits, work, debt and money, consumer issues, family matters, housing, law and courts, immigration and health. In the pandemic, there was an initial drop in the numbers of people with a mental health condition being supported, but this has increased during the pandemic. The most common advice sought in this group was for debt, followed by benefits and universal credit, housing and employment.

ONS data indicates that the rate of GP diagnosed depression in England between March and August 2020 fell by 24%. Given the population data indicating a potential higher rate of depression and depressive symptoms in the pandemic, this suggests that fewer people with depressive symptoms were seeking support from primary care. This is concerning because untreated depression is a risk factor for suicide, particularly in males [25]. Over this same period all diagnoses by GPs in England fell by 30%. Therefore, as a percentage of all GP diagnoses, depression diagnoses rose by 1.3% to 15.6% compared to 2019 levels [26]. This suggests that overall fewer people were seeing their GP for health (including mental health) problems, however, out of those who did, there was a higher rate of depression than in 2019. This increase in depression diagnoses as a proportion of all diagnoses was higher in people living in the more deprived areas.

A survey of members of the Royal College of Psychiatry in September 2020 found that more members reported an increase in workload in emergency and urgent mental health care [27]. This survey was completed by 689 members working in the NHS in the UK, which was a response rate of 5.3%. Whilst there may be some bias in who responded to the survey, this does support the findings that mental health conditions have worsened in lockdown and that reduced presentation to primary care may indicate a picture of worsening population mental health where people are presenting to services later and in crisis.

The PHE COVID-19 mental health surveillance report has found that different support strategies were more likely to be used by different population groups [2].

- Women were more likely than men to undertake self-care activities or speak to family and friends about their mental health.
- Older adults and adults with less education were more likely to take medication and less likely to speak to a mental health professional or use a helpline or online forum, than younger adults and adults with more education.
- People from Black, Asian and minority ethnic groups were more likely to use an online forum or helpline, and less likely to take medication
- Adults who live alone were more likely to speak to health professionals, undertake in self-care activities and talk to others about their mental health than adults who live with others.

6.3 FUTURE MENTAL HEALTH NEED

Although there is some mixed evidence it is likely that mental health need has already changed as a result of COVID-19, especially for certain groups. It is also possible that changes in mental health need as a result of the pandemic will continue because of:

- It may be too early to see some of the impacts of the pandemic on mental health.
- The ongoing challenge of the pandemic may continue to affect mental health.
- The pandemic may have environmental, cultural and socio-economic impacts, which in turn will continue to impact mental health. Examples include the possibility of recession, rise in unemployment and rise in deprivation.

The extent to which these factors may influence mental health in the future is uncertain, however, it is important to consider the best available evidence and the impacts of the pandemic on the wider determinants of mental health to give an indication or prediction of potential future need.

Centre for Mental Health model

The Centre for Mental Health has developed a model for mental health need arising from COVID-19 with physicians, researchers and economists from NHS England and NHS Trusts [28]. The report acknowledges that there are many unknowns associated with this figure, for example the length of the pandemic and duration and severity of the social restrictions are unknown, and that there is limited previous experiences of pandemics to base the statistical models. However, it attempts to make a forecast based on the best available current research. The toolkit also allows local data to be inputted to provide local forecasts.

The model forecasts that as a direct consequence of the pandemic, up to 8.5 million adults in England (almost 20% of that population) will need either new or additional mental health support. Table 2 below summarises the population groups highlighted in the model to be at risk of mental ill health and the forecasted impact on Plymouth.

Table 2: The Centre for Mental Health forecast for demand for new demand for mental health services applied to Plymouth

Population group	Description	Forecasted new demand for services in Plymouth
People without pre-existing mental health conditions	It is forecasted that over 3 million people in England who have not previously experienced mental health issues prior to the pandemic will require services for moderate-severe depression or anxiety.	**15,360**
People with pre-existing mental health conditions	5 million people who have existing mental health conditions are estimated to require additional support for moderate to severe anxiety or depression. This is approximately two-thirds of all individuals with mental health conditions.	**26,767**
Healthcare workers	200,000 NHS workers in England are predicted to suffer from post-traumatic distress, high psychological distress and burnout. This is based on experiences with other outbreaks of severe acute respiratory syndrome. No specific predictions were made for other workers, such as carers or key workers due to a lack of available research, however, it is likely that they will also be at risk of poor mental health.	**838**
People recovering from severe COVID-19	Research suggest people with severe COVID-19 admitted to intensive care units will have a higher rate of anxiety, depression and post-traumatic stress disorder.	**42**
Adult family members of those recovering from severe COVID-19	This group are also at increased risk of adverse mental health conditions, including anxiety, depression and post-traumatic stress disorder.	**27**
Bereaved people	36,000 people in England are estimated to require support for depression, anxiety and PTSD due to not being able to say goodbye to loved ones or be with them in their last moments.	**175**
People economically affected by COVID-19	Around 30,000 people in England may require services for depression due to unemployment, however, this figure could rise as the full economic impact is revealed.	**238**

Overall, the model predicts that there will be 43,461 new people in Plymouth who will require mental health services. This is slightly lower than the total of the individual figures as a discount rate is applied to avoid double counting the people who may be included in more than one group. However, it is worth noting that these models use assumptions based on current research which is evolving constantly. In addition, there are no timeframes given for when people may require services and no information on the level of need that will be required. An updated model is due to be published in May 2021 taking into account more recent evidence, but this is not yet available for inclusion in this report.

For a full explanation of the model and local data applied to the model, see Appendix 1.

Risk and protective factors

Our individual and community circumstances have a significant impact on our mental health. Some elements of our lives may increase the risk of developing a mental health condition, whereas other parts of may protect against such illness. The impact of the COVID-19 pandemic on these protective and risk factors will be considered to understand how the pandemic may impact mental health now and in the future. However, it is important to acknowledge that the future is especially uncertain and ongoing monitoring of these determinants will be vital.

Risk factors

Deprivation and inequality

It is well established that deprivation (a lack of money, resources and access to life opportunities) or being in a position of relative disadvantage (having significantly less resource than others) is a risk factor for poorer health including mental health [1]. Factors such as employment, income and relationships contribute to a 'spiral of adversity' and poor mental health outcomes [29]. The prevalence of psychotic disorders among the lowest fifth of household income is 9 times higher than in the highest and there is double the level of common mental health problems between these two same groups.

As outlined in the introduction, Plymouth residents experience a higher level of deprivation than the national average. For example, 30% of Plymouth residents live in the most deprived quintile of neighbourhoods in England [1].

There is evidence that the impacts of the pandemic on mental health are unevenly distributed in the population. In general, those already experiencing relative disadvantage more greatly affected, which could result in greater health inequalities.

Unemployment and poor working conditions

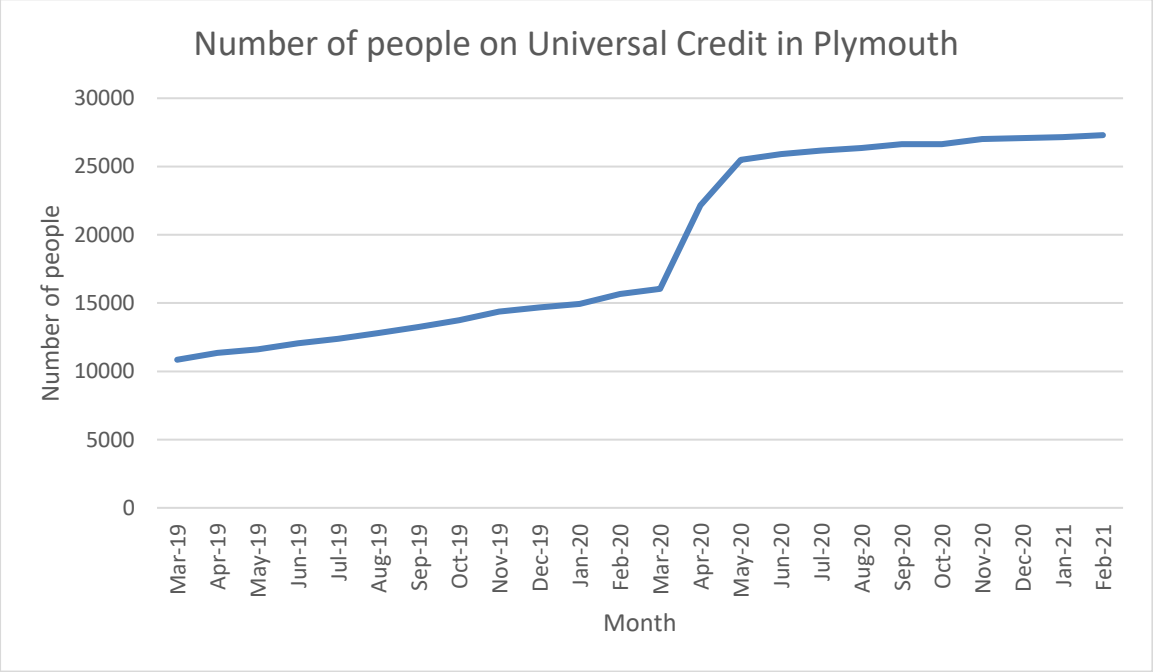
Unemployment and poor working conditions are risk factors for poor mental health. Conversely, stable and rewarding employment is a protective factor for mental health and can be a vital element of recovery from mental health problems [1]. The workplace provides an opportunity to build resilience, develop social networks and social capital [30]. Conversely, unemployment and unstable employment are strongly linked to mental health problems [29], with people who are unemployed at 4 to 10 times more likely to report anxiety and depression and to complete suicide [31]. And impact is bidirectional. People

with a common mental health condition are four to five times more likely to be permanently unable to work [32]. In addition, it is important to distinguish between 'good work', characterised by fair treatment, autonomy, security and reward, and 'bad work', where individuals feel unsupported, undervalued and demotivated. For example some flexible employment practices, such as zero-hours contracts, can be abused by managers and lead to financial insecurity, anxiety and stress [33].

In 2019, Plymouth had an unemployment rate of 4.5%, which is not statistically different from the England average of 3.9% [34].

The pandemic continues to have a severe impact on employment and this can be shown by the number of individuals in Plymouth on Universal Credit over the past two years, in Figure 2 [35]:

Figure 2: Number of people on Universal Credit in Plymouth between March 2019 and February 2021. Source: Department of Work and Pensions benefit statistics.



This is a stark rise in those claiming universal credit in Plymouth from 15,669 in February 2020 to 27,299 in February 2021, an increase of almost 75%. National evidence suggests that the impact on employment is not felt equally across the society and has interacted with existing inequalities. The Institute for Fiscal Studies' COVID-19 and Inequalities report in June 2020 highlighted that younger workers and those on low incomes are much more likely to have lost their job due to COVID-19 and are more likely to have experienced a reduction in earnings, than older and higher-income workers. They were also more likely to expect larger further cuts to their incomes. Furthermore, the self-employed and workers in less secure work arrangements (for example, zero hours contracts) were more likely to be negatively affected [36]. Mothers, and in particularly lone mothers were also more likely to work in sectors that have been shut down or in jobs where they are unable to work from home, exacerbating pre-existing difficulties at a time where childcare is likely to be interrupted also. Certain ethnic minorities (in particular Bangladeshi and Pakistani workers)

were also more likely to be in shutdown industries. A conclusion of the report is that the ability to continue working through the lockdown period, and to work safely (i.e. from home) is distributed unevenly by gender, ethnicity, education and earnings, which were all key axes of inequality before the pandemic.

Poverty and financial insecurity

Low income and debt are risk factors for mental illness. Personal and financial security is a protective factor. Poverty can also be both a causal factor and a consequence of mental ill health across the life course [1].

Unmanageable financial debt is associated with poorer mental health [37], [38]. A quarter of people experiencing common mental health conditions also have financial problems, which is three times more than the general population [39]. Half of all adults with a debt problem also have a common mental health and 86% of survey respondents said their financial situation had made their mental health problems worse [37].

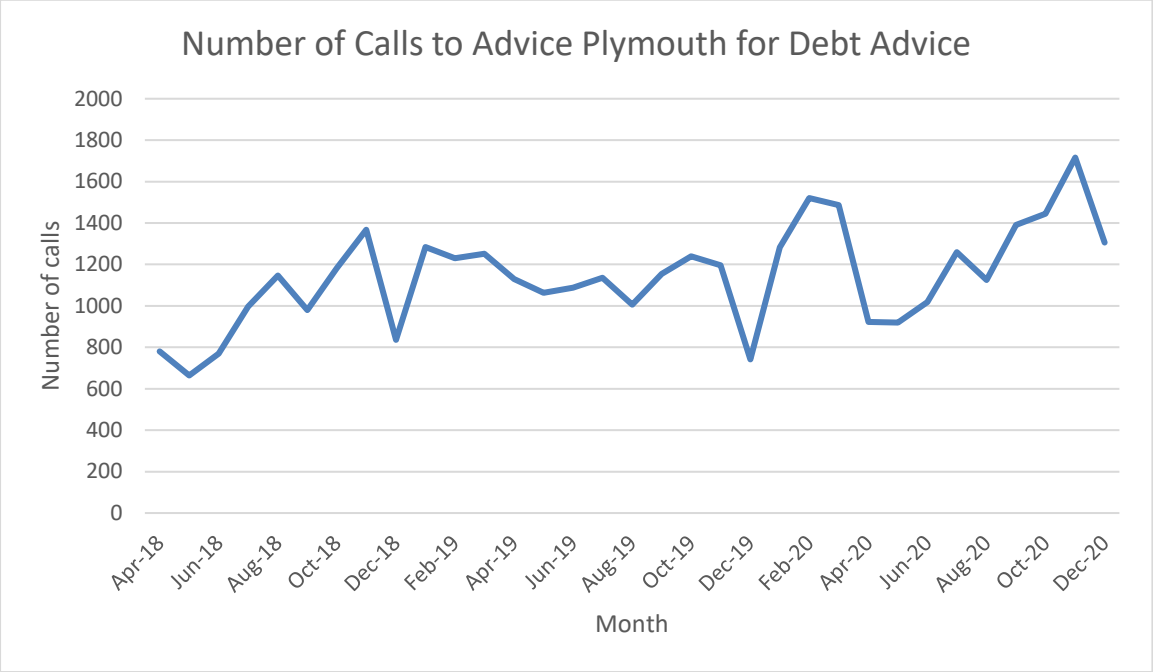
In Plymouth in 2015, 16.3% of the population were living in an income-deprived household. Low income is defined as both those in and out of work who have low earnings. This was significantly worse than the England average of 14.6% [34].

During the period between July-September 2020 (when there was a re-opening of the economy) the Resolution Foundation estimate that 23% of working-age adults reported that their household income was lower than in February 2020 [40]. Looking at income and spending together the report found that over this time period 41% of adults saw their income and spending change by the same amount, spending fell relative to their income for 21%, while 28% saw incomes fall more than their spending. Those from the lowest income quintile were overrepresented in this latter category compared to those in the highest income quintile. Furthermore half of those who entered the pandemic with the most meagre of savings have been forced to dip into them to cover everyday costs such as housing and food and 54% of adults in families from the lowest income quintile have borrowed more to cover these costs.

These findings are supported by those of the debt charity StepChange where in September a survey estimated that 29% of adults in Great Britain had experienced at least one negative change in circumstance since the beginning of COVID. This included unemployment or redundancy, furlough, fall in hours worked, fall in income from self-employment, fall in income due to parental leave, fall in income due to self-isolation and fall in income for another reason [41]. Among those affected 70% reported a fall in household income suggesting that some people were insulated against the fall in income, but the majority were not. 14% of those affected reported a fall in income and an increase in expenditure and parents with dependent children were significantly overrepresented in this group.

Locally calls to Advice Plymouth (Figure 3) appear to have reduced at the start of the pandemic, but have gradually increased since then, reaching a peak in November 2020. However, there may be many reasons for this rise, for example greater awareness of the service and so it will be important to monitor this data in the future, given the link between debt and mental health.

Figure 3: Number of calls to Advice Plymouth for debt advice between April 2018 and December 2020



Poor housing and homelessness

Insecure, poor quality and overcrowded housing causes stress, anxiety and depression, and are a risk factor for mental health conditions [1]. Everybody who experiences homelessness will feel stress and anxiety and may report depression [42]. Compared to the general population, homeless people are twice as likely to have a common mental health condition, psychosis is up to 15 times more prevalent [43], and they are over nine times more likely to complete suicide [44]. In addition, people experiencing homelessness find it more difficult to access health services, including mental health care [45].

Statutory homelessness rates in Plymouth in 2017/18 was 2.6 per 1,000 households, which was not significantly different to the England average of 2.4 per 1,000 households. In Plymouth in 2018/19 81% of adults in contact with secondary mental health services live in stable and appropriate accommodation. This is significantly better than the England average of 58% and this large difference was the case for the two years preceding 2018/19 as well [1].

Research by the National Housing Federation in June 2020 showed that 31% of adults in the UK had experienced mental or physical health problems due to the condition of their home or lack of space during the initial lockdown, with people reporting a lack of space at home during lockdown more likely to experience depression [46].

Early in the crisis, measures were taken nationally to house people who were experiencing rough sleeping. There is evidence from other areas that there was a very positive impact on the health of the people who were housed, including better mental health, positive impacts on drug dependency and improved access to addiction support [47]. However, there is a concern that the economic impact of COVID-19 may increase the numbers of people experiencing homelessness after government support finishes.

Crime and violence

The relationship between crime and mental health problem is complex. People in contact with the criminal justice system have a higher prevalence of mental health needs compared to the general population [48]. These disorders are more severe and complex and are often combined with poor physical health and substance misuse [49]. People with mental health problems are three times more likely to be a victim of crime than the general population [50]. Being a victim of crime, or exposure to violent or unsafe environments, including being a victim of intimate partner violence or domestic abuse can also increase the risk of developing a mental health problem [51].

In Plymouth violent offences per 1,000 population in 2019/20 was 36.5, which is higher than the England average of 29.5. Sexual offences per 100,000 population in the same year was also higher in Plymouth (3.7 per 100,000) than nationally (2.5 per 100,000) [1].

The Office for National Statistics found that police data showed an increase in domestic abuse-related offences during the COVID-19 pandemic, however, there has been a gradual increase over recent years prior to the pandemic as recording has improved. There has also been a gradual increase in demand for domestic abuse victim services during the pandemic, which the report suggests does not necessarily indicate an increase in the number of victims, but a potential increase in the severity of abuse and a lack of available support mechanisms [52].

Alcohol consumption

Alcohol and mental health problems are often co-existent. Alcohol use is a risk factor for mental health and experiencing mental health problems can increase the likelihood of developing an unhealthy relationship with alcohol [53].

In Plymouth in 2018/19 the directly standardised rate of hospital admissions for alcohol related admissions was 636 per 100,000 which is comparable to the England average of 664 per 100,000 [34].

The relationship between the COVID-19 pandemic and alcohol consumption is difficult to assess. The shutdown of the hospitality industry for much of the pandemic has meant that fewer people consumed alcohol in pubs and bars. However, in March 2020 during the first lockdown supermarket sales of alcohol increased by 67%, which is higher than the increase in overall sales of 43% [54]. According to a poll during the first lockdown most people said that they were drinking about the same amount as previously, but a significant proportion were drinking more or less than before lockdown [55]. Provisional data from ONS have shown that in England and Wales there were 7,423 deaths in 2020 from alcohol-specific causes. This is 19.6% higher than in 2019 and the highest annual total of this dataset (data collection started in 2001) [56]. Of particular concern will be those who were already struggling with alcohol dependence before lockdown and those who were on the brink of alcohol dependence and dependence was triggered by the stresses of the pandemic (for example, bereavement or financial insecurity). These groups may have had trouble to access services during the pandemic and will need support to address both their alcohol dependence and any underlying issues.

Protective factors

Community wellbeing and social capital

The mental wellbeing of individuals is influenced by factors at a community level such as social networks, sense or local identify, levels of trust and reciprocity and civic engagement. These resources are known as social capital and are protective mental health factors. Community assets improve the health and quality of the community. They include physical assets such as public green space, play areas and community buildings, and social assets such as volunteer and charity groups, social networks and the knowledge and experiences of local residents. These assets have potential to protect and increase community wellbeing and thus strength resilience.

Community wellbeing and social capital is difficult to measure in a single metric. The proportion of adult social care users who have as much social contact as they like gives some indication of the connectedness of some of the more vulnerable people in our society. In Plymouth the proportion of adult social care users who have as much social contact as they would like in 2019/20 was 41.4%, which is similar to the England average of 45.9% [1].

The impact of the coronavirus pandemic on communities and social capital are complex and difficult to measure. Whilst the control measures have reduced the ability of communities to physically come together and socialise, neighbours have been looking out for each other and providing informal support. For example, there are over 2000 groups listed on the mutual aid website in May 2021 [57]. ONS weekly research in April 2020 showed that 64% of adults said that local community members would support them if they needed help during the pandemic, over three quarters said that they thought people were doing more to help others since the pandemic and nearly two thirds of adults had checked in on neighbours who might need help at least one in the last seven days [58].

Physical activity and use of outdoor green and blue spaces

Undertaking physical activity and spending time in green and blue spaces is well established as a protective factor for our mental health and our health in general [59].

In Plymouth in 2019/20 the percentage of physically active adults (defined as adults doing at least 150 minutes of moderate intensity exercise per week in the previous 28 days) was 65.9%. The percentage of physically inactive adults was (defined as adults doing less than 30 minutes of moderate intensity exercise per week in the previous 28 days) was 19.7%. These figures are comparable to the average in England [34].

There is limited data on how physical activity and use of outdoor space has changed during the pandemic and these changes are likely to vary due to a range of individual factors. For example, people in the most deprived groups are less likely to have access to an outdoor space than people in the least deprived groups (69% compared to 87%, respectively). People in more deprived groups are less likely to have access to a garden. Furthermore, during the first lockdown in Spring 2020, people from more deprived groups were less likely to report that they were doing more physical activity than before the pandemic, when compared to less deprived groups. People living in urban areas were also more likely than people living in rural areas to report that they were doing less physical activity than before the pandemic [60].

The potential impact of the pandemic on these risk and protective factors is summarised in the Table 3:

Table 3: The impact of the pandemic on risk (A) and protective (B) factors for mental health.
Red = statistically worse than England average, Amber = statistically similar to England average.

(A) Risk factor	Metric	Pre-pandemic level in Plymouth	Impact of pandemic
Deprivation and inequality	Deprivation score	26.6	Likely to worsen
Unemployment and poor working conditions	Unemployment rate	4.5%	Likely to worsen Large (75%) increase in people in Plymouth claiming Universal Credit
Poverty and financial insecurity	Living in income-deprived household	16.3%	Likely to worsen Increased calls to Advice Plymouth for debt advice
Poor housing and homelessness	Statutory homelessness	2.6 per 100,000	Improved with initiative to provide accommodation for homeless people, but may increase in future due to economic impacts and end of eviction protection measures
Crime and violence	Violent offences Sexual offences	36.5 per 100,000 3.7 per 100,000	National increase in domestic abuse-related offences
Alcohol consumption	Hospital admissions for alcohol-related conditions	636 per 100,000	Likely to worsen in risk groups National increase in alcohol-related mortality in 2020

(B) Protective factor	Metric	Pre-pandemic level in Plymouth	Impact of pandemic
Community wellbeing and social capital	Adult social care users who have as much social contact as they would like	41.4%	Unclear. Reduced ability to meet people, but examples of increased community cohesion
Physical activity and use of outdoor space	Physically active adults Physically inactive adults	65.9% 19.7%	Likely to worsen in risk groups

It is helpful to consider the impact of the pandemic on protective and risk factors at an individual and community level. Strengthening protective factors and minimising risk factors provides a mechanism by which the mental health demands and needs can be addressed in the recovery from the pandemic.

6.4 DISCUSSIONS WITH MENTAL HEALTH PROVIDERS

A series of meeting with ten providers of mental health and affiliated services were held in December 2020 to inform this needs assessment. These providers, listed in Table 4, were in both the statutory and third sector.

Table 4: Mental health service providers in Plymouth interviewed as part of this needs assessment

Service	Brief description
Livewell South West Mental Health	Providers of statutory mental health services in the city, which includes (but not exclusively) the inpatient unit, Community Mental Health Teams (CMHTs), Improving Access to Psychological Therapy (IAPT), and the First Response Team (a new service set up in May 2020 as a crisis advice line).
Advice Plymouth	A charity that delivers an advice an information service around many areas including, benefit and tax, employment, housing, money and debt.
Colebrook Support Services	Support Services forms a part of the wider Colebrook organisation and provides supported accommodation, support to vulnerable people in the community to develop independence and skills via a number of different services.
Colebrook Head Space	Head Space offers an out-of-hours service for people who consider that they are approaching a mental health crisis, where individuals can access peer support in a non-clinical, safe environment.
Rethink Plymouth	A charity that provides a range of support including a variety of group and one-to-one support for people affected by mental illness.
Devon Mind	A charity that provides advice and support to empower anyone in Devon experiencing a mental health problem.
Wolseley Trust	A business and Community Economic Development Trust that provides the social prescribing service to the majority of the primary care networks in Plymouth.
Elder Tree Befriending	A charity that provides a befriending service for vulnerable and socially isolated people over the age of 50 and aims to engage their beneficiaries in social engagement activities close to where they live to generate peer support.
Community Connections	A multi-disciplinary team within the Local Authority that work with and in communities to support and empower citizens to make sustainable change in their lives. This includes working with people who are homeless or at risk of homelessness.
Community Connections Youth Team	Work with young people in Plymouth who are up to 25 where there is a need, delivering range of services, projects and facilities including youth centres, street-based youth work, and a young carers project, a group aimed at young people on the autistic spectrum.

An open conversation was held with each manager. The purpose of these meetings was to understand the impact of the pandemic on mental health from a provider's perspective, which would add a local context to the evidence, and was therefore a more qualitative approach. However, the conversations were based around the questions in Box 2 in order to guide the conversation and give some consistency between different meetings.

Box 2: framework for discussion with mental health providers

1. What services does your organisation provide?
2. Do you have data on numbers of service users you are seeing before and during COVID-19?
3. Can you describe any changes to the complexity of cases you are seeing?
4. What changes have there been in your workforce?
5. What was the balance between demand and supply of your service before and during COVID-19?
6. What are the changes in service delivery you have made due to COVID-19?
7. What has worked to improve your service?
8. What have been the main challenges you have faced during COVID-19?
9. What is the key change would you make to address change in need due to COVID-19?
10. What are the barriers to achieving this?

Each meeting was recorded, and the transcript reviewed. The information that came out of these meetings is a snapshot of the perspectives of a sample of providers. It should be treated as a starting point and general assessment of what some mental health providers are seeing in their service and the system that can be explored, reviewed and tested further as more robust evidence becomes available, both locally and nationally.

The following five themes from these conversations will be discussed below:

1. Changes to service delivery and workforce
2. Impact of changes to service delivery on clients
3. Changes in demand and ability to meet that demand
4. Current and future challenges
5. Potential service and system improvements

Changes to service delivery

A high level of flexibility was reported by all organisations in adjusting their service and redeploying staff in response to the pandemic and control measures. Face to face work reduced substantially or fully and drop-in sessions for clients ceased completely. All of the providers reported a rapid change to remote working and remote provision of services using telephone, video or other technology to maintain contact and support for individuals and groups.

Some providers set up a new telephone support line, which had the impact of removing barriers to access (such as having to make an appointment and having an assessment), but providers also reported that an element of this then became a crisis service, which was unusual for some organisations and they had to manage that carefully.

Many organisations reported that client facing work restarted at various times in the course of the pandemic when national or local guidance allowed, but this was at a much lower capacity due to physical distancing requirements and only for particular individuals where there was a particular need.

Some organisations also stated that they had increased other activities such as social media presence, television/radio work and outreach in order to attempt to engage a greater number of people.

Impact of changes to service delivery meeting needs of clients

Many providers commented on the benefits and disadvantages of remote delivery of mental health services to the population.

Some providers reported that many people were struggling to access GPs and mental health teams and so had come to other organisations whose service model was not necessary designed to manage people with that higher level of need.

The reduction in the ability for individuals to drop into a service was also problematic. Some providers reported that these drop-in sessions are often where people with poorly defined needs can come in and hidden issues are picked up during more informal conversations.

Providers generally reported that the remote delivery of their service was good for some people who preferred having a service that was easier and more convenient to access. However, there was also an understanding that this did not suit everybody and that some people preferred or needed face to face interactions and that those who did not have the means or skills to use technology were disadvantaged.

Some providers commented that it is much more difficult to communicate with and build a relationship and trust with people when you are not face to face, which limited the usefulness of the interactions. One provider noted that there has been a drop off in the numbers attending group video interactions in recent months because of this. In addition, the peer support element of some of the services is also limited by the remote delivery.

Changes in demand and need

It was difficult for many of the providers to accurately comment on changes to demand before and after the start of the pandemic. This was mainly because of the changes to

service delivery outlined above meant that the changes in demand were difficult to capture and compare with pre-pandemic levels. Furthermore, it is not clear in all cases whether any changes can be attributed to the pandemic. However, providers were in general able to provide an impression or some data as to the demand that they have seen since the start of the pandemic, and this is summarised below:

- Livewell South West Mental Health:
    - Community Mental Health Teams: initial reduction in referrals at start of pandemic, which has remained lower than pre-pandemic levels.
    - IAPT: initial reduction in referrals at the start of the pandemic, which gradually increased through 2020, but still below pre-pandemic levels.
    - First Response Unit: received over 1700 calls a month from July to November (most recent data provided). This new service may have contributed to reduced demand in other services.
- Advice Plymouth: calls to Advice Plymouth for debt and any reason initially dropped at the start of the pandemic, potentially because of the reduction in being pursued for their debt. However, demand has risen gradually since then and numbers are now higher than would expect pre-pandemic.
- Colebrook support services: numbers in service and number of hours delivered has remained relatively constant over the course of 2020, but the service can only support people when they have the staffing, so this is a reflection of the staffing availability than demand.
- Colebrook Head Space crisis café: numbers were going up and up since before COVID-19, and demand since the pandemic has appeared to fluctuate, perhaps with the strictness of control measures.
- Devon Mind: Number of contacts rose significantly with the pandemic with the number of contacts per month at about the same level as the number of contacts that were seen per quarter before the pandemic. Also seeing a higher number of calls from people in crisis since the start of the pandemic and opening of the telephone lines.
- Rethink Plymouth: a modest increase in the number of clients compared to the previous year, and anecdotally more complex cases are being seen
- Elder Tree Befriending: a modest increase in the number of beneficiaries compared to before the pandemic and have not seen a big increase in need and the service feels able to meet that need.
- Wolseley Trust, social prescribing: the number of referrals from GPs to social prescribers has remained relatively constant comparing before and after the start of the pandemic. However, the trust have also conducted 1500 welfare checks on vulnerable people and 28 % of these resulted in the need some sort of support, and so numbers seen in the service are higher. In addition, anecdotally, it feels like the mental health issues are becoming more complex with an increase in the level of anxiety, loneliness and feelings of worthlessness.
- Community connections homelessness: difficult to compare because of government policy on housing people who are rough sleepers and the moratorium on evictions. However, they are seeing more complexity coming through, but that was the case

before the pandemic. Reported an issue with young people and substance misuse and losing of their accommodation because of it.

- Youth work: difficult to compare because of lack of walk in facilities, where additional needs were picked up. Anecdotal evidence that depression and suicide attempts in some of the older young people has visibly increased, as well as an increase in substance misuse.

From the reports above the pattern of changing needs reported by providers is not the same. It is too early to speculate on whether these changes are as a result of the pandemic or if they are indicative of future patterns of need. There may also be numerous explanations for them, for example the new First Response Unit and reduced access to GPs may have contributed in a reduction in referrals to the CMHTS. In contrast, some of the services that do not require a referral but have changed to open access telephone lines have seen their demand go up.

Current and potential challenges

Many current and potential future challenges were raised by providers and these are summarised below. Some are current issues and others are potential future challenges. In addition, some are COVID-19 specific and others are more general.

- Staff wellbeing: due to the impacts of higher demand, working remotely and in isolation, with limited physical interaction with team members and clients. This is especially important for many of these organisations because staff in often have lived experience of mental health issues themselves. This has also resulted in difficulties with recruitment, integration and retention of staff.
- Difficult to interact meaningfully with clients remotely: due to reduced ability to build a relationship and trust, as well as pick up on on-verbal cues and additional concerns. This has made it harder to meet the needs of the individual and more sessions may be needed to compensate for this.
- Reduced capacity and/or effectiveness of group sessions: due to physical distancing restrictions on numbers when face to face and lack of peer to peer interaction when using remote technologies.
- Difficulty interpreting and keeping up changes in COVID-19 guidance.
- Lack of ability to have walk in or drop-in sessions in the youth work has resulted in a reduced ability to identify unspecified or hidden needs.
- Circular signposting: a number of providers commented that for some clients it was difficult to maintain motivation to engage if they were regularly being signposted to other organisations.
- Individuals not able to access formal mental health services at the time of need: this may be because of barriers to access, or because they had failed to engage at a previous time.
- Poor transition between services at times, for example from Child and Adolescent Mental Health Services (CAMHS) to adult services or on release from prison.
- Uncertainty about future resources and funding for VCSEs.

- Escalation of need due to reduction in formal and informal support during the pandemic, and other stressors such as redundancy, furlough, isolation, substance misuse, and domestic violence.
- Additional stressors and implications of the British exit from the European Union and the environmental crisis.

Potential service and system improvements

The following is a summary of thoughts from providers on how their service and the system could be improved. These were conversational suggestions and should be taken as such, but they do provide some insight into their views.

- A blended approach of face to face and remote services. Many providers discussed the benefits of this when COVID-19 restrictions have ceased as it would allow greater access and reach and cater for different preferences of engagement.
- Ongoing strengthening of collaboration between Community Mental Health Teams, primary care, and VCSEs. This was commented on by almost all providers and included thoughts such as sharing of knowledge of needs and how to meet them, sharing of resources, supporting people into other services if appropriate and linking with associated services such as debt advice in a more proactive manner, for example with a pathway of referral.
- Strengthening of public mental health, prevention, early intervention and managing people at a more primary level. Some providers commented that need was increasing prior to the COVID-19 pandemic and even with expansion of services, it would be hard to meet the need. A more proactive than reactive approach would have the aim of improving the wellbeing of the population and maintaining capacity at a secondary level.
- Ensuring that messaging on what people can access and how is made as simple as possible. In addition, linking with particular settings such as housing offices and foodbanks where these messages may be needed.
- Awareness of trauma informed practice across the system may influence how services approach people if they are signposting them to other services
- Strengthening of organisations that work in and with communities.
- The youth service is working on a citywide qualitative and quantitative survey/consultation to discover needs, issues and concerns. This will inform further in-depth work and then how and what services are provided.
- Investing in young people friendly outdoor space.

7. SUMMARY OF KEY FINDINGS

Plymouth profile pre-pandemic:

- Levels of deprivation in Plymouth is higher than the national average.
- Before the pandemic some mental health and wellbeing indicators and outcomes in Plymouth were:
    - Worse than the national average:
        - Prevalence of common mental disorders and hospital admissions for intentional self-harm.
    - Statistically similar to the national average:
        - Low life satisfaction, low worthwhile, low happiness and high anxiety scores, and suicide rate.
    - Better than the national average:
        - Excess under 75 mortality rate in adults with serious mental illness.

Since the start of the pandemic:

- Nationally, there is emerging evidence that at a population level, indicators for mental health and wellbeing have worsened since the start of pandemic. In general, this has followed a pattern of an initial large decrease at the start of the pandemic, followed by a recovery over 2020, that has not returned to pre-pandemic baselines. More recent evidence suggests a decline in population mental health in the winter of 2020/21.
- There is no evidence for population level increases in suicides or self-harm since the start of the pandemic.
- There is emerging evidence nationally that the mental health of certain groups is being disproportionately affected by the pandemic. This includes, young adults, women, adults living with children, people with pre-existing mental or physical health problems, adults on low income or relative socioeconomic position, adults not in employment, certain ethnic groups, older adults who were asked to shield or are isolated, adults with financial worries, carers, and frontline health and care staff.
- Different groups in the population have tended to use different strategies to cope with mental distress.
- The total number of GP diagnoses of depression decreased in the pandemic. This is concerning because undiagnosed depression is risk factor for suicide. GP diagnoses of depression as a proportion of all GP diagnoses has increased.

Future mental health need:

- The changes in mental health seen so far may not be the full extent of the impact of the pandemic on mental health. This is because:

    - It may be too early to see some of the impacts of the pandemic on mental health.
    - The ongoing challenge of the pandemic may continue to affect mental health.
    - The pandemic may have environmental, cultural and socio-economic impacts, which in turn will continue to impact mental health. Examples include the possibility of recession, rise in unemployment and rise in deprivation.
- Predicting any future changes is fraught with many uncertainties but may signal areas that need closer monitoring.
- The Centre for Mental Health report predicts that as a direct result of the pandemic, up to 8.5 million adults in England (almost 20% of that population) will need either new or additional mental health support. The vast majority of these will be in people who have existing mental health conditions or the general population. Other groups identified were NHS works, the bereaved and the unemployed. **In Plymouth these figures equate to almost 27,000 of the estimated 39,000 people with common mental disorders requiring additional support and over 17,000 from the general population requiring new support for mainly moderate-severe depression or anxiety**.
- Public Health England describes a number of protective and risk factors related to that are well known to influence mental health. The risk factors are deprivation and inequality, unemployment and working conditions, poverty and financial insecurity, poor housing and homelessness, crime and violence, and alcohol consumption. The protective factors are community wellbeing and social capital and physical activity and use of outdoor space. The pandemic is likely to adversely affect many of these factors, for example, the number of people on Universal Credit in Plymouth has increased significantly since the start of the pandemic.

Perspectives of mental health providers in the city

- There has been a rapid change to remote service delivery to support clients since the start of the pandemic, with limited ongoing face to face work at a reduced capacity when possible for specific needs. Remote delivery was good for some individuals due to the convenience of access; however, other individuals would prefer or need face to face interaction. Providers generally considered remote interactions to be of poorer quality due to the difficulties of building a relationship and trust and ability to pick up on non-verbal cues and additional or hidden issues.
- Some providers reported that they were managing a higher level of need through their phone lines than they were equipped to.
- Changes in demand and need since the start of the pandemic are difficult to accurately quantify because of the changes in service delivery models. Demand generally fell at the start of the pandemic and increased thereafter. In some cases, this demand has stayed below pre-pandemic levels, but in others it is has overtaken pre-pandemic levels. There is also a suggestion that reduced access to mental health services during the pandemic may be increasing mental health needs.
- At the time, providers felt that they are able to meet the need that they are faced with, however, there are signs of increasing need across many services.

- Challenges for providers include staff wellbeing, recruitment and retention, having meaningful engagements with clients, reduced capacity, difficulty keeping up with guidance, circular signposting, difficulties for individuals to access formal mental health services at the time of need, poor transitions between services, uncertainty about the future and resources, escalation of needs due to the pandemic and additional stressors, such as the British Exit from the European Union.
- Potential service and system improvements suggested were: a blended approach of face to face and remote delivery, strengthening of collaboration between mental health teams, primary care, social prescribers and VCSEs, strengthening of public mental health, prevention and early intervention, clear messaging about services available, greater awareness of trauma informed practice, strengthening of organisations working at a community level, wider consultation with the community to understand needs, issues and concerns, and improving outdoor space for young people.

8. CONCLUSIONS FROM EVIDENCE AND INTELLIGENCE

Bringing these findings together, this report finds a number of conclusions:

- It is likely to be too early to see the extent of the mental health impact of the COVID-19 pandemic. Further evidence is likely to emerge in the coming months and years and therefore the evidence base for the impact of the pandemic on mental health will become more robust. Furthermore, the future of the pandemic is uncertain and therefore the ongoing impact on mental health is also uncertain.
- Current national evidence and data suggests that already population level mental health and wellbeing is being negatively affected by the pandemic.
- Whilst the pandemic is a collective trauma the burden of distress is greater in certain groups. The evidence shows that the mental health and wellbeing of some specific groups is disproportionately affected. Some of these groups correlate with the groups that are already more vulnerable to mental health issues and so there is a risk that the pandemic will widen and entrench mental health inequalities.
- There is also evidence that the pandemic is having a major impact on the risk and protective factors for mental health. In general, the pandemic has increased the risk factors for mental health problems, especially in the already more vulnerable groups. This may therefore lead to increasing mental health needs and increasing socio-economic inequalities in the future.
- In Plymouth, mental health services have seen varying patterns of demand and it is difficult to draw conclusions from the intelligence we have so far due to the changes in service delivery and because there may be numerous explanations. The new First Response Unit and reduced access to GPs may have contributed in a reduction in referrals to the CMHTS. In contrast, some of the services that do not require a referral but have changed to open access telephone lines have seen their demand go up.
- At the time of interviews, supply of services is generally able to meet the demand faced in Plymouth, however, there are a few signs in some of the services that continuing to meet this demand will be difficult.
- National modelling predicts that there will be a very significant increase in mental health needs as a result of the pandemic. Escalation of mental health needs as a result of the pandemic, may be seen across two main groups: those without pre-existing mental health issues and those with pre-existing mental health conditions.
- Escalation of needs may occur in the general population because a large number of people are likely to have had additional challenges to their wellbeing as a result of COVID-19. Whilst most people may not develop any or only mild mental illness, if a proportion of these develop mental illness requiring service use, this is likely to lead to a large rise in demand for mental health services.
- In the population with pre-existing mental illness, additional needs may develop because of the challenges of the pandemic as with the general population, but in addition they are more likely to have had disruption to their care during this time, which may contribute to relapse and/or escalating needs.

- Local intelligence suggests that there has not been a sudden substantial increase in demand for mental health services in 2020. Providers are currently able to keep up with demand, but they are facing challenges. However, mental health is complex and multi-factorial. Individuals have different challenges and resources, and these have been affected in different ways and over a different timeframe. Therefore, a predicted increase in mental health needs will not happen suddenly, but is more likely to be a slower, gradual and insidious increase. Given the difficulty in managing current levels of mental health needs and the general increase in the prevalence of mental health conditions before the pandemic, this may in time become very difficult to manage in the system.

Table 5 summarises the findings across four key indicators of mental health, looking at the situation in Plymouth before the pandemic and the national and local evidence for the impact of the pandemic on these indicators.

Table 5: Impact of the pandemic on key indicators for mental health.

Indicator	Pre-pandemic Plymouth rate	Known impact of COVID-19 nationally	Impact of COVID-19 in Plymouth
Prevalence of common mental disorders	18.2 %	• The population prevalence of anxiety and depression symptoms have likely increased, especially in risk groups. • There have been increases in loneliness, psychological distress and low life satisfaction in risk groups. • The proportion of GP diagnosed depression as a proportion of all GP diagnoses has increased.	• Demand for open-access telephone and online support services has generally increased. • Reduced demand for IAPT and CMHTs but this may be due to new First Response Service. • General increase in risk factors for mental health may further exacerbate this in at risk groups.
Self-reported wellbeing Low life satisfaction Low worthwhile Low happiness High anxiety	4.0% 3.8% 7.7% 22.2%	• Evidence of increases in anxiety symptoms, psychological distress and low life satisfaction scores.	• Demand for open-access telephone and online support services has generally increased. • General increase in risk factors for mental health may further exacerbate this in at risk groups.
Emergency hospital admissions for intentional self-harm	244 per 100,000	• Currently, no significant changes in self-harming thoughts or behaviour have been found. However, certain groups have been at higher risk, including those who have suffered abuse and financial concerns	• No current evidence found for changes in rates of self-harming. • General increase in risk factors (e.g. unemployment) factors for mental health may lead to future increases in at risk groups.
Suicide rate	11.7 per 100,000	• Currently, no change in suicide rates have been found since the start of the pandemic, but previous emergencies have been associated with a rise in suicide rate.	• No current evidence found for changes in rates of suicide. • Some anecdotal evidence of increase in suicide thoughts and attempts in some groups. • General increase in risk factors (e.g. unemployment) for mental health may lead to future increases in at risk groups.

9. GAPS

Gaps in intelligence

The evidence presented in this needs assessment indicates how the mental health needs of certain groups has been influenced by the COVID-19 pandemic. However, there are some groups, who are known to be at increased risk of mental health issues that are not covered in this needs assessment, either because of the scope of this report or the lack of evidence available either nationally or locally. It is therefore unclear how the needs of these groups have changed because of the pandemic and/or whether these needs are being met. These groups include:

- Children and young people. Although the needs assessment does comment on young people and the perspectives of the Youth Service were sought, a specific focus on children and young people was beyond the scope of this report.
- BAME groups: there is limited evidence nationally and locally on the impact of the pandemic on the mental health of certain ethnic groups and their use of services
- Victims of domestic abuse and crime.
- People who are homeless or at risk of homelessness.
- Carers and healthcare workers: There is national evidence that the mental health of these groups have been adversely affected, however, it is unclear if the mental health needs of these groups are being met locally.

Gaps in service provision

The findings from this needs assessment suggests that particular groups that are more likely to have gaps in mental health support as a result of the COVID-19 pandemic:

- Young people: evidence suggests their mental health and wellbeing is more likely to be affected by the pandemic and they more likely to be economically affected for example with job losses. Local intelligence has indicated an increasing mental health need in this group as well as increased problems with substance misuse and housing. In addition, the services provided by youth workers have been severely affected.
- People with pre-existing mental health conditions: due to being particularly vulnerable to the impacts of the pandemic and reduced access to services at a time of need may lead to an escalation in needs.
- People who have a low income, are socioeconomically deprived, unemployed and/or in financial debt. These factors are risk factors for mental ill health and the pandemic may have exacerbated this.
- Groups with little or no digital access: due to not being able to access the majority of mental health services that are currently operating online as well as having less readily available informal support of family and friends. People who do now know how to use digital technology, people with limited finances or means to purchase technology and people with complex lives may be particularly affected by this.
- People who work in mental health services: due to additional workload as a result of the pandemic and providers commented that a lot of their workforce have lived experience of mental health problems, which may make them more vulnerable.

10. RECOMMENDATIONS

The widespread impact of COVID-19 and the social and economic consequences of the pandemic have highlighted the urgent importance of promoting mental health and tackling mental ill health at a population level. The burden of mental illness prior to COVID-19 was already significant and the pandemic is widely expected to increase this burden and exacerbate existing mental health inequalities [24]. National and local evidence presented in this needs assessment indicates that mental health need may be increasing, despite being too early to see the full impact.

In response to the findings and gaps identified in this needs assessment, a range of recommendations have been made. These recommendations use a proportionate universalism approach which addresses whole population mental wellbeing (primary prevention), and the wider determinants (protective and risk factors) of mental health alongside targeted early interventions (secondary prevention), especially for those at a higher risk of developing mental illness and improving care and treatment services for mental health (tertiary prevention).

A public mental health approach attempts to build the resources and resilience of individuals and communities so that they can face the challenges in their lives in order to prevent the onset, development and escalation of mental health problems. It aims to strengthen the protective factors for good mental health and reduce the risk factors for poor mental health at an individual and community level. This upstream approach will, in turn, impact positively on the NHS and social care system and there is evidence that a range of prevention activities are cost-effective [61]. Targeted interventions aim to reduce mental health inequalities and improvement to mental health services will improve the lives of those who have developed mental health issues.

The PHE Prevention Concordat for Better Mental Health

The recommendations are framed around the domains of the PHE Prevention Concordat for Better Mental Health [62]. The Prevention Concordat is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health makes a valuable contributing to achieving a fairer and more equitable society. The Concordat is intended to provide a focus for cross-sector action to deliver a real and noticeable increase in the adoption of public mental health approaches across:

- Local authorities
- The NHS
- Public, private and voluntary and social enterprise sector organisations
- Educational settings
- Employers

It also acknowledges the important role of people with lived experience of mental health problems.

The consensus statement describes this commitment that is made by signatories to the concordat (Box 3):

Box 3: The PHE Prevention Concordat for Better Mental Health consensus statement.

The undersigned organisations agree that:

To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focused leadership and action throughout the mental health system, and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help through the use of upstream interventions.

There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at a local level. This should draw on the expertise of people with lived experience of mental health problems, and the wider community, to identify solutions and promote equity.

We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.

We will work collaboratively across organisational boundaries and disciplines to secure place-based improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of resources.
We will build the capacity and capability across our workforce to prevent mental health problems and promote good mental health, as outlined in the Public Mental Health Leadership and Workforce Development Framework Call to Action.

We believe local areas will benefit from adopting the Prevention Concordat for Better Mental Health.

We are committed to supporting local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers, employers and the voluntary and community sector to adopt this concordat and its approach.

The overriding recommendation of this health needs assessment is that key organisations within the Health and Care system in Plymouth should sign and work together to meet the commitments of the Public Health England Prevention Concordat for Better Mental Health.

This would set a clear direction to the local health and social care system that all should work towards a tangible increase in the promotion of mental health and wellbeing and the prevention of mental ill health. The public health team should continue to provide system leadership, working within the existing multi-agency groups and networks in the city, to co-develop a strategy and action plan for increasing work to promote mental health and wellbeing and prevent mental ill health across the system.

The five domains of the concordat are:

- Understanding local needs and assets
- Working together
- Taking action for prevention and promotion, including reducing health inequalities
- Defining success and measuring outcomes
- Leadership and direction

Examples of actions that can be taken within each domain are:

Understanding local needs and assets

- Share the results of this needs assessment widely across mental health and wider partners in the city.
- Undertake a specific children and young people COVID-19 emotional health and wellbeing needs assessment to complement the findings from this report. This is particularly important so that a life course approach can be taken, which acknowledges that mental health risk is often determined in childhood.
- Continuing to monitor the emerging evidence for the impact of COVID-19 on mental health and mental health inequalities. This includes monitoring national evidence particularly via the PHE COVID-19 mental health and wellbeing surveillance reports [2].
- Undertake a BAME audit of service within the mental health system, to review how equitable our services are.
- Undertake a city-wide consultation, for example via the Plymouth Survey or in a bespoke piece of work to understand the wellbeing and needs of different population groups in the city. This should be a coordinated effort between organisations to avoid over-surveying the population and could be repeated at specified time intervals to monitor ongoing changes. Further active consultation may be required to understand the needs of particular harder to reach groups such as people with complex lives (characterised by a combination of substance/alcohol misuse, homelessness and mental health issues) victims of domestic abuse.
- Close monitoring of demand for mental health services at different levels in the city so that early signals of increasing need can be identified.
- Further our understanding of the local COVID-19 impact on the wider determinants of mental health. In particular poverty, deprivation, financial issues and debt and unemployment, which are likely to have been impacted by the pandemic.

Working together

There are many examples of good partnership working in Plymouth within the mental health sector. This is evident in the collaboration across sectors in the various mental health

boards and for a in the city, as well as the recent Health and Wellbeing Board Mental Health Workshop in October 2020.

- Collaborative work across organisational boundaries and sectors should continue and be strengthened to embed good mental health promotion and mental ill health prevention within:
    - The local authority
    - The NHS
    - Public, private and voluntary and social sector organisations
    - Educational settings
    - Businesses
- Explore how collaboration between mental health partners in the city at all levels (mental health teams, primary care and VCSEs) can be strengthened. This includes sharing knowledge of needs and approaches that work as well as resources and improving how individuals are supported into other services when appropriate.
- A wide range of local organisations and communities should be actively involved in shaping and delivering a joint system-wide approach to public mental health. This includes engagement with the community and people with lived experiences of mental health problems in order to develop and deliver services that are equitable and relevant to our population.

Taking action for prevention and promotion, including reducing health inequalities

Population level interventions

- **5 ways to wellbeing:**

  Promotion of the Thrive Plymouth Year 4; 5 Ways to Wellbeing (Connect, Learn, Be Active, Notice, Give) population approach to improving mental wellbeing and raising mental health awareness. This can be alongside with national campaigns such as Every Mind Matters, which promotes mental health literacy. These messages can also be targeted to more vulnerable groups.

- **Promoting mental health and wellbeing in the workplace:**

  All workplaces should be encouraged to promote mental health and wellbeing during the COVID-19 pandemic and after, for example by completing the Workplace Wellbeing Charter [63]. From the limited evidence available, universal mental health promotion programmes have been found to have positive impacts in about half of studies examined. Common elements of successful programmes included factors such as a supportive atmosphere and embedding a wellness culture at an organisation level. Modelling suggests that these programmes give a positive return on investment to the business in terms of increased productivity and reduced absences and modestly reduce GP visits [64].

More targeted measures might include modifying workloads, flexible working hours, wellbeing support, the use of wellbeing champions, actively engaging with employees about wellbeing, and signposting to additional support. These measures may be particularly important to employees who are working from home, self-isolating, and/or have childcare or other caring responsibilities.

- **Community empowerment:**

  Organisations working in and with communities should be supported to build on our community assets. Such organisations have built relationships with communities and have good insights into the needs and challenges faced. There is some evidence that there has been a stronger sense of community since the pandemic and this should be built upon. There is a substantial body of evidence on the effectiveness of community participation and empowerment and on the health benefits of volunteering with research indicating that it brings a positive return on investment [65]. Furthermore, the National Institute for Health and Care Excellence (NICE) guidance also endorses community engagement as a strategy for health improvement.

Wider determinants of mental health

- **Services relating to the wider determinants of mental health:**

  Improve the connection between mental health services and services linked to the wider determinants of mental health, including financial, debt, housing, food banks and unemployment services. The use of these services indicates that the individual is at an increased risk of mental health problems. A proactive approach to mental health and wellbeing in the context of the pandemic should therefore provide mental health literacy training to frontline housing and advice workers and consider messaging and support linked to these settings.

- **Providing debt advice to protect mental health**

  Organisations that provide debt advice should be supported because the pandemic is likely to have a significant impact in this area. Conservative estimates from the evidence suggest that these services offer a positive return on investment of at least £2.60 for every £1 invested, and this could be significantly higher if the greater health benefits, including to families and the reduced risk of homelessness is taking into account [64]. Cost savings come from reduced GP visits, treatment for depression, workplace absences due to stress and depression productivity losses.

- **Employment**

  Innovative and city-wide approaches to increasing employment rates in the city are likely to be needed as a priority during and after the pandemic. There is likely to be a significant reduction in employment because of the pandemic, which may continue for some time because of an economic downturn and there is evidence of a large rise in Universal Credit claimants in Plymouth already. The very close association between unemployment and poor mental health and so a public mental health plan

should consider employment and in particular those groups who have been shown to be more affected by the pandemic, such as young people.

- **Outdoor spaces**

  Plymouths green and blue space assets should continue to be valued and supported because of their benefits to many aspects of our lives including mental health and wellbeing. The Green Minds project is a fantastic example of this already taking place in the city. Investing in young person friendly space should be specifically explored to so that spaces and places for young people to socialise and develop friendships can be provided. These spaces would also provide a place for youth work to engage with young people and address their needs.

Mental wellbeing services

- **Messaging**

  Ensuring that messaging on what people can access and how is widespread and made as simple as possible. In addition, linking with particular settings such as housing offices and foodbanks where these messages may be needed.

- **Face to face services:**

  Organisations should be supported to re-introduce face to face services when it is safe and prioritised based on level of need and risk.

- **Digital technology:**

  The use of digital technology to deliver mental health and wellbeing services should continue after the pandemic as part of a blended approach of face to face and digital services. This would provide for different preference and increase access.

- **Collaboration:**

  Greater collaboration and communication between mental health service providers at all levels to improve how service users are supported into other services rather than signposted, when appropriate.

- **First Response Unit:**

  The new First Response Unit crisis helpline provides immediate trained mental health support for those in crisis. Getting support for mental health problems at the time of crisis has been raised as an issue by service providers and so this service should be promoted more widely and potentially expanded if required.

- **Addressing loneliness to protect the mental health of older people:**

Organisations that support older people in the community should be further supported to improve reach, especially during the time of COVID-19. Befriending and engaging older people in social activities have been shown to reduce loneliness and is overall cost saving, by reducing the cost of depression treatment and GP visits and improves the number of people contributing their time as volunteers. Furthermore, these calculations of cost-effectiveness do not take into account additional health benefits such as delay in physical and mental decline and the costs associated with this [64].

- **Trauma-informed practice:**

  Staff across the mental health and wider system should be trained in taking a trauma-informed approach with service users.

- **Staff wellbeing**

  The mental health and wellbeing of all staff providing health (mental and physical) and social care should be paramount. There is no caring for others without caring for yourself. There is also emerging evidence that these individuals are more likely to suffer adverse mental health issues because of the pandemic, a phenomenon seen in previous pandemics. A multi-level approach involving mental health promotion in the workplace together with early detection and rapid provision support to those who require it should be available to all staff.

- **Transitions between services**

  The pathways by which transitions between mental health services (for example from CAMHS to adult mental health service) should be reviewed to minimise the additional stress that may occur as a result of a sudden change in support at a time of significant change in their lives.

Defining success and measuring outcomes

- System partners should agree set of strategic aims for better mental health that are translated into actions and integrated into operational plans.
- A set of key mental health indicators and outcomes should also be measured and monitored, for example:
  - Prevalence of common mental health disorders,
  - Self-reported wellbeing (life satisfaction, happiness, anxiety and feelings of worth),
  - Emergency hospital admissions for intentional self-harm,
  - Suicide rate.

- Well as these direct mental health measures, factors related to the risk and protective factors for the development of mental health conditions should also be measured, for example:
    - Deprivation score and inequalities,
    - Unemployment rate,
    - People living in income-deprived households,
    - Statutory homelessness rate,
    - Violent and sexual offenses,
    - Hospital admissions for alcohol-related conditions,
    - Adult social care users who have as much social contact as they would like,
    - Physically active and physically inactive adults.

- Evaluation should be built into mental health interventions to build knowledge of what works locally. A framework such as RE-AIM (reach, effectiveness, adoption, implementation, maintenance) is appropriate for the practical evaluation of public health interventions as it gives greater depth to the analysis than solely looking at outcome measures.

Leadership and direction

- Plymouth City Council's public health team should continue to provide systems leadership for public mental health and continue to advocate for a prevention and promotion approach in the existing fora and multi-agency groups in the city; including in the:
    - Plymouth Mental Health Programme Board
    - Plymouth Suicide Prevention Strategic Partnership Group
    - Plymouth Emotional Health and Wellbeing of Children and Young People Group
    - Plymouth Mental Health Network
- Senior leaders across the system should continue understand the value of good mental health as an asset to society, consider mental health in all policy decisions and make sure that a wide range of organisations address public mental health and are held to account for jointly agreed actions. The Health and Wellbeing Board Mental Health Workshop in October 2020 was a demonstration of leadership from across the system in this area.

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APPENDIX 1

The Centre for Mental Health devised a toolkit for local areas to calculate the forecasted demand for mental health services resulting from the COVID-19 pandemic. Local data can be inputted into the model to provide local forecasts of new service demand as a result of the pandemic (Covid-19 Forecast Modelling Toolkit | Centre for Mental Health).
The data that was required to be inputted into the model and how that data was calculated is set out below:

Population group	Calculations and assumptions	Estimated number of people in population group in Plymouth	Estimated new demand for mental health services in Plymouth
People (>16 years) without pre-existing mental health conditions	• Plymouth mid-year 2017 population was 263,070. The under 16 years population was 47,120, so the over age 16 population of Plymouth was 215,950. (Plymouth Report | PLYMOUTH.GOV.UK) • The prevalence of common mental disorders in Plymouth in those over 16 years old is 39,279 (Public Health Profiles - PHE).	176,671	15,360
People (> 16 years) with pre-existing mental health conditions	• The prevalence of common mental disorders in Plymouth in those over 16 years old is 39,279 (Public Health Profiles - PHE).	39,279	26,767
Healthcare workers	• The number of Plymouth residents who are NHS workers is not accurately known. • The number of the number of full-time equivalent professionally qualified clinical staff (includes all doctors, nurses and health visitors, midwives, ambulance staff and scientific, therapeutic and technical staff) working in University Hospitals Plymouth (UHP) in March 2020 was used as a proxy (Microsoft Power BI). However, it is likely that some staff at UHP do not live in Plymouth and some Plymouth residents work in acute healthcare outside of UHP. This figure also does not take into account primary care or social care staff.	3,761	838

People recovering from severe COVID-19	• There is no easily available data on the total number of patients who required mechanical ventilation for COVID-19. • As of 5 May 2021, University Hospitals Plymouth admitted a total 1,272 patients with COVID-19 (Healthcare | Coronavirus in the UK (data.gov.uk)). • Data on COVID-19 patients who required mechanical ventilation is provided daily and not as a cumulative total. At each of the three peaks of hospital admissions the number of patients on a mechanical ventilation bed was on average one seventh of the number of patients admitted to hospital. • Assuming that one seventh of the total hospital admissions required mechanical ventilation, this would give a total of 182 people who required mechanical ventilation in University Hospitals Plymouth since the start of the pandemic. • This assumes that all patients in UHP were Plymouth residents, whereas in reality a significant proportion of patients would be Plymouth or Devon residents. This figure also does not take into account those who passed away.	182	42
Adult family members of those recovering from severe COVID-19	• The model uses the figure from the number of people who are recovering from severe COVID-19 and multiples this by 1.47, which is the average family size (2.47) minus one (the patient).	268	27
Bereaved people	• The model quires input of the total deaths in Plymouth between 20 March 2020 to 30 July 2020 when visiting restrictions were in place. There after only deaths from COVID-19 should be used. • In Plymouth between 20 March 2020 and 30 July 2020, 990 people passed away (Death registrations and occurrences by local authority and place of death - Office for National Statistics). • In Plymouth between 31 July and present (5 May 2020) 141 people have died and had COVID-19 on their death certificate (Deaths | Coronavirus in the UK (data.gov.uk)) • This gives a total of 1131 deaths.	1,663	175

	• This is multiplied by 1.47, which is the average family size (2.47) minus one (the patient).		
People economically affected by COVID-19	• The model requires the input of the number of new Universal Credit Claimants since the start of the pandemic. • In March 2020 there were 16,050 Universal Credit claimants in Plymouth, and in March 2021, there were 27,671 Universal Credit claimants in Plymouth (Stat-Xplore - Log in (dwp.gov.uk)).	11,621	238

These numbers were entered into the toolkit, as shown below:

Population group	Research study author	Number of people in population group (pre-Covid)	Research determined increase (percentage)	Mental health condition	Calculated predicted new cases of mental health condition	Percentage or number of people who may access services	Predicted extra demand for services	Discount rate	Most likely predicted new demand for services	Confidence rating of study
General population without pre-existing mental health conditions	Fancourt et al	176,671	16.3%	Moderate severe anxiety	28,797	25%	7,199	10%	6,486	Amber
	Fancourt et al	176,671	22.3%	Moderate severe depression	39,398	25%	9,849	10%	8,874	Amber
People with pre-existing mental health conditions	Fancourt et al	39,279	67.4%	Moderate severe anxiety	26,474	49.9%	13,211	0%	13,211	Amber
	Fancourt et al	39,279	56.3%	Moderate severe depression	22,114	61.3%	13,556	0%	13,556	Amber
Healthcare workers	Maunder et al	3,761	30.4%	Burnout	1,143	25%	286	0%	286	Green
	Maunder et al	3,761	13.8%	Post traumatic distress	519	25%	130	0%	130	Green
	Maunder et al	3,761	44.9%	High psychological distress	1,689	25%	422	0%	422	Green
People recovering from severe Covid-19	Bienvenu et al	182	41.0%	Anxiety (38%-44%)	75	25%	19	0%	19	Green
	Bienvenu et al	182	29.5%	Depression (26-33%)	54	25%	13	0%	13	Green
	Bienvenu et al	182	23.0%	PTSD (22-24%)	42	25%	10	0%	10	Green
Adult family members of those recovering from severe Covid-19	Davidson et al	268	19.5%	Anxiety (15-23%)	52	25%	13	0%	13	Green
	Davidson et al	268	6.0%	Depression	16	25%	4	0%	4	Gren
	Davidson et al	268	35.0%	Post traumatic stress disorder	94	25%	23	0%	23	Green
Bereaved people	Lurndorff M et al	1,663	9.8%	Prolonged grief disorder	163	25%	41	0%	41	Green
	Lurndorff M et al	1,663	14.0%	Post traumatic stress disorder	233	25%	58	0%	58	Green
	Gries et al	1,663	18.4%	Depressive symptoms	306	25%	76	0%	76	Green
People economically affected by Covid-19	Paul K et al	11,621	8.2%	Major depression	953	25%	238	0%	238	Amber
TOTAL		461,142			122,121		45,150		43,461	