RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2024

MENTAL HEALTH AND DEMENTIA - ADULTS

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Foreword

This document presents a three-year update of the Joint Strategic Needs Assessment (JSNA) for mental health and mental wellbeing among adults in Rutland. It reviews the population health needs in relation to mental health, its socio-economic determinants, impact on health outcomes, outlines the relevant policy and guidance, existing services and the range of services that are currently provided. It also estimates the unmet needs and presents recommendations based on the findings.

In general, the purpose of a JSNA is to:

- Improve the health and wellbeing of the local community and reduce inequalities for all ages.
- Determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- Provide a source of relevant reference to the Local Authority, Integrated Care Board (ICB) and NHS England for the commissioning of any future services.

The Local Authority and ICBs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, ICBs and NHS England's plans for commissioning services to be informed by up-to-date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, ICBs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with ICBs and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, a relevant working group was created. The outputs of the JSNA may include:

- Subject-specific chapters of an assessment of current and future health and social care needs
- An online infographic summary of each chapter
- An online data dashboard that is updated regularly to allow users to self-serve high level data requests.

Please note, the majority of the indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. It should be noted that where local context has been provided for Rutland, data often includes small counts and as such caution should be taken when drawing conclusions.

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AMHPs	Approved Mental Health Professionals
APCC	Association of Police and Crime Commissioners
APMS	Adult Psychiatric Morbidity Survey
ASB	Antisocial Behaviour
ASD	Autism Spectrum Disorders
ASPD	Anti-Social Personality Disorder
BMI	Body Mass Index
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
CHD	Coronary Heart Disease
CIPFA	Chartered Institute of Public Finance and Accountancy
CIS	Clinical Intervention Schedule
CMD	Common Mental Disorders
CNA	Certified Normal Accommodation
CSEW	Crime Survey for England and Wales
DHSC	Department of Health and Social Care
DMS	Defence Medical Services
ELSA	English Longitudinal Study of Ageing
ESA	Employment Support Allowance
FTRS	Full Time Reserve Service
GAD	Generalised Anxiety Disorder
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
IMHA	Independent Mental Health Advocacy
JSNA	Joint Strategic Needs Assessment
LGBT+	Lesbian, Gay, Bisexual, Transgender and others
LLR	Leicester, Leicestershire, and Rutland
LSOA	Lower Layer Super Output Area

LTC	Long Term Condition
OCD	Obsessive-Compulsive Disorder
ONS	Office for National Statistics
MCN	Multiple Complex Needs
MHB	Mental Health Bulletin
MOD	Ministry of Defence
MUS	Medically Unexplained Symptoms
NHSMHD	NHS Mental Health Dashboard
NICE	National Institute for Care Excellence
NOS	Not Otherwise Specified
NPCC	National Police Chiefs' Council
PFA	Police Force Areas
PTSD	Post-Traumatic Stress Disorder
QOF	Quality and Outcomes Framework
RCRP	Right Care Right Person
SAMHSA	Substance Abuse and Mental Health Services Administration
SMD	Severe and Multiple Disadvantage
SMI	Severe Mental Illness
VAP	Violence Against the Person
YOI	Youth Offender Institution

1. Executive Summary

This Joint Strategic Needs Assessment (JSNA) aims to provide an understanding of adult mental health issues and mental wellbeing in Rutland. It incorporates national and local evidence to support local priority setting. Not all information is available at county or district level, particularly as commissioning data are now largely published at ICB level, and where available, numbers may be too low to reach robust statistical conclusion. Where appropriate, local Leicestershire and Rutland context is provided in such cases.

Population

- Rutland's population is on average older than the national average – one in four (25%) are older adults, compared to 19% nationally (Census 2021). The projected increase in the oldest groups (85+) is by 45% in the next decade, with significant implications for mental and physical morbidity and multi-morbidity (40% increase in people with four or more conditions).
- Although Rutland's population can be regarded as relatively affluent according to standard socio-economic indicators, there are pockets of deprivation, particularly of rural character. Issues deriving from loneliness, barriers to housing, or poor access to services can have significant impact on mental wellbeing.

Who is at Risk

- Nationally and locally, there are increasing numbers of women accessing perinatal mental health services, indicating a growing need in this population group.
- There are indications that the rates of access to mental health treatments for prison populations is still below the pre-pandemic levels.
- Nationally, the rates of mental health problems among students are rising, with more than 5% prevalence reported recently, although there are no data to confirm this at a local level.
- Local survey suggests high mental health needs among the armed forces personnel, with relatively low accessibility of services for this group. Rutland has proportionately high numbers of UK armed forces personnel and veterans. Enhanced local data collection for this group has been recommended.

Mental Health Needs

- Of the estimated 5,500 Rutland residents with a **common mental health disorder (CMD),** approximately 4,000 are diagnosed (on GP registers), thus as much as 1,500 are potentially

undiagnosed.

- This includes a total of 720 estimated cases of dementia, of which less than a half are registered with GPs in 2023. This is well below the national standard to dementia diagnosis.
- Access to Talking Therapies is below the target (just over 60%); spend has also fallen in 2022/23 to 80% of the target (latest financial data available only at LLR level), with higher than national proportion of people waiting over 90 days in-treatment.
- For **dementia**, Rutland has higher than average prevalence of conditions which are risk factors, such as hypertension, stroke and CHD but lower than expected lifestyle factors (e.g. obesity or smoking) – there is scope for further enhancing early detection and treatment of cardiovascular conditions to help prevent rise of dementia in the future.
- Community-based memory services in Rutland are accessed at slightly higher than national rate (by around 210 individuals per year).
- There are around 70 deaths due to dementia every year in Rutland; statistically this is not significantly different than national rate.
- Nationally the waiting times for those with suspected **neurodevelopmental disorders** (ASD/ADHD) are rising. However, looking at local indicators (such as average waiting times and proportions of those receiving assessment under 13 weeks), these compare favourably with national average.
- For **severe mental illness (SMI)** there is also a gap between the estimated prevalence of 790 (bipolar disorder plus other psychotic disorders) and diagnosed (GP-registered) prevalence of just over 310.
- Nationally, the risk of premature mortality in people with SMI is almost four times higher compared to those without SMI, this disparity is even higher in Rutland (4.5 times higher risk). A large component of this appears to be cancer mortality, although local numbers are too low to draw robust statistical conclusions.
- Less than a half of people with SMI in East Leicestershire and Rutland had a full physical health check (as of June 2023). Breast screening rates for women with SMI are only half of those in the general population.
- The annual rate of **suicide** in Rutland is relatively low (less than 3 per year, on average) and hospital admission rates for self-harm (45 admissions in a year) are lower than the national average. However, it is estimated that the number of people having thoughts of self-harming and/or attempting suicide each year in Rutland could be in in a ballpark of 2,000.
- Nearly 70% of those entering **drug treatment** in Rutland have mental health needs, as well as over 60% of those entering alcohol-only treatment, according to drug and alcohol misuse services. However, the rates of hospital admission for alcohol-related mental health issues

appears to be significantly lower than elsewhere in England (about a third of the national rate, depending on methodology).

- The rates of contact with **secondary mental health services** are rising nationally as well as locally (by as much as 14% year-on-year recently). In 2022/23, over 2,000 Rutland adults were in contact with services, 1.9% (N=40) were admitted as inpatients, a proportion which is lower than national average of 2.6%. Furthermore, the mental health rate of bed occupancy (in-year occupied bed-days) in Rutland is relatively low, about a third of the national rate.

Mental Health Services

- A number of statutory and non-statutory services are working together to provide mental health and wellbeing support.
- Services are primarily commissioned and operate across Leicester, Leicestershire and Rutland (LLR) and cover a range of services, such as talking therapies, community teams, early intervention teams, recovery teams, crisis support, dementia services and a number of specialist services. All services are described in more details in the report.

Return on Investment

- Evidence indicates that there is a positive return of around £5.30 on every £1 spent on mental health interventions in the workplace, although many other programmes can have significant economic impact, including perinatal depression prevention, parenting programmes, early identification of mental disorders in young and older people and psychological interventions in patients with long-term conditions.

Gaps and Recommendations

- Currently, the care for people with personality disorders (PD) is fragmented with gaps in service, and poor access due to stigma. There is increasing evidence that treatment for PD is effective and should be made more accessible. The estimated prevalence of PD is at least 4,000 in Rutland.
- There is a lack of flexible mental health outreach for people who sleep rough and may have dual diagnosis with substance misuse.
- It is recognised that 50% of mental health problems are established by age 14 and 75% by age 25, there is a need for earlier diagnosis and treatment and better transition from children's mental health services.
- There are gaps in the continuity of care for people self-harming, attending Emergency Department and returning back to locality Primary care and local services, particularly for those

at university who may be at a part-time address.

- Improve rates of physical health checks and cancer screening in people with SMI.
- Enhance engagement with the voluntary and community sector.
- Develop prevention services for carers of people with mental health difficulties to provide support before that person reaches a crisis.
- Although some work to understand the health and wellbeing needs of Rutland's armed forces population has been undertaken recently, the small numbers of respondents make it difficult to draw conclusions on the wider needs of this population, particularly that this population has recently changed.
- Further modelling of the impact of current demographic trends on future mental health needs and demand for health care, particularly for dementia, would be recommended to understand growing health needs better.
- There is perceived need for more granular and up-to-date local information on services provided for Rutland population.

Some of the identified gaps and recommendations apply across the local commissioning footprint.

2. Policy and Guidance

2.1. National Mental Health Policy and Guidance

2.1.1. NHS Long Term Plan (2019)[1]

The National Health Service (NHS) Long Term Plan, published in January 2019, outlined key strategies and commitments regarding mental health services in England. It offered a comprehensive approach to improving mental health services in England, with an emphasis on prevention, early intervention, integration, and innovation. It set out a number of goals to address the growing demand for mental health support and improve outcomes for individuals. Focusing on early intervention and prevention, increasing access to services, service integration, increasing funding and resources for children and young people, improving perinatal mental health services, developing mental health workforce, it highlighted the role of harnessing digital technology and reducing stigma surrounding mental health issues and ultimately reducing the number of suicides and addressing the underlying social and economic factors contributing to mental health problems.

2.1.2. Advancing Mental Health Equalities Strategy (2020)

The Advancing Mental Health Equalities Strategy by NHS England[2] outlined a comprehensive approach to address disparities and promote equity in mental health care through a number of aims such as addressing the underlying factors contributing to mental health inequalities, improving access to mental health services for marginalized and underserved communities, targeted interventions in schools, workplaces, and communities, tackling stigma and discrimination, or tailored support and interventions for specific population groups. The Strategy puts an emphasis on the importance of data on mental health inequalities, collaboration and partnership working, workforce diversity, and monitoring and evaluation.

2.1.3. National Disability Strategy (2021)[3]

The National Disability Strategy in the UK outlines a comprehensive plan to address the barriers and challenges faced by disabled people across various aspects of life, including independent living, employment, skills, education, transport and public spaces. It focuses on improving access to health and social care services for disabled people, mental health and rehabilitation support, and personal care.

2.1.4. National Partnership Agreement: Right Care, Right Person (2023)

Set out around the Right Care, Right Person approach, which aims to ensure that individuals in mental health crisis are seen by the right professional, the agreement between the Department of Health and Social Care (DHSC), Home Office, NHS England, National Police Chiefs' Council (NPCC), Association of Police and Crime Commissioners (APCC) and College of Policing [4].

The Right Care, Right Person (RCRP) framework was developed to help police to make decisions about when to respond to incidents.

2.1.5. Suicide Prevention Strategy (2023)

In September 2023, the Government published the Suicide prevention strategy for England: 2023 to 2028[5].

The strategy and corresponding action plan set out ambitions for the next five years a) to reduce the suicide rate, with initial reductions made within at least half this time, b) to improve support for people who have self-harmed, and c) improve support for people who have been bereaved by suicide.

The strategy includes over 100 actions focused on improving data, providing targeted support to these priority groups, addressing common risk factors linked to suicide, promoting online safety, providing crisis support, reducing access to means of suicide, and providing bereavement support.

2.1.6. Major Conditions Strategy and A Mentally Healthier Nation (2023)

In April 2022, the Government launched a Mental health and wellbeing plan: discussion paper and call for evidence, intended to inform a new 10-year, cross-government mental health strategy. The discussion paper and consultation questions focused on promotion of mental wellbeing, prevention of mental health conditions, early intervention, quality and effectiveness of treatment, support for people with mental health conditions and support for people in crisis. The responses to the consultation for the 10-year strategy were to be used to inform the Major Conditions Strategy and to develop the new Suicide Prevention Strategy (see 2.1.5). In January 2023, the Government announced that it will publish a Major Conditions Strategy that will include mental health to ensure that mental health conditions are considered alongside physical health conditions.

In response, mental health charities, including the Mental Health Foundation, Mind and Rethink Mental Illness, with many other mental health charities and organisations published in January 2023 a document entitled Mentally Healthier Nation, setting out priorities for a ten-year, cross-government mental health strategy. The document includes policies on prevention, equality, and support that the group would like to see implemented following the next general election [6].

2.1.7. NHS Long Term Workforce Plan (2023)

The NHS Long Term Workforce Plan was published in June 2023 by the Department of Health and Social Care. The plan estimates a shortfall of over 15,800 full time-equivalent mental health nurses by 2036/37[7]. The plan sets out an ambition to increase training places for mental health nursing by 93% to over 11,000 places by 2031/32. This would start with an increase in mental health nursing places of 38% by 2028/29. The increase in places would include an expansion of the nursing apprenticeship scheme so that by 2028/29, 28% of mental health nurses are qualifying via this route.

However, it is expected that there will continue to be shortfalls in mental health staffing in the medium-term.

Prior to 2019, the following key policies were published:

2.1.8. Mental Health Act (1983)

The Mental Health Act (1983) in the UK is legislation that provides a legal framework for the care and treatment of individuals with mental disorders. It balances the need to protect the rights of individuals with mental disorders while ensuring they receive appropriate care and treatment when necessary. It provides a legal framework for the detention, assessment, and treatment of individuals with mental health needs, with safeguards in place to protect their rights and interests.

The Act has undergone various reforms over the years, with the most recent amendments introduced by the Mental Health Act 2007 and ongoing discussions about further reforms to modernize and improve mental health legislation, including the **2018 Review of The Mental Health Act,** an independent review of the Mental Health Act 1983, published in December 2018[8].

In June 2019, the then-Government accepted further recommendations to tackle the disproportionate number of people from Black, Asian and minority ethnic groups who are detained under the Act, and further steps to end the use of police stations as a place of safety.

2.1.9. The Five Year Forward View for Mental Health (2016)[9]

The Five Year Forward View for Mental Health, a report from the independent Mental Health Taskforce to NHS England, was published in February 2016. The Taskforce made a series of recommendations, including achieving parity of esteem between mental and physical health, wider, cross-government action across areas such as employment, housing and social inclusion, Tackling inequalities. It also addressed inequalities in access to services among certain black and minority ethnic groups, whose first experience of mental health care often came when they were detained under the Mental Health Act, often with police involvement.

It made specific recommendations for supporting more new and expectant mothers through maternal mental health services each year, providing mental health care to more children and young people, increasing access to talking therapies, improving integrated care for people living with long-term physical health conditions, meeting the physical health needs of people with a severe mental illness and helping this group find and stay in employment. It also recommended making a community-based crisis response available across England and providing a mental health liaison service for people of all ages in every acute hospital. It also made a commitment to reducing suicides by 10%.

2.1.10. NICE Guidance

The National Institute for Care Excellence (NICE) issued the following guidance documents for mental health:

- *Social, Emotional and Mental Wellbeing in Primary and Secondary Education (NG223)* published in 2022 - covers ways to support social, emotional and mental wellbeing in children and young people in primary and secondary education, and people with special educational needs or disability in further education colleges[10].
- *Depression in Adults: Treatment and Management (NG222)* published in 2022 – deals with identifying, treating and managing depression in people aged 18 and over, provides advice on preventing relapse, and managing chronic depression, psychotic depression and depression with a coexisting diagnosis of personality disorder[11].
- *Mental Wellbeing at Work (NG212)* published in 2022 – provides best evidence on how to create the right conditions for mental wellbeing at work[12].
- *Antenatal and Postnatal Mental Health: clinical management and service guidance (CG192)* published in 2014, updated 2020 - covers recognising, assessing and treating mental health problems in perinatal period[13].
- *Generalised Anxiety Disorder and Panic Disorder in Adults: management (CG113)* published in 2011, updated 2020 - covers the care and treatment of people aged 18 and over with chronic anxiety or panic disorder (with or without agoraphobia or panic attacks), aiming to help people achieve complete relief of symptoms, better functioning and a lower likelihood of relapse[14].
- *Decision-Making and Mental Capacity (NG108)* published in 2018 - discusses decision-making in adults (aged 16 and over) who may lack capacity now or in the future, providing health and social care practitioners to support people to make their own decisions where they have the capacity to do so[15].
- *Eating Disorders: Recognition and Treatment (NG69)* published in 2017 – covers assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders[16].
- *Mental Health of Adults in Contact with the Criminal Justice System (NG66)* published in 2017 - covers assessing, diagnosing and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system[17].
- *Transition Between Inpatient Mental Health Settings and Community or Care Home Settings (NG53)* published in 2016 - covers the period before, during and after an admission to, and discharge from, a mental health hospital, aiming to improve experience of transition[18].
- *Workplace Health: Management Practices (NG13)* published in 2015 - covers how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of

line managers. The 2016 update covered recommendations about older employees, aged over 50 in paid or unpaid work [19].

- *Older People: Independence and Mental Wellbeing (NG32)* published in 2015 - covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older[20] .
- *Mental Wellbeing in Over 65s: Occupational Therapy and Physical Activity Interventions (PH16)* published in 2008 - covers promoting mental wellbeing in people aged over 65 focusing on practical support for everyday activities, based on occupational therapy principles and methods[21] .

2.1.11. NICE Quality Standards

- *Decision Making and Mental Capacity (QS194)* published in 2020[22] - aims to support the implementation of the aims and principles of the Mental Capacity Act 2005 and relevant Codes of Practice.
- *Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups (QS167)* published in 2018[23] – includes quality statements on support for people with mental health problems and physical health checks for people with serious mental illness.
- *Mental Health of Adults in Contact with the Criminal Justice System (QS163)* published in 2018[24] – sets out standards for recognising, assessing and managing mental health problems in adults who are in contact with the criminal justice system.
- *Transition Between Inpatient Mental Health Settings and Community or Care Home Settings (QS159)* published in 2017[25] – contains quality statements on access to independent advocacy services, out-of-area admissions, communication on discharge and suicide risk.
- *Violent and Aggressive Behaviours in People with Mental Health Problems (QS154)* published in 2017[26] - covers short-term prevention and management of violent and physically threatening behaviour among adults, children and young people with a mental health problem.
- *Healthy Workplaces: Improving Employee Mental and Physical Health and Wellbeing (QS147)* published in 2017[27] - describes high-quality care in priority areas for improvement.
- *Learning Disability: Identifying and Managing Mental Health Problems (QS142)* published in 2017[28] - covers the prevention, assessment and management of mental health problems in people with learning disabilities in all settings.
- *Mental Wellbeing and Independence for Older People (QS137)* published in 2016[29] - describes high-quality care in priority areas for improvement, including statements on physical activity, social participation and risk of decline.
- *Antenatal and Postnatal Mental Health (QS115)* published in 2016[30] - covers the organisation

of mental health services for women during and after pregnancy, describes high-quality care in priority areas for improvement.

- *Mental Wellbeing of Older People in Care Homes (QS50)* published in 2013[31] – sets out a number of quality statements on recognition of mental health conditions, sensory impairment, physical problems and on access to healthcare services in this group.
- *Service User Experience in Adult Mental Health Services (QS14)* published in 2011 and updated in 2019[32] - covers improving the experience of people using adult NHS mental health services.

2.1.12. NICE Clinical Knowledge Summaries

NICE also publishes accessible summaries of the current evidence base and advice on best practice across clinical areas (full list at https://cks.nice.org.uk/), including mental health:

- Antenatal and postnatal depression (revised in April 2022)
- Attention deficit hyperactivity disorder (revised in August 2023)
- Autism in adults (revised in May 2020)
- Bipolar disorder (revised in January 2024)
- Dementia (revised in January 2024)
- Depression (revised in December 2023)
- Eating disorders (revised in July 2019)
- Generalized anxiety disorder (revised in February 2024)
- Mental health in students (October 2020)
- Obsessive-compulsive disorder (revised in February 2024)
- Post-traumatic stress disorder (revised in December 2023)
- Psychosis and schizophrenia (revised in September 2021)
- Self-harm (revised in November 2023)

2.2. Rutland Joint Health and Wellbeing Strategy

The Rutland Joint Health and Wellbeing Strategy: The Rutland Place based Plan 2022 – 27[33], includes seven priority themes. Of these, the 'cross-cutting themes' priority brings together three themes which interlink with multiple priorities across the strategy. One of these themes is 'supporting good mental health'.

The Leicester, Leicestershire and Rutland (LLR) vision for mental health of both children and adults across the system is 'We will deliver the right care to meet the needs of individual patients at the right time. We will integrate with health and social care partners to care for people when they feel they have mental health needs'.

The Rutland Joint Health and Wellbeing Strategy 2022-27 will progress the Rutland place specific elements of this work to champion Rutland's needs and support the delivery of mental health prevention, care and treatment services that improve local patient experience and outcomes.

2.3. Dementia Policy and Guidance

2.3.1. National Dementia Strategy[34]

This is a best practice guideline compiled by the Department of Health with the support of over 50 stakeholders. The aim of the strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. The strategy identifies 17 key objectives which, when implemented, should result in improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia. This strategy was published in 2009.

2.3.2. Prime Minister's Challenge on Dementia[35]

Originally launched in 2012, a programme of action to deliver sustained improvements in health and care, create dementia friendly communities and boost dementia research. With a republish in 2015, the government's key aspirations include improved public awareness and understanding of the risk factors of dementia, equal access to diagnosis, coordination and continuity of care for people with dementia, dementia training for all NHS staff, dementia friendly health and care settings, dementia friendly businesses and all tiers of local government being part of a local Dementia Action Alliance. It also announced that funding for dementia research was on track to be doubled by 2025.

2.3.3. NICE Guidelines[36]

A NICE guideline of particular note is "Dementia, disability, and frailty in later life – mid-life approaches to delay or prevent onset.'[37] It includes recommendations on promoting a healthy lifestyle to reduce the risk of, or delay the onset of, disability, dementia and frailty by helping people to: stop smoking, be more active, reduce their alcohol consumption, improve their diet and lose weight and maintain a healthy weight if necessary.

2.3.4. NHS England Transformation Framework – The Well Pathway for Dementia[38]

A transformation implementation plan which covers preventing well, living well, supporting well and dying well. The pathway also covers areas such as researching, integrating, commissioning, training and monitoring well.

2.3.5. Dementia: Good Care Planning – information for primary care and commissioners[39]

Aimed at primary care and commissioners, particularly GPs, who provide care plan reviews. It is

designed to help improve care planning in dementia by supporting a standardised approach, highlighting good practice, ensuring alignment with relevant cross condition care plans and helping to reduce local variation in the process.

2.3.6. Royal College of Psychiatry – Dementia care pathway[40]

This document outlines the pathway to help support the delivery of care around people with dementia or mild cognitive impairment (both medically and socially). One of the main aims of this pathway is to standardise timely diagnosis and post diagnostic care (for patients and carers).

It defines benchmarks for the Dementia Care Pathway, including achieving and maintaining a diagnosis rate of at least two-thirds, increasing the number of people being diagnosed with dementia and starting treatment within 6 weeks of referral and improving the quality of post-diagnostic treatment and support for people with dementia and their carers.

2.3.7. NHS Leicester, Leicestershire and Rutland Integrated Care Board Five-Year Plan 2023/24 – 2027/28[41]

Sets out how care and outcomes for patients will be improved, the equity gap across LLR will be reduced and financial stability will be achieved. Specifically with regards to dementia, the approach includes improving the dementia care pathway to support delivery of the Living Well with Dementia Strategy (see 2.3.8 below).

2.3.8. Leicester, Leicestershire and Rutland (LLR) Living Well with Dementia Strategy (2019-2022) and 2024-2028 draft[42]

This strategy looks to support those with dementia and carers for those with dementia, using NHS England Well Pathway for Dementia as a framework. It aims to improve the experience of people throughout their journey with dementia.

The principles of this joint strategy are guided by NICE guidelines, the Organisation for Economic Co-operation and Development framework for Dementia and the Dementia I-statements from the National Dementia Declaration, as well as the NHS England Well Pathway for Dementia, and similarly is divided into the following chapters: Preventing Well, Diagnosing Well, Supporting Well, Living Well and Dying Well. Consultation on the Strategy closed in September 2023. The draft document provides an update to the strategy developed in 2019, reflecting priorities for 2024-2028.

2.3.9. Other

There are also a range of other relevant local documents which include:

- Leicester, Leicestershire and Rutland Joint Carers Strategy Refresh 2022-2025[43], which establishes priorities in order to provide better support to carers locally.
- Leicestershire Dementia Joint Strategic Needs Assessment 2018-2021[44]

- Leicestershire County Council Strategic Plan 2022-2026[45] outlines the county council's vision and priorities.

3. Who is at Risk

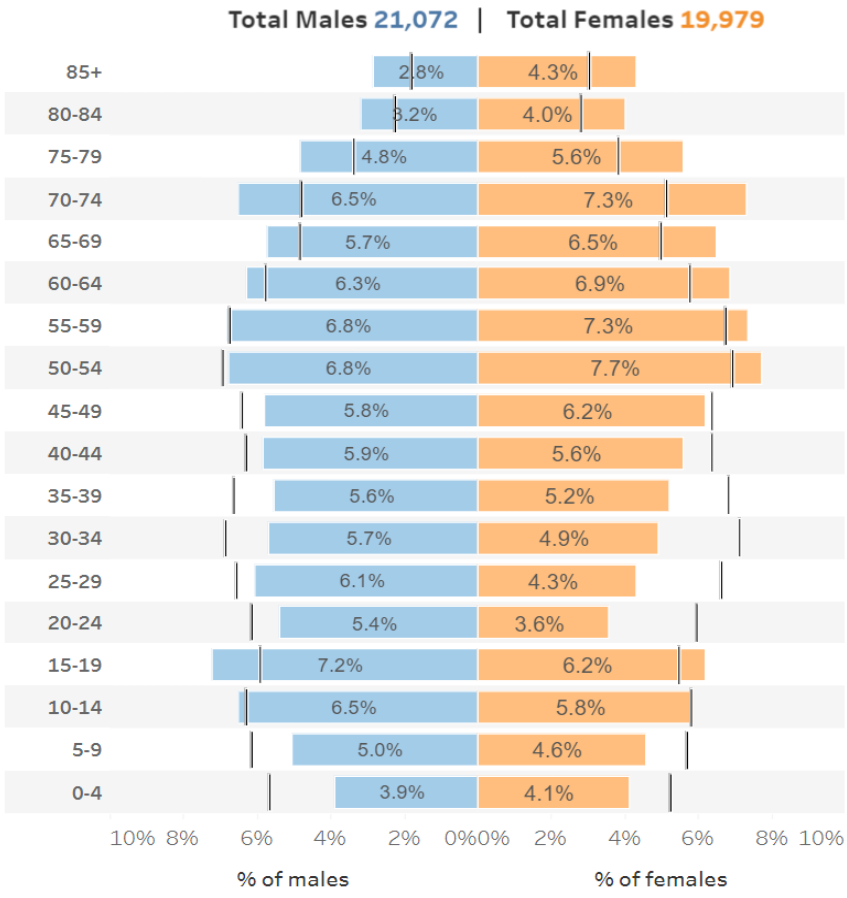
This section presents current insights into the population of Rutland, highlighting groups which may be at higher risk of mental health issues and evidence as to why this might be the case. Some important population factors, rather than specific groups, are also described.

3.1. The population of Rutland

The 2021 Census estimated the resident population of Rutland to be approximately 41,050. There were approximately 1,093 fewer females (19,979) than males (21,072). Compared to nationally, Rutland has a higher proportion of the population aged over 65 and over 85. Approximately 25.3% (10,386 people) of the population in Rutland is aged 65 and over and 3.5% (1,456 people) of the population in Rutland is aged 85 and over, compared to 18.5% and 2.4% respectively across England (Figure 1).

Figure 1. Rutland population - Census 2021

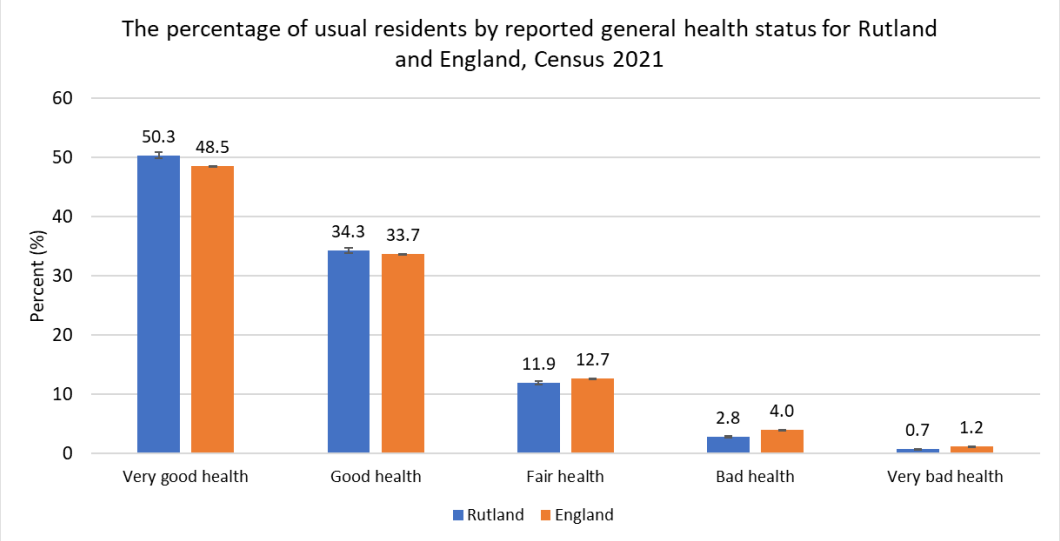
Rutland population estimate by sex and five year age band as a percentage of the population and compared to national estimates (black lines)



(Source: ONS, Census 2021)

According to the 2021 Census, a significantly larger proportion of the usual resident population in Rutland is reported to be in very good health or good health when compared to the resident population in England. A significantly smaller proportion of the resident population in Rutland is reported to be in fair health, bad health or very bad health than nationally (Figure 2).

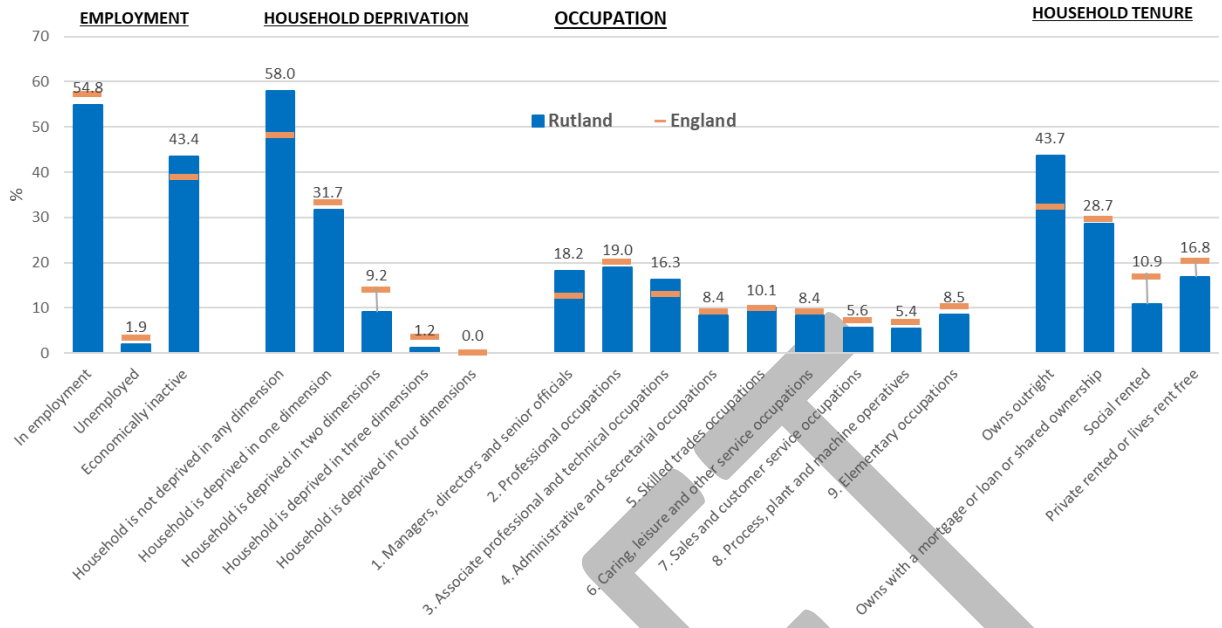
Figure 2. General health profile of Rutland resident population, Census 2021



(Source: ONS, Census 2021)

A broad socio-economic profile of Rutland's population, based on Census 2021, shows a larger proportion of households as not deprived in any dimension (58.0% vs 48.4% nationally), and a smaller proportion as deprived in one or more dimensions (household deprivation). Further, a larger proportion of Rutland households are owned outright than nationally (household tenure). Rutland residents aged 16 and over in employment are more likely to be managers, directors and senior officials or work in associate professional and technical occupations than the national average (occupation). Other indicators show a broadly similar pattern to the national average (Figure 3).

Figure 3. Summary of socio-economic indicators for Rutland and England, Census 2021

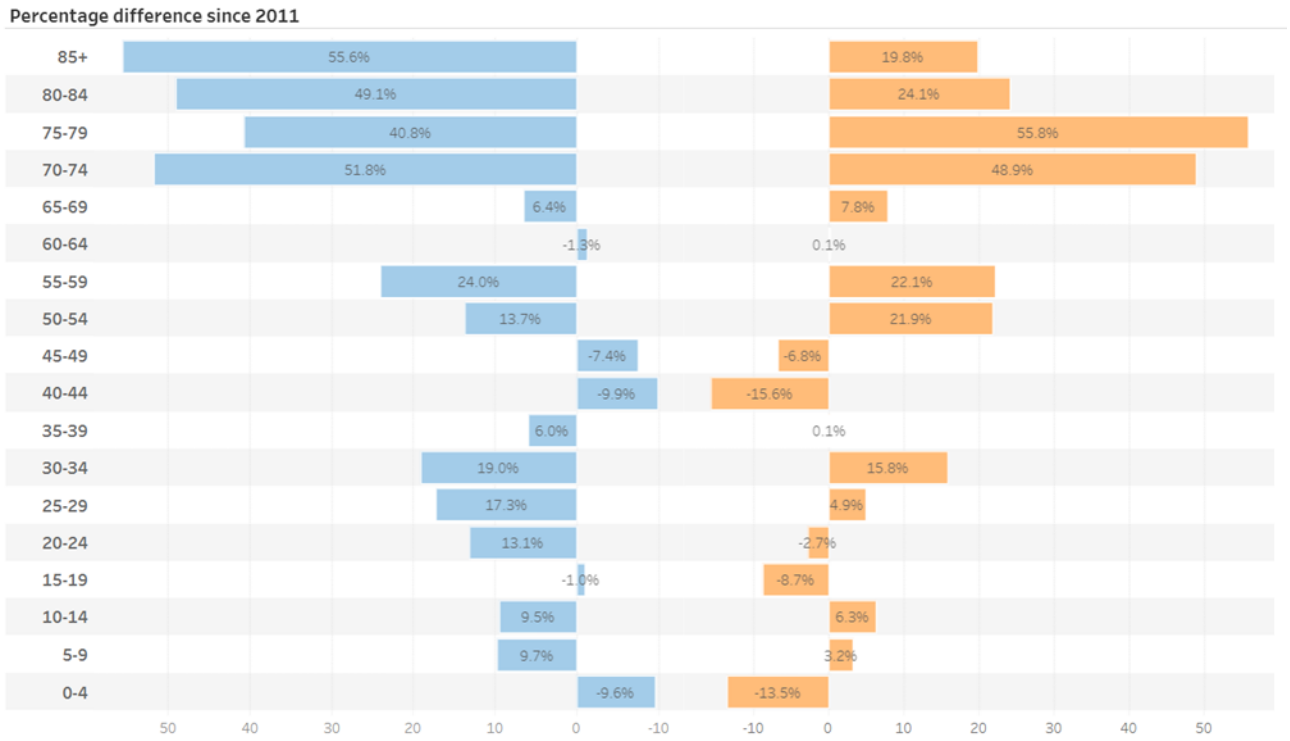


(Source: ONS, Census 2021)

Although Rutland can be described as an affluent county that performs well in terms of socio-economic and health outcomes, this average view can mask pockets of deprivation, particularly in areas where social isolation, poor access and older-age economic deprivation combine to significantly affect health in general, and mental health in particular. While socio-economic factors can contribute as much as 40% to health outcome[46], precise estimation of that impact is difficult for different populations. The general constructs such as the English Indices of Deprivation (IoD 2019[47]) are heavily skewed towards urban type of deprivation, with varied weights applied to domains such as income, employment, education/skills/training, health, crime, barriers (housing/services) and living environment. While Rutland performs well on the overall IoD 2019 score (placing within 6% least deprived local authority areas in England), and within health deprivation and disability domain (inside 5% least deprived areas), when barriers to housing and services are considered separately, Rutland places within 40% most disadvantaged local authorities across England. A much more comprehensive and nuanced description of socio-economic and health inequalities in Rutland is presented in the following JSNA chapter: https://www.lsr-online.org/uploads/rutland-health-inequalities-jsna.pdf?v=1666863138

The recent and projected changes in population age structure are likely to have significant impact on the burden of morbidity, including mental health. The population of Rutland increased by 9.8% between the 2011 and 2021 Census; this rate of increase is above the national increase of 6.6% and the East Midlands increase of 7.7%. Male population is rising at a faster rate (11.4%) compared to the female population (8.3%) since 2011. In Rutland there has been a 24.5% increase in the older population (aged 65 and over) since 2011 (Figure 4).

Figure 4. Population change in Rutland between Census 2011 and Census 2021 by five year age band and sex.

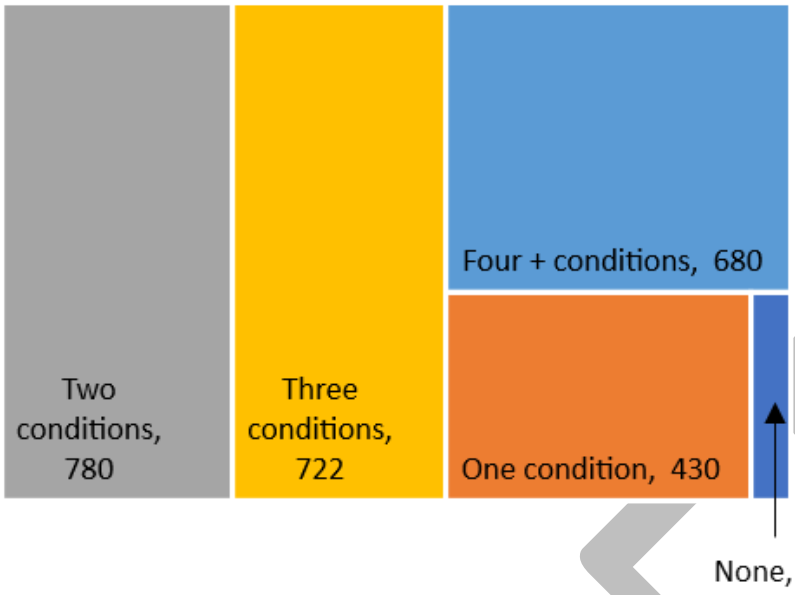


(Source: ONS, Census 2011 and Census 2021)

The population of Rutland is projected to increase by 7% in the next decade, by approximately 2,920 people (to around 44,430); this includes an increase of around 2,675 (25%) in the older population (65 and over) by 2033; the number of people aged 80 and above is projected to rise by around 1,430 (45%) by 2033. This is in comparison to the projected increase of 4% in England's population in the next decade, with a projected increase of 21% in those aged 65+ and a 35% projected increase in those aged 80+. A steeper projected rise in the older age groups in Rutland than nationally.

The population projections and current morbidity trends point toward a rise in the numbers of people with several chronic conditions (both mental and physical) in the near future[48]. This is important for planning purposes, for both health services and community care. An important factor is the increasing role of multi-morbidity – Rutland is expected to experience a rise of almost 2,200 in the older population with at least two chronic conditions (a rise of approximately 30% from current estimates) and a rise of around 680 with four or more conditions (a rise of over 40% from current estimates), within a decade (Figure 5).

Figure 5. Estimated increase (number of residents) in morbidity and multimorbidity, Rutland 2023-2033



Source: Health in 2040: projected patterns of illness in England. The Health Foundation; 2023

It is important to note that the assumptions underlying the population projections are based on current and past demographic behaviours (births, deaths and migration) and trends; with a wide level of uncertainty, they are not forecasts. International migration was at unprecedented levels in recent years and is a prime factor for that uncertainty[49] .

Further details on the demographic and economic picture of Rutland's population are available in the Rutland JSNA 2022-25 Demography and Growth chapter.

3.2. Protected Characteristics

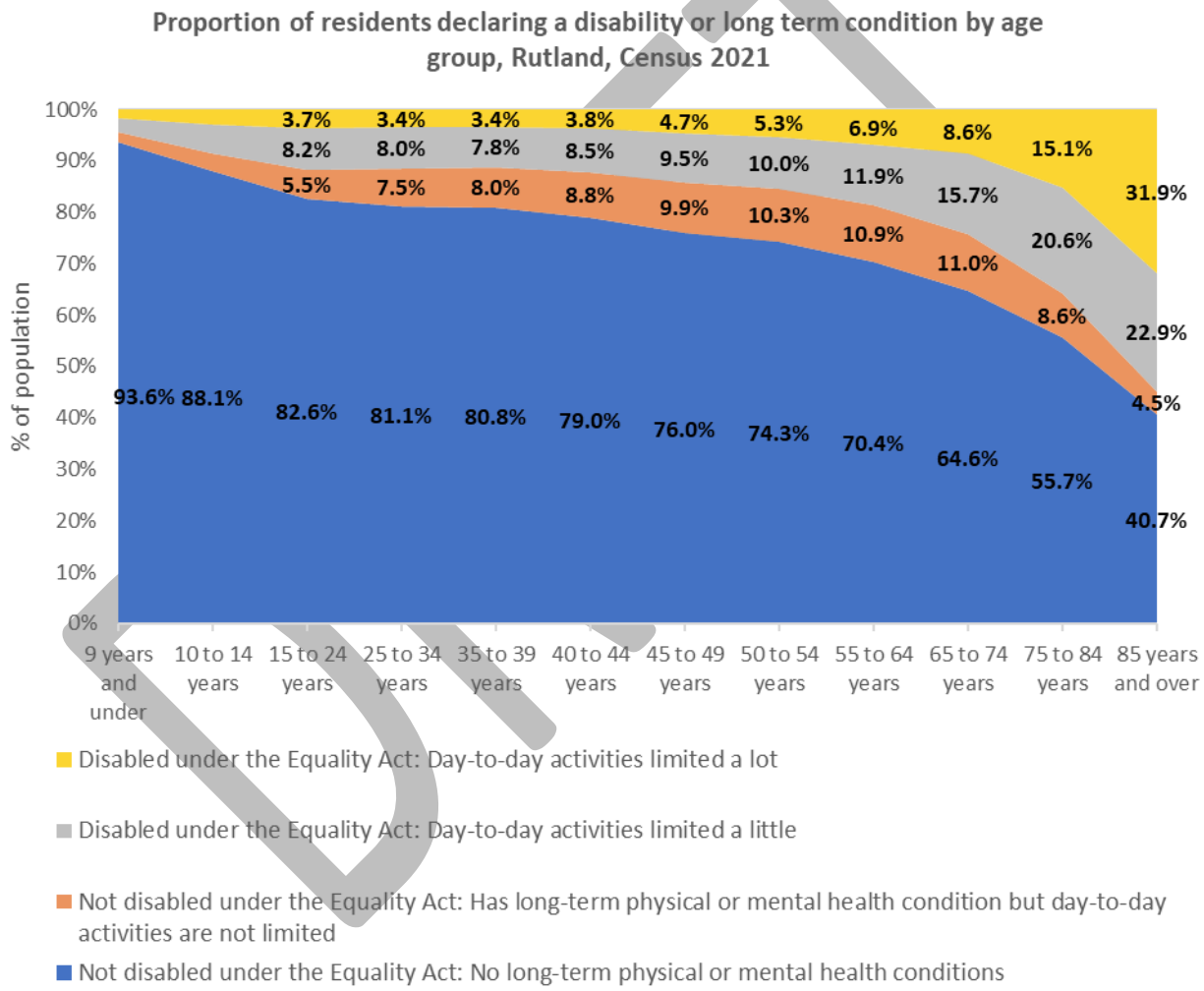
In the context of equality and discrimination law, 'populations with protected characteristics' refers to groups of individuals who are legally protected from discrimination and harassment based on specific characteristics or attributes. Equality Act 2010[50], which provides the legal framework for addressing discrimination and promoting equality in various areas of society identifies nine protected characteristics – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

The Equality Act 2010 places legal obligations on individuals, employers, service providers, educational institutions, and other organizations to promote equality and prevent discrimination based on these protected characteristics. It also establishes legal mechanisms for addressing complaints of discrimination, harassment, and victimization. By protecting individuals with these characteristics, the law aims to create a more inclusive and equitable society where everyone has the opportunity to participate fully and without discrimination in all aspects of public life.

3.2.1. Disability and chronic ill-health

In Census 2021, 15.5% of Rutland's population (N=5,808) declared that they were disabled under the Equality Act, with 5.3% (N=1,972) reporting that they are limited a lot in their daily activities. As comparison, for England these proportions were 16.9% and 7.0%. In addition, 8.9% (N=3,328) of Rutland's population, although not disabled, had a long-term physical or mental health condition, which is higher than the national average of 6.9%. These proportions are highly dependent on age, with rates of disability and chronic disease rising steeply in the older population. More than half of the over 85s are disabled in Rutland (Figure 6).

Figure 6. Disability and long-term conditions (LTC), Census 2021



(Source: ONS, Census 2021)

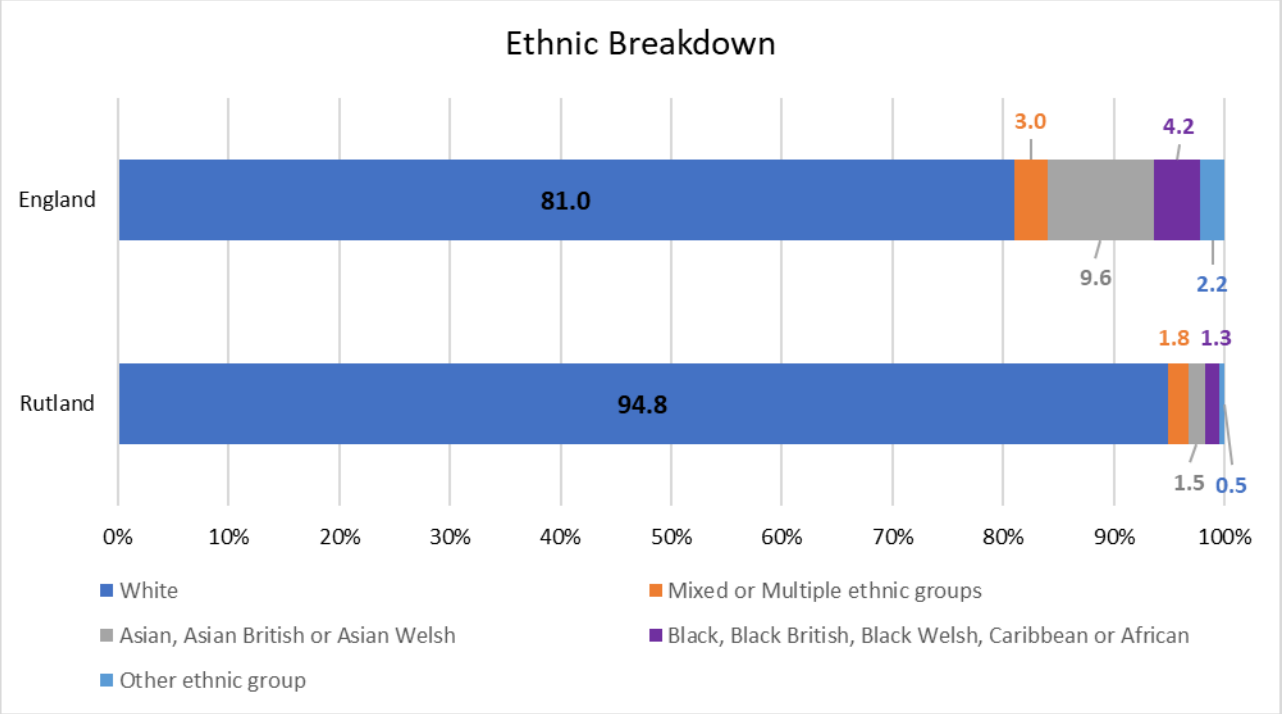
3.2.2. Ethnicity, national identity, and religion

There is evidence for higher prevalence of mental health issues in some minority ethnic groups, for example rates of schizophrenia could be 5-6 time higher in the black population and 2.5 times higher

in Asian groups[51]. Ethnic minority groups can experience barriers in access to mental health care and could remain undiagnosed.

Rutland population was in the majority of white ethnicity (94.8% vs. 81.0% nationally), the proportion of the population in Rutland which identifies with an ethnic minority group is significantly smaller than in England (5.1% vs. 19.0%). The proportion of the Rutland population which identify as white ethnicity is significantly larger than the proportion in England. The largest ethnic minority population in Rutland is Mixed or Multiple Ethnic Groups, which constitutes 1.8% of Rutland's population, followed by those of Asian descent (1.5%), the proportion of black minority (1.3%) and those identifying with other ethnic groups (0.5%) (Figure 7).

Figure 7. Ethnic profile of the population in Rutland and England, Census 2021



(Source: ONS, Census 2021)

In addition to ethnicity, religion and national identity can also play a part in mental health and wellbeing. Research indicates that there is a positive correlation between religion and mental health, possibly through positive cognitive appraisals, increased social support, healthier lifestyles and meditative practices. However, negative impacts (e.g., guilt or dependency) are also possible and such research is often criticised for biased recruitment of subjects and lack of reliable comparators from non-religious groups[52].

Christian denominations are the most predominant religion in Rutland (55.4%) as well as nationally (46.3%), a significantly larger proportion of Rutland's population report being Christian than nationally. 37.1% of Census 2021 respondents in Rutland declared themselves as having no religion,

which is not significantly different to the national average of 36.7%. The proportion of people identifying themselves as each of Muslim, Buddhist, Hindu, Sikh or Jewish is significantly lower in Rutland than nationally (Table 1).

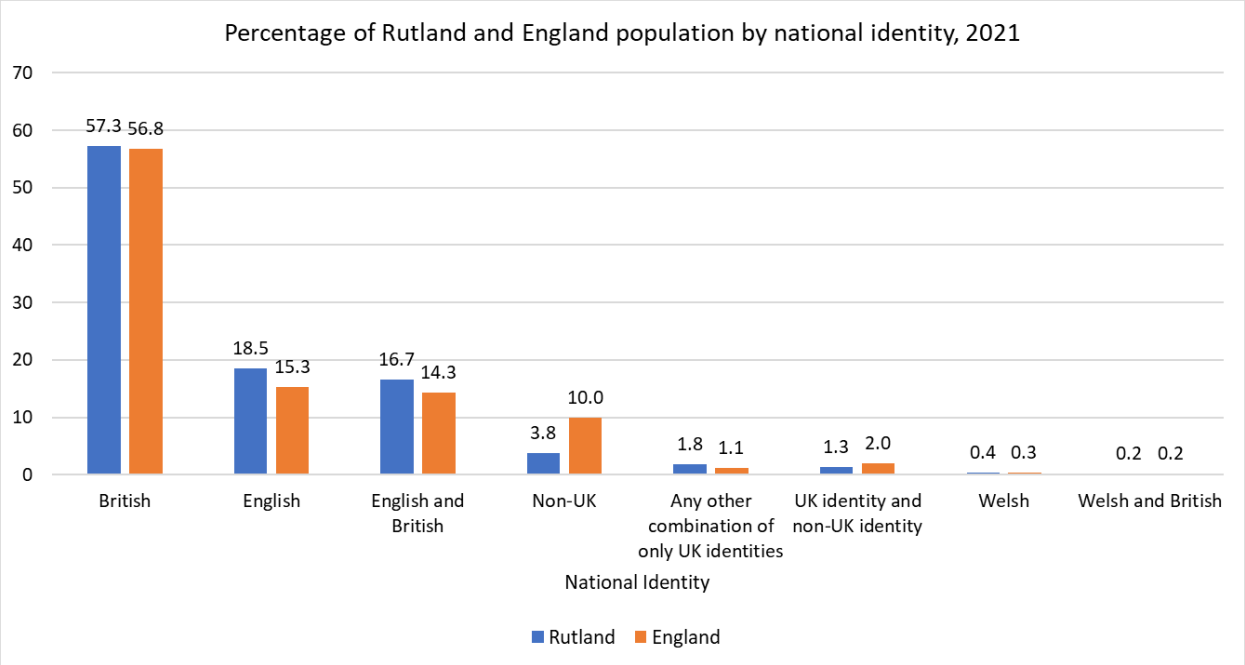
Rutland has a significantly larger proportion of the population identifying as British, English or both (92.4%) when compared to England as a whole (86.3%). Those with Non-UK identities in Rutland constitute just 3.8% of the population, a significantly smaller proportion than nationally (10.0%) (Figure 8).

Table 1. Religious breakdown of Rutland and England population, Census 2021

	Rutland		England
	Value	Percent	Percent
Total: All usual residents	41,052	100.0	100.0
Christian	22,728	55.4	46.3
No religion	15,239	37.1	36.7
Not answered	2,231	5.4	6.0
Muslim	258	0.6	6.7
Other religion	201	0.5	0.6
Buddhist	150	0.4	0.5
Hindu	125	0.3	1.8
Sikh	67	0.2	0.9
Jewish	53	0.1	0.5

(Source: ONS, Census 2021)

Figure 8. National identity of Rutland and England population



(Source: ONS, Census 2021)

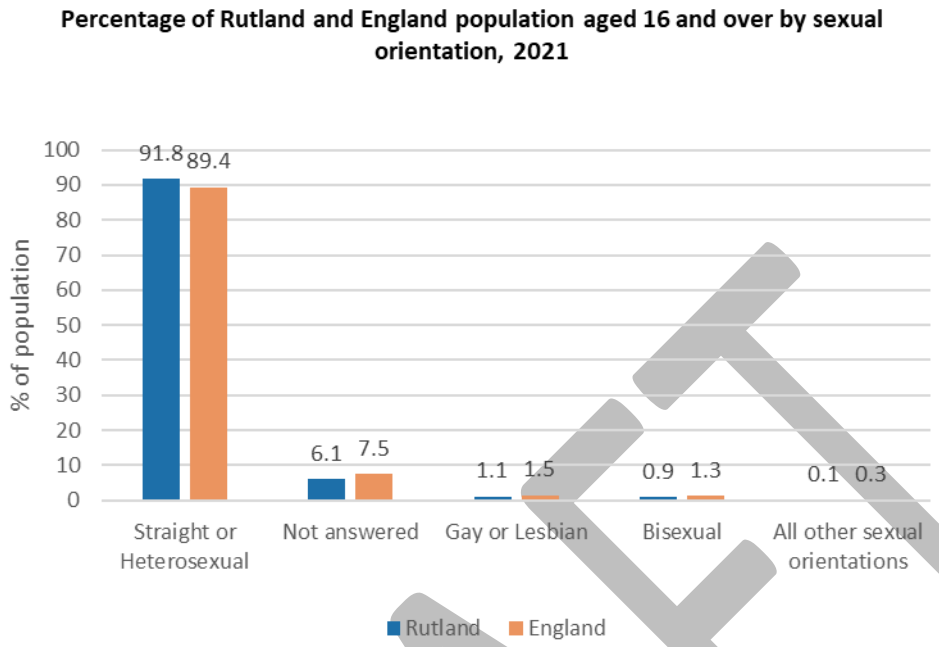
3.2.3. Sexual orientation and gender reassignment

Research shows higher risk of depression, anxiety, self-harm and suicide in LGBT+ population. Gay men have been shown to have a four-times higher risk of attempted suicide, with women more prone to suicidal thoughts and self-harm when compared to the general population[53]. The relative proportion of LGB is rising in the UK - the Annual Population Survey (2022), estimated 3.1% of the UK adult population as lesbian, gay or bisexual (LGB) in 2020, almost double the figure from 2014 (1.6%), with a similar pattern estimated for the East Midlands.

In Census 2021 a significantly smaller proportion of those aged 16 and over in Rutland declared themselves to be gay/lesbian or bisexual when compared to the national average. Of note is a significantly better response rate (only 6.1% not answered, compared to 7.5% in England) (Figure 9).

Of those aged 16 and over there was a total of around 380 gay/lesbian and 290 bisexual Rutland residents and overall 2.1% of residents aged 16 and over reported sexual orientation other than heterosexual (3.1% nationally).

Figure 9. LGBTQ population in Rutland and England



(Source: ONS, Census 2021)

In Census 2021 a total of 80* Rutland residents aged 16 and over declared that their gender was different to their sex at birth (0.2% of those aged 16 and over, compared to the 0.5% national average). This number includes 15 trans women and 20 trans men.
Other categories include 10 non-binary residents aged 16 and over and 5 in other gender identity groups.

3.2.4. Pregnancy and maternity

Pregnancy and the postpartum period can be times of significant emotional and psychological changes for women, and common mental health problems can arise during this period. Transient mood changes that occur in the days following childbirth are common and typically resolve within a few weeks. More serious and common mental health problems may include:

- Perinatal depression, a term specifically referring to depression that occurs during pregnancy or in the first year after childbirth with symptoms such as persistent sadness, low energy, changes in appetite and sleep patterns, feelings of worthlessness or guilt, and difficulty bonding with the baby.
- Perinatal anxiety disorders, such as generalized anxiety disorder (GAD) and panic disorder,

* All numbers rounded to nearest 5

which can occur in that period, involving excessive worry, restlessness, irritability, trembling or palpitations.

Personal history of mental illness, experiencing stressful life events, lack of social support, lifetime history of abuse, marital conflicts, childcare stress, chronic physical illness, preeclampsia, gestational diabetes mellitus, being exposed to second-hand smoke and sleep disturbance are among the major contributing factors to perinatal depression[54].

Other less common mental health problems include post-traumatic stress disorder (PTSD) which can follow a traumatic childbirth experience, such as a complicated delivery or medical emergency, perinatal obsessive-compulsive disorder (OCD), with obsessions often related to the baby's safety or cleanliness, leading to compulsive behaviours like excessive checking or cleaning, relatively rare but severe postpartum psychosis, characterized by hallucinations, delusions, confusion, and rapid mood swings. There is evidence that women who are forced migrants are at a particular risk of PTSD [55].

Importantly, any pre-existing severe mental illness tends to relapse in the postpartum period. Early recognition, support, and appropriate treatment are essential for managing these mental health problems during pregnancy and maternity as problems may go unrecognised and untreated due to stigma. Healthcare providers play a crucial role in assessment, diagnosis, and treatment planning, but support from family and friends, as well as community resources, are equally important in addressing mental health challenges and promoting maternal well-being.

Estimates suggest that 12% of pregnant women experience depression and 13% anxiety, rising, respectively, to 15% and 20% postpartum. Often pregnant and postpartum women experience both conditions. 1-2 per 1,000 women may develop psychosis postpartum. The mental health of mothers in the perinatal period affects foetal well-being, obstetric outcomes and the development of the child, and there are risks to using psychotropic medication[56].

Estimates presented in this section have potential caveats and were derived in 2019 from 2017/18 data by applying national estimates to local birth data.

In 2017/18 in Rutland, less than 10 women were estimated to have severe depression or PTSD in the perinatal period. Estimates suggest that in 2017/18 in Rutland there were up to 40 women with mild-moderate depression and anxiety and twice as many with adjustment disorders and distress in the perinatal period (Table 2).

Table 2. Estimated prevalence of mental health disorders in the perinatal period in Rutland, 2017/18

Indicator	Time Period	Rutland Value	CIPFA range*
Severe depressive illness in perinatal period: Estimated number of women	2017/18	8	8-118
Mild-moderate depressive illness and anxiety in perinatal period (lower and upper estimate): Estimated number of women	2017/18	27 – 40	Lower estimate: 27-393 Upper estimate: 40-589
PTSD in perinatal period: Estimated number of women	2017/18	8	8-118
Adjustment disorders and distress in perinatal period (lower and upper estimate): Estimated number of women	2017/18	40– 80	Lower estimate: 40-589 Upper estimate: 80-1,178

*Range of values for Rutland's CIPFA comparators

(Source: Office for Health Improvement and Disparities, Fingertips)

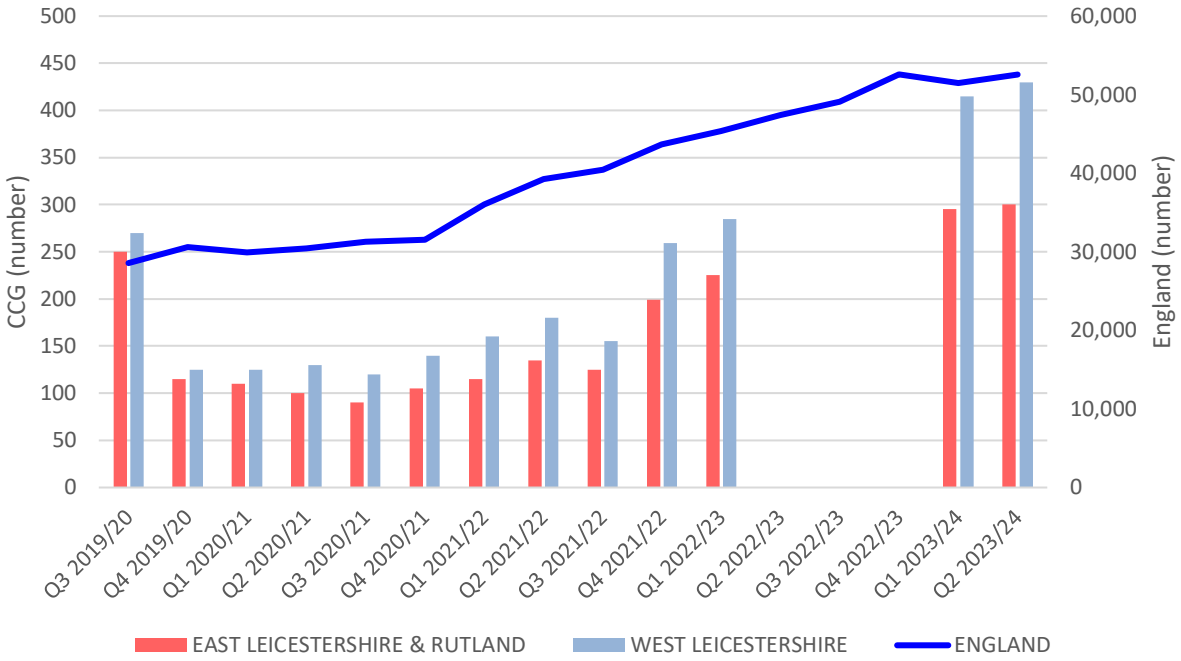
Perinatal Mental Health Services

The trends in the numbers of women accessing community perinatal mental health services have been increasing in Leicestershire and Rutland. 730 women across Leicestershire and Rutland were recorded as accessing community perinatal mental health services in quarter 2 of 2023/24 financial year - 300 in East Leicestershire and Rutland and 430 in West Leicestershire. The observed growth was similar to that observed nationally (Figure 10).

In 2022/23 the spend on this service across Leicester, Leicestershire and Rutland was over £2.55 million, with over £2.7 million planned for 2023/24 across LLR[†].

[†] *NHS England NHSMH Dashboard Q2 2023/24 (February 2024 – no financial data for sub-STP areas provided)*

Figure 10. Women accessing specialist community perinatal mental health services (trend – rolling 12 months) – Leicestershire, Rutland and England



Source: NHS Mental Health Dashboard (February 2024)

3.2.5. Marriage and partnerships

The interaction between being in a relationship (whether marriage or civil partnership) and mental wellbeing is complex, with people in poor quality relationships having worse mental health outcomes than those who are single, while good relationships are strongly linked to higher levels of mental wellbeing. The positive side includes higher level of social and emotional support, reduction in feelings of loneliness, social integration with a partner's family and their social network, lower stress levels and better mental well-being.

However, marital or partnership conflict or communication issues, can lead to increased stress, anxiety, and depression. Being in an unsatisfying or unhappy marriage or partnership can negatively impact mental health, particularly unresolved conflicts, past traumas, or unaddressed issues within the relationship can contribute to mental health challenges. Other issues impacting mental health may involve overdependence on a partner, isolation from wider social networks and loss of autonomy[57].

All of these are highly individualised, and the quality and dynamics of the relationship play a significant role in determining whether the impact is positive or negative.

In 2021, 52.2% of those aged 16 and over in Rutland were either married or in a civil partnership, significantly higher than the national average of 44.7% (Table 3). There were around 4,790 people

living alone in Rutland in 2021 - 28.7% of households were one-person households, significantly below the national average of 30.1% of households. Over half of those living alone (2,589 people) were over the age of 65.

As these are crude rates, a variety of factors are involved, such as demographics, mainly age, and deprivation.

Table 3. Population aged 16 and over by legal partnership status in Rutland and England, Census 2021

	Rutland		England	
	Count	**Percent**	**Count**	**Percent**
Total: All usual residents aged 16 and over	34,300	100.0	46,006,957	100.0
Never married and never registered a civil partnership	10,140	29.6	17,450,122	37.9
Married or in a registered civil partnership	17,891	52.2	20,561,642	44.7
Separated, but still legally married or still legally in a civil partnership	746	2.2	1,033,518	2.2
Divorced or civil partnership dissolved	3,157	9.2	4,171,639	9.1
Widowed or surviving civil partnership partner	2,366	6.9	2,790,036	6.1

(Source: ONS, Census 2021)

3.3. Education, Learning and Development

Level of education achieved can have a significant impact on mental health, and this relationship is complex and multifaceted[58]. Educational attainment is often associated with various social, economic, and psychological factors that can influence an individual's mental well-being. Higher levels of education are generally associated with greater access to financial resources through employment opportunities, healthcare, and social support. Education can open doors to a wider range of employment opportunities and higher-paying jobs. Having stable employment and financial security can reduce the stress and anxiety related to economic stability, which is a significant factor in mental health. Education can enhance cognitive skills, problem-solving abilities, and coping strategies as well as improve health literacy, enabling individuals to better understand and manage their physical and mental health.

Individuals with higher educational attainments are more likely to have better social networks, including friendships and professional relationships. These social connections can provide emotional support and reduce feelings of loneliness and isolation, which are important for mental well-being. Education can also promote greater awareness and reduce stigma surrounding mental health issues. Individuals with higher levels of education may be more open to seeking help and discussing mental health concerns. Education is associated with healthier lifestyle choices, including regular exercise, a balanced diet, and reduced rates of tobacco and alcohol use. These factors can have a positive impact on mental health. Education is considered one of the social determinants of health, including mental health[59].

Rutland's population has a higher level of educational attainment than nationally. The 2021 Census showed that 13.1% of Rutland's population aged 16 and over had no qualifications and 8.6% had level 1 and entry level qualifications, both values are significantly lower than the England average (18.1% and 9.7% respectively). The proportion of Rutland's population that had level 2 qualifications (15.4%), an apprenticeship (5.6%) and level 4 qualifications or above (37.9%) was significantly larger than the proportion of England's population (13.3%, 5.3% and 33.9% respectively). The proportion of Rutland's population that had level 3 qualifications (17.0%) was not significantly different to the national figure (16.9%).

3.4. Social Media

Social media can also have various effects on mental health, both positive and negative - effects that can vary widely from person to person and depend on individual usage patterns and experiences. The positive effects may include enabling social connections, information and awareness regarding mental health issues or reduction of stigma, providing a platform for self-expression and creativity, and support groups on social media platforms where individuals with shared experiences can connect, share advice, and provide mutual support[60].

However, there are several potential negative effects, such as online harassment and cyberbullying, negative social comparison, or addiction-like behaviours which interfere with daily life activities.

The resulting problems may include feelings of inadequacy, low self-esteem, procrastination, reduced productivity, all the way to severe psychological consequences, including anxiety, depression, and feelings of isolation.

Concerns about privacy, data security, and the potential for information to be misused on social media platforms can lead to anxiety and mistrust. Seeing updates and activities of others can lead to a fear of missing out (FOMO) on experiences, which can induce stress and anxiety.

Social media algorithms can create echo chambers where individuals are exposed to information and opinions that align with their existing beliefs, potentially leading to polarization and reinforcing biased views[61].

Exposure to negative news in the standard media can also lead to increased anxiety and stress, particularly in times of political change, economic downturn, or global adversities. Sensational or graphic reporting in particular can lead to distorted perception of risk and safety, while repeated reporting of distressing news can lead to 'compassion fatigue'. Although less of a problem than in social media, standard news outlets can also contribute to the polarisation or radicalisation of opinions. On the positive side, media can provide useful educational content, lead to a sense of engagement with community and the wider society[62].

3.5. Lifestyle

Lifestyle plays a crucial role in mental health, and the choices individuals make in their daily lives can significantly impact their psychological well-being. While positive lifestyle choices can promote good mental health, unhealthy behaviours can contribute to mental health challenges. Positive behaviours include regular physical activity, healthy diet, adequate sleep, stress management, maintaining healthy social relationships and a strong support network, and engaging in meaningful activities that provide a sense of purpose can boost self-esteem, promote happiness, and reduce the risk of depression.

Conversely, unhealthy lifestyle choices that have been shown to effect poor mental health include sedentary lifestyles (lack of physical activity and prolonged periods of sedentary behaviour have been associated with an increased risk of depression and anxiety), poor diet, high in processed foods, chronic sleep deprivation or poor sleep quality can impair cognitive function, mood regulation, and overall mental well-being, prolonged exposure to chronic stress without effective coping mechanisms can lead to the development of anxiety and depression. Lack of social connections and feelings of loneliness can have a detrimental impact on mental health and increase the risk of depression and anxiety, substance misuse, including excessive alcohol consumption and drug addiction, can worsen existing mental health issues and increase the risk of developing new ones. Engaging in negative coping strategies, such as avoidance, self-medicating with substances, or engaging in risky behaviours, can exacerbate mental health problems[63].

It is important to recognize that mental health is influenced by a combination of genetic, environmental, and lifestyle factors. While lifestyle choices can significantly impact mental well-being, mental health disorders are complex, and individuals may require professional help and support to address their mental health needs.

3.6. Employment

Employment provides not only financial security but also a sense of purpose, social connections, and opportunities for personal growth, while involuntary unemployment is likely to have significant negative impacts on an individual's mental health.

Various aspects of the work environment can influence mental well-being positively or negatively. Employment generally provides a source of income, which can reduce financial stress, and often a sense of purpose and meaning in life. It can enable the development of social connections, enhancing emotional support and reducing feelings of isolation. It can provide routine and structure to daily activities, leading to a sense of stability and predictability. Employment can also offer opportunities for skill development and personal growth, contributing to a positive self-concept and mental well-being.

However, the negative impacts may include work-related stress, which can lead to mental health

issues such as anxiety, depression, and burnout. Workplace bullying, harassment, discrimination, or toxic work environments can have a detrimental impact on mental health and well-being. Imbalanced work-life schedule or excessive overtime can both contribute to exhaustion, stress, and mental health problems. Job insecurity, such as temporary employment or frequent layoffs, can lead to anxiety and uncertainty about the future. Lack of autonomy or control of one's job can be stressful and negatively affect mental health. Jobs that are unfulfilling or do not align with an individual's interests and values can lead to dissatisfaction and unhappiness. Irregular or rotating shift work can disrupt sleep patterns and contribute to sleep disorders, which can negatively impact mental health.

The impact of employment on mental health varies from person to person and is influenced by individual factors, job characteristics, and work environments. Employers can play a significant role in promoting mental well-being by creating supportive work environments, offering employee assistance programs, and addressing issues related to workplace stress and mental health stigma.

Further discussion of employment is provided in section 5.2 which notes the impact of wider economic factors on mental health in Rutland.

3.7. Rurality

Living in rural areas, can have a significant impact on mental health. Whether these effects are predominantly positive or negative can vary depending on individual factors, such as access to resources, and the specific challenges and opportunities that rural living presents.

Potentially positive effects include strong communities with supportive social networks, access to natural settings and outdoor activities, resulting in reduced stress, improved mood, and enhanced well-being, and a more relaxed pace of life compared to urban areas.

However, there are also significant risks to mental health resulting from limited access to healthcare facilities, including mental health services. This can result in delayed or inadequate mental health care. Smaller communities can sometimes lead to concerns about privacy and stigma surrounding mental health issues. At an individual level, the experience of social isolation can a be a significant contributory factor to feelings of loneliness and depression, especially among older adults.

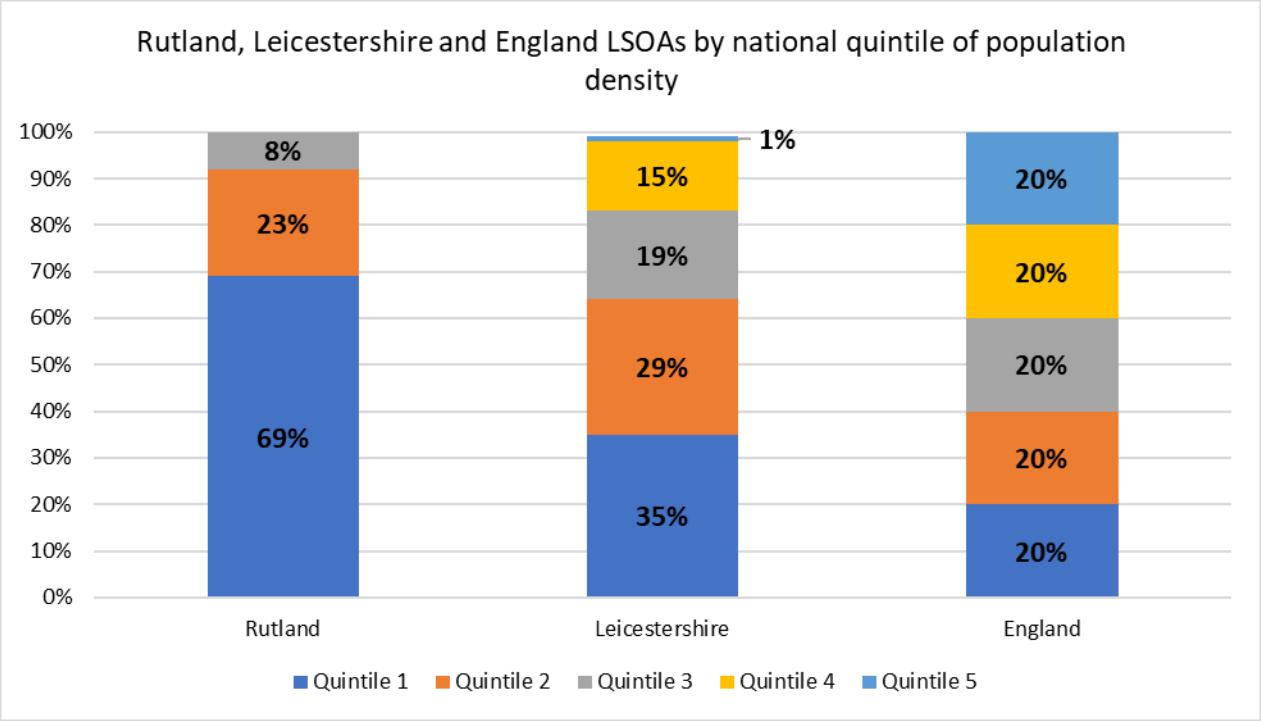
For the younger adults, rural areas may have fewer job opportunities, lower wages, and limited career options, impacting negatively on mental health, compounded by poor public transport and long travel distances to essential services. Rural areas may have limited access to high-speed internet and digital technologies. This can affect individuals' ability to access online mental health resources and telehealth services.

It is important to note that the impact of rurality on mental health is not uniform and can vary widely based on individual circumstances and the specific rural community in question. Addressing the mental health needs of rural communities requires a comprehensive, multidisciplinary approach

that considers the unique challenges and strengths of rural living.

As currently available urban-rural classification is based on Census 2011, population density from Census 2021 is presented here as a more recent proxy (Figure 11). Over two thirds of Rutland's Lower Layer Super Output Areas (LSOAs) (69%) are in the lowest national quintile by population density (less than 872 usual residents per square kilometre), with no LSOAs in Rutland in the second highest or the highest quintile.

Figure 11. Rutland, Leicestershire and England LSOAs by national quintile of population density, Census 2021



Quintile 1: lowest national quintile of population density (less than 872 usual residents per square kilometre) to quintile 5: highest national quintile of population density (over 6,658 usual residents per square kilometre)

Source: ONS, Census 2021

A comprehensive assessment of rural health inequalities in Rutland is provided in the following JSNA chapter: https://www.lsr-online.org/uploads/rutland-health-inequalities-jsna.pdf?v=1666863138

3.8. Loneliness

Loneliness is a complex emotional state that arises when individuals perceive a gap between their desired and actual social connections. It can affect people of all ages and backgrounds, and is closely associated with symptoms of depression, anxiety, and low self-esteem. Individuals who are lonely may be more prone to developing clinical depression, generalized anxiety disorder and social

anxiety.

Chronic loneliness can contribute to elevated stress levels. The stress response, when activated over extended periods, can negatively impact physical and mental health, potentially leading to conditions such as cardiovascular disease and immune system dysfunction. Loneliness has been associated with inflammation, compromised immune function, cardiovascular problems, a higher risk of chronic diseases, cognitive decline and impairments in attention, memory, and problem-solving. It can disrupt sleep patterns, leading to difficulties falling asleep or staying asleep, with further consequences on individual's mental health.

Some individuals may turn to alcohol or drugs as a way to cope with the emotional pain of loneliness, leading to substance use disorders and addiction.

Loneliness is a known risk factor for the development or exacerbation of various mental health disorders, including mood disorders (depression and bipolar disorder), anxiety disorders, and psychotic disorders. Persistent loneliness can be a significant risk factor for suicidal thoughts and behaviours.

Addressing loneliness and nurturing social connections is essential for maintaining good mental health and overall well-being.

According to the Active Lives Adult Survey (Sport England), in 2019/20 24.77% of adults (aged 16 and over) responded 'Always or often' or 'Some of the time' to the question 'How often do you feel lonely'. This was not significantly different to the national figure of 22.26%.

3.9. Other Groups at Risk

This section describes other groups potentially at higher risk of mental ill health.

Many sub-groups of the population are missed in the general statistics but can be at a much higher risk of mental ill-health with specific vulnerabilities and combinations of common or group-specific risk factors. A substantial proportion of people in prison experience depression, anxiety, self-harm or attempt suicide. Victims of crime also have higher risk of developing mental health problems. Other groups include the homeless, migrants, adult social care users, armed forces personnel and their families.

3.9.1. Prison population

The experience of being in prison, along with the factors leading up to incarceration, can affect individuals in various ways, both psychologically and emotionally. Individuals with pre-existing mental health conditions may find it challenging to access the necessary treatment and support within prison.

Prisoners have an increased risk of mental health conditions including depression, due to the harsh and restrictive environment of prisons, loss of freedom and separation, and anxiety as result of the

stress of incarceration, concerns about safety, violence, and the uncertainty of the future. This includes acute anxiety or panic attacks. Other common problems include post-traumatic stress disorder (PTSD) and substance misuse; both drug and alcohol abuse are prevalent in prison populations and incarceration may exacerbate pre-existing substance use disorders or lead to their development[64].

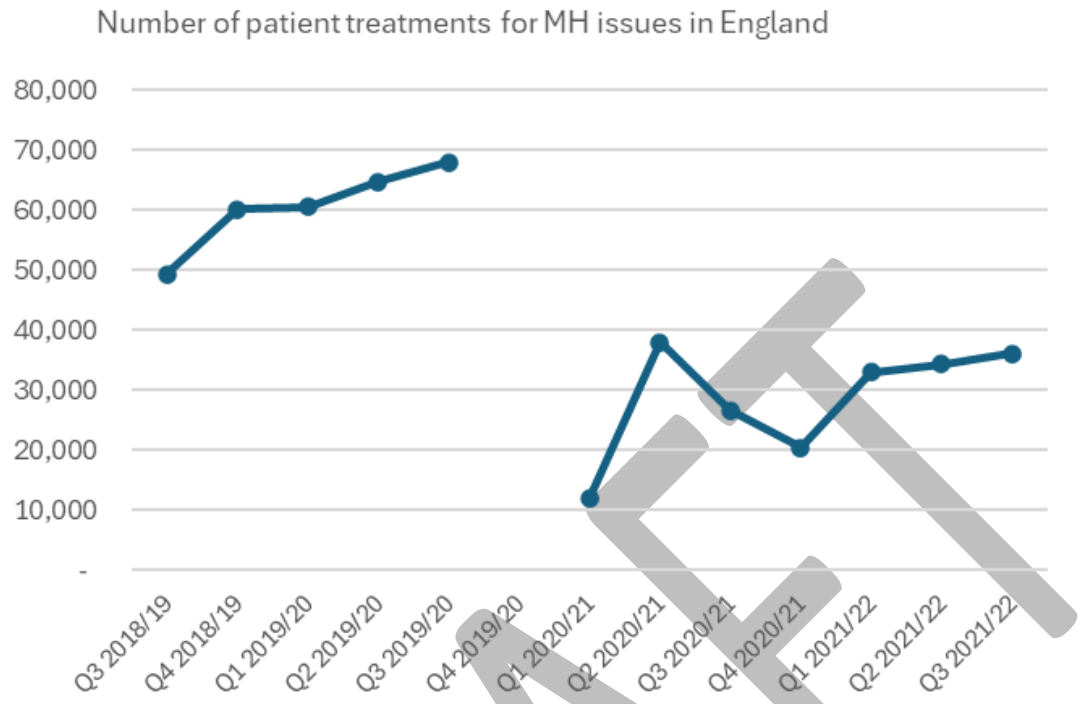
Imprisonment often results in social isolation and separation, loneliness and feelings of abandonment, stigma associated with being in prison, feelings of shame and low self-esteem, loss of personal freedom and autonomy and the resulting distress. In some prison environments, violence and victimization can be common, leading to increased stress, fear, and trauma among inmates. After release, individuals may face difficulties reintegrating into society. Some prisons offer limited access to mental health care[65].

It is important to note that the impact of imprisonment on mental health can vary widely based on individual factors, the conditions of incarceration, and the availability of mental health support within the prison system. Efforts to improve mental health care within the prison system and support for individuals both during and after their incarceration are critical steps in mitigating the negative effects of imprisonment on mental health.

The recent (2023) *Survey of Prison Mental Health Services in England*[66], based on a sample of over 7,700 people representing 14% of the prison and Youth Offender Institution (YOI) population offers some estimates of the prevalence of mental health problems in that population. The most common diagnoses were anxiety and/or depression, and talking therapies were the most commonly offered main intervention. A diagnosis of personality disorder was the third most commonly presented problem (over 17% nationally). Attention deficit hyperactivity disorder accounted for nearly 9% of primary presented problems nationally, and post-traumatic stress disorder and other trauma diagnoses accounted for 8%.

In England in 2021 there were nearly 124 thousand treatment episodes for mental health issues for the adult prison population (excluding assessments), although rates were much higher prior to the COVID-19 pandemic (Figure 12).

Figure 12. Quarterly figures for mental health treatment in the prison population in England before and after the COVID-19 pandemic



(Source: NHS England NHSMH Dashboard Q3 2022/23)

There are four prisons for men within Leicester, Leicestershire and Rutland. Leicester prison has an in-use uncrowded capacity (or Certified Normal Accommodation, CNA) of 212 and had a population of 324 in June 2023 (153% of the in-use CNA). Gartree prison in Market Harborough in Leicestershire has an in-use CNA of 621 and a population of 593 in June 2023 (95% of the in-use CNA). Stocken prison in Stretton in Rutland has an in-use CNA of 964 and a population of 1,055 in June 2023 (109% of the in-use CNA). In addition, HMP Fosse Way, a new Category C prison in Leicester received its first prisoners on 29 of May 2023. Fosse Way has a planned capacity of 1,930 male inmates. In June 2023 it had an in-use CNA of 301 and a population of 123 (41% of the in-use CNA).[67] Female prisoners are generally sent to Peterborough prison.

The report on an unannounced inspection of HMP Stocken Prison by HM Chief Inspector of Prisons 16-27 January 2023 suggested that around 85 prisoners were referred for mental health assessment each month[68].

3.9.2. Migrant population and traveller communities

Migrant populations, including refugees, asylum seekers, immigrants, and displaced individuals, often face unique mental health challenges due to the complex and stressful nature of migration. These challenges can result from pre-migration experiences, the migration journey itself, and post-

migration settlement conditions. Mental health issues in migrant populations can manifest in various ways and may include trauma and post-traumatic stress disorder (PTSD) as a result of events in their home countries, such as conflict, violence, persecution, or natural disasters. Migrant populations are at higher risk of depression and/or anxiety due to the stressors associated with migration, language barriers, cultural adjustment, discrimination, and uncertainty about legal status[69].

The process of adapting to a new culture and society can be stressful. Migrants may grapple with issues related to identity, discrimination, and navigating unfamiliar social norms and systems, they may experience social isolation and loneliness due to language barriers, limited social networks, and the absence of familiar support systems. The challenges of finding housing, employment, and access to healthcare in the host country can be overwhelming for migrants, contributing to stress and mental health difficulties. Limited proficiency in the host country's language can hinder communication, access to services, and social integration, which may exacerbate mental health issues. Experiences of discrimination and racism can negatively impact mental health, leading to feelings of injustice, anger, and reduced self-esteem[70]. However, it is essential to recognize that not all migrants will experience mental health issues.

International migration is an important driver of population change. The usual resident population in England and Wales grew by more than 2.0 million because of positive net migration since 2011.

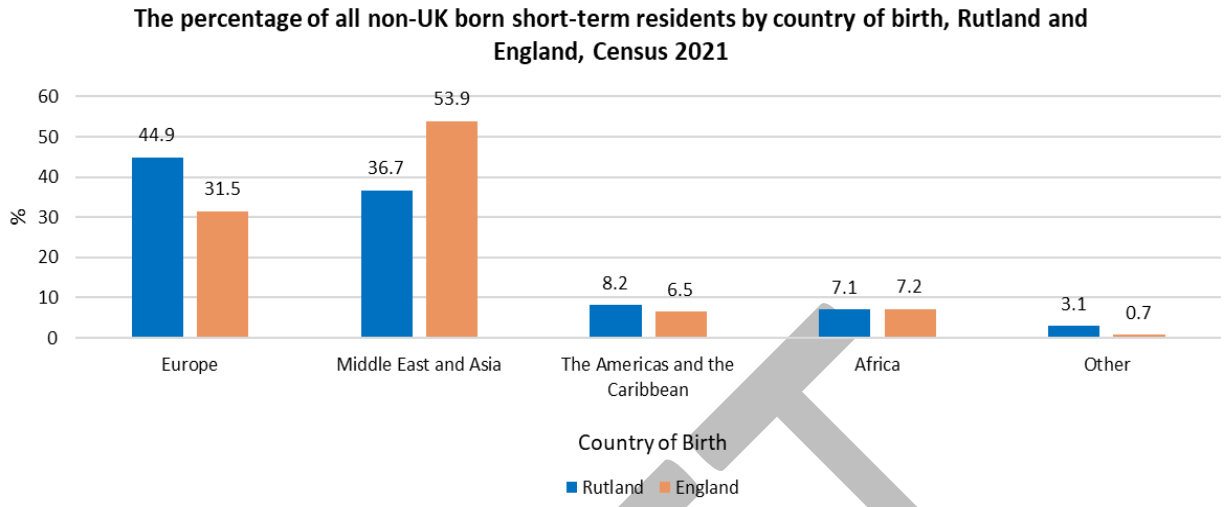
Subgroups regarded as vulnerable include asylum seekers, refugees, and those trafficked for forced labour or sexual exploitation, although these may be a minority in terms of numbers.

There were 98 non-UK born short-term residents across Rutland recorded in Census 2021.

In Rutland almost half (44.9%, N=44) of non-UK born short-term residents were of European descent, 32.7% from countries which were part of the EU in 2001 – including 24.5% from Germany. In Rutland 36.7% of non-UK born short-term residents were born in the Middle East and Asia, almost a third (29.6%) recorded Eastern Asia as their place of birth - including 19.4% from China and 8.2% from Hong Kong.

According to the 2021 Census, the proportion of non-UK born short-term residents in Rutland that were born in the Middle East and Asia was significantly smaller than the proportion in England (36.7% and 53.9% respectively), whilst the proportion born in Europe was significantly larger in Rutland than in England (44.9% and 31.5% respectively) (Figure 13).

Figure 13. Non-UK born short-term residents by country of birth



(Source: ONS, Census 2021)

Traveller communities are identified as a vulnerable population for a number of socioeconomic and health reasons such as barriers to employment and high levels of unemployment[71], which is recorded for almost a third of all adults in those communities (women are at particular risk of unemployment), lower that national average educational attainment, lower level of homeownership, with a quarter of accommodation being caravans or other mobile homes (vs 0.3% nationally), high levels of perceived discrimination (community and service providers), barriers to accessing healthcare and other services, delayed healthcare seeking and poorer health outcomes.

Census 2021 data shows that a total of 55 Rutland residents identify as Gypsy or Irish Traveller and 18 identify as Roma. The proportion of Rutland residents identifying as Gypsy or Irish Traveller at the time of the 2021 Census (0.13%) was significantly larger than the proportion in the East Midlands (0.09%). The proportion of Rutland residents identifying as Roma at the time of the 2021 Census (0.04%) was significantly smaller than the proportion in the East Midlands (0.15%) and the proportion in England (0.18%) (Table 4).

Table 4. Traveller population of Rutland, Census 2021

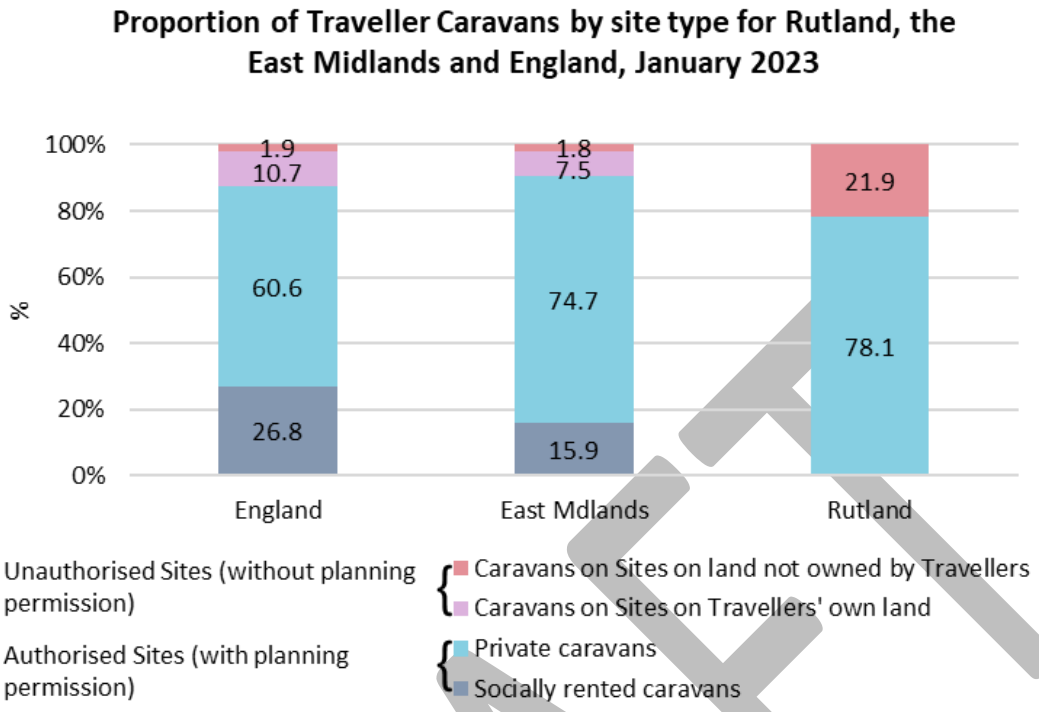
Area	Total	Gypsy or Irish Traveller		Roma	
	Population	Number	%	Number	%
England	56,490,070	60,073	0.11	99,138	0.18
East Midlands	4,880,047	4,160	0.09	7,196	0.15
Rutland	41,048	55	0.13	18	0.04

(Source: ONS, Census 2021)

The latest biannual count of traveller caravans in England (January 2023) reports 32 traveller caravans across Rutland.

Compared to the national average, a significantly larger proportion of traveller caravans were private caravans on authorised sites in Rutland (78.1% vs 60.6% nationally). The proportion of traveller caravans which were private caravans on authorised sites in Rutland was not significantly different to the regional average of 74.7%. In Rutland there were no socially rented caravans on authorised sites. A significantly larger proportion of traveller caravans in Rutland (21.9%), than nationally (1.9%) or regionally (1.8%), were caravans on unauthorised sites on land not owned by travellers (Figure 14).

Figure 14. Traveller caravans by site type for Rutland, the East Midlands and England, January 2023



(Source: Department for Levelling Up, Housing and Communities 2023)

3.9.3. Crime

The relationship between crime rates and mental health of individuals is complex, multifactorial and bidirectional. On one hand, mental health of an individual can have an impact on their possible criminal behaviour, on the other, exposure to levels of local crime can affect the mental health of individuals[72].

Effects of crime on mental health vary depending on factors such as the type of crime, the frequency of crime in a community, individual vulnerabilities, and the availability of support systems. Some of the important factors, at individual and population levels include victimisation, fear and anxiety, community-level trauma, disruption of social networks or stigmatisation, leading to a sense of injustice, anger, and negative impacts on mental health. Homicides and other violent crimes can lead to profound grief and loss within communities. Communities with high crime rates may also experience higher rates of drug and alcohol abuse, which can exacerbate mental health issues[73].

Police officers, emergency responders, and healthcare professionals who frequently deal with crime scenes and victims can experience significant psychological stress, leading to conditions like PTSD and depression[74].

It is important to note that individuals diagnosed with a mental health disorder are accountable for a fraction of violent offenders (1%) and are responsible for only a small percentage of societal violence and criminal behaviour (5%), on the contrary, they are more likely to be the victims of

crime, being more vulnerable through impaired judgement, coping skills or social isolation. Exception are individuals with severe mental illness, namely schizophrenia and bipolar disorder, particularly people with triple morbidity (severe mental illness, substance use disorder and antisocial personality disorder) who are substantially more likely to be violent than people with severe mental illness alone[75]. Despite this, persistent stereotypes continue to exist which often associates mental health disorders with criminal and violent behaviour; an image that is frequently reinforced through mass media outlets. Important factors include socio-economic, poverty, lack of education or employment opportunities, homelessness, substance misuse, rates of incarceration and access to mental health care.

The indirect costs of crime are likely to be much higher than the direct costs, although any intangible impacts (including anxiety and mental distress) are particularly difficult to measure or estimate. A 2012 study based on English survey data (British Household Survey Panel, BHPS, and English Longitudinal Study of Ageing, ELSA) found that crime caused considerable mental distress of residents, mainly driven by property crime, but also, at an individual level, by violent crime. Local crime appeared to create more distress for females and is mainly related to depression and anxiety[76].

It is important to monitor local rates as crime is not randomly distributed and is most commonly linked to high levels of deprivation and social disorganisation[77].

National and Police Force Area crime rates

There are two primary offence groups: victim-based crimes and other crimes against society. Victim-based crimes are those with a specific identifiable victim. All Crime Survey for England and Wales (CSEW) crime is victim based, as it is derived from a survey of people's experiences of crime and must have a victim for it to be recorded.

Police recorded crime includes both victim-based and other crimes that do not normally have a direct victim, referred to as "other crimes against society". Victim-based crimes include violence against the person (VAP), sexual offences, including rape, robbery, theft offences, and criminal damage and arson. Other crimes against society include drug offences, possession of weapon offences, public order offences and miscellaneous crimes against society.

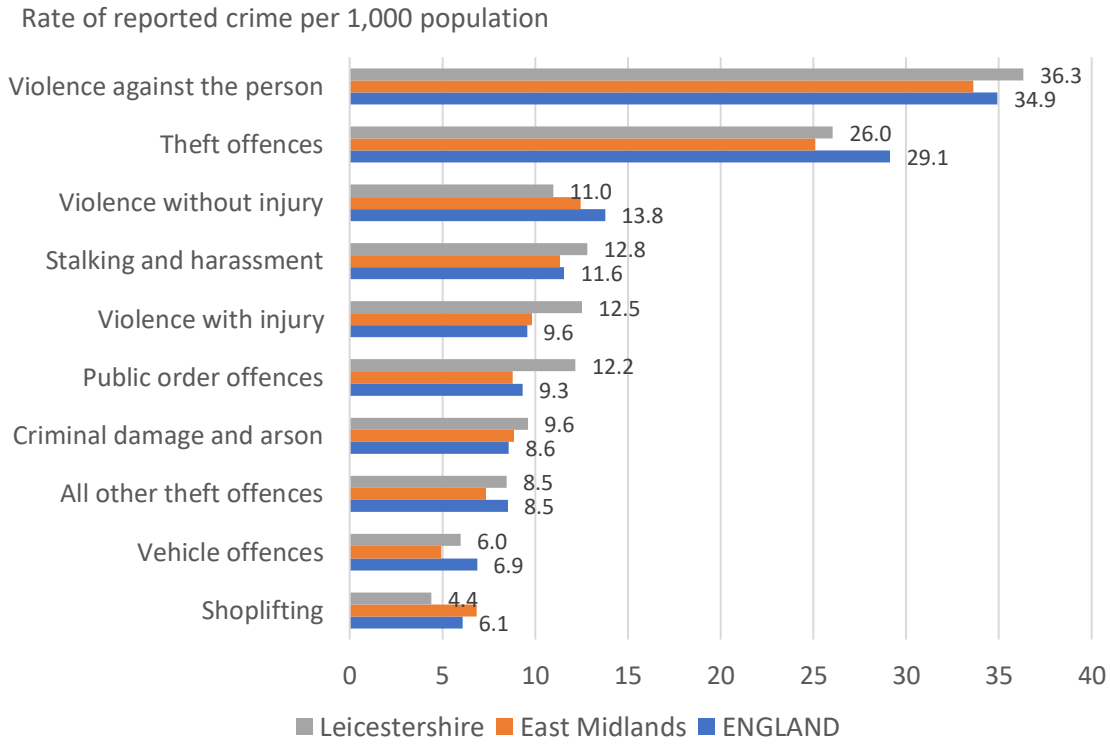
It is important to stress that these are not additive, as some events can be reported under more than one category.

Figure 15 presents the published comparative crime rates for police areas for year ending June 2023 for Leicestershire, East Midlands and England[78].

In the latest nationally reported year, the total crime rate for Leicestershire police force area (including Leicester, Leicestershire and Rutland) was 94.4 per 1,000 residents, compared to

England's 92.5 per 1,000 residents and 86.4 per 1,000 residents for the East Midlands. The most common type of crime in England was violence against the person (VAP, 35 per 1,000 residents), closely followed by theft offences (29 per 1,000 residents). Violence without injury constituted 14 per 1,000 residents, stalking and harassment nearly 12 per 1,000 residents and violence with injury nearly 10 per 1,000 residents. While the local (LLR) rates of theft offences (26 per 1,000 residents) and violence without injury (11 per 1,000 residents) were lower than national, the VAP rate was slightly higher (36 per 1,000 residents), as were stalking and harassment and violence with injury (both at 13 per 1,000 residents). It is important to stress that these are not additive, as some events can be reported under more than one category.

Figure 15. Police force area crime rates for Leicestershire, East Midlands and England- year ending June 2023



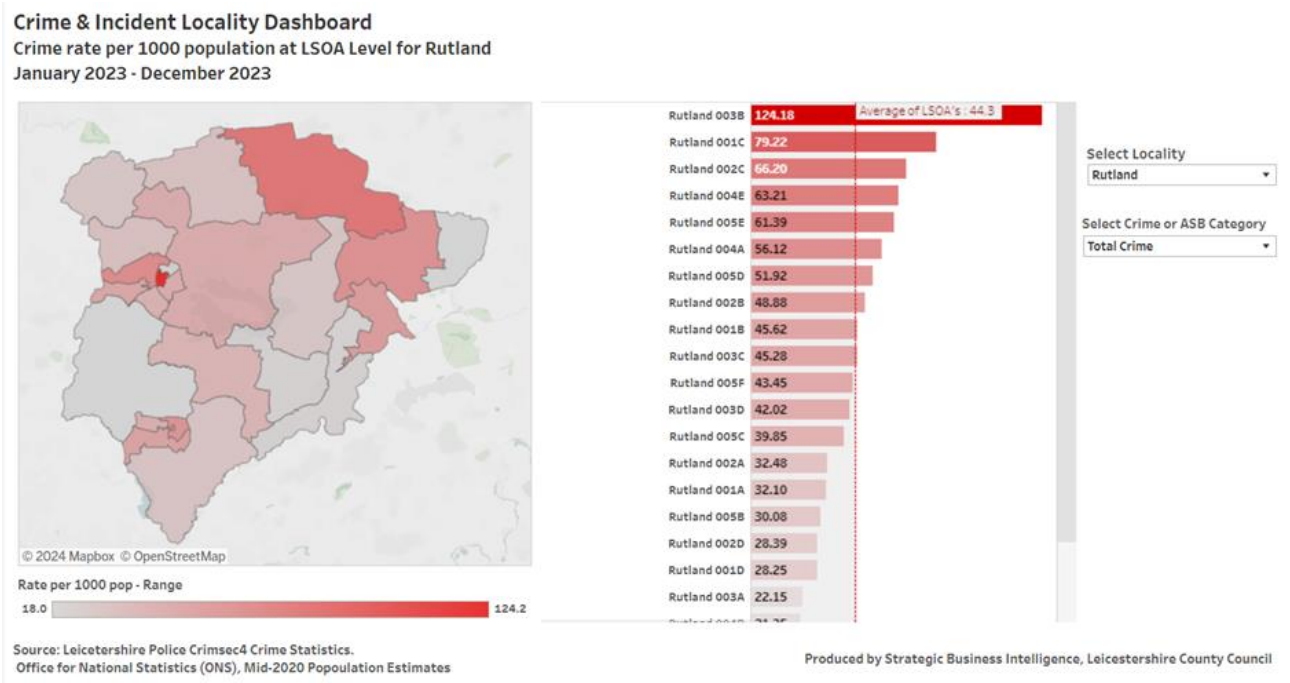
(Source: ONS 2023)

Crime rates in Rutland

Territorial police forces of England and Wales report crime and outcomes data on a monthly basis as a cumulative year-to-date aggregate (*Crimsec4* form). This system allows for a more up-to-date and granular look at the local rates. It is important to stress that this system records the outcome rather than where and when the original offence occurred, and as such the rates reflect police activity rather than the actual crime rate. Furthermore, all figures can be subject to revisions and, particularly for drug offences, time trends have to be treated with caution.

In Rutland in the year between January 2023 and December 2023 there were approximately 1,800 incidents of crime or anti-social behaviour (ASB) recorded (a rise from around 1,445 four years ago in January 2020 to December 2020). This equates to around 44.5 incidents per 1,000 residents in 2023, however local LSOA rates vary, between 124.18 (Rutland 003B - Oakham North East) and 18.02 (Rutland 004D - Ryhall and Casterton) per 1,000 (Figure 16).

Figure 16. Variation in reported crime rate across Rutland by LSOA, January to December 2023



(Source: Leicestershire County Council Crime Dashboard, 2023 – Leicestershire Police Crimsec4 Statistics, ONS Mid-2020 population estimates)

Table 5 presents the rates across Rutland using categories best matched to the national and regional averages presented in the previous section. This was derived to provide some comparison to the national data from the ONS data (presented in Figure 15). It shows that VAP rates for Rutland County (rather than LLR total) were lower than national (17 per 1,000 vs 35 per 1,000), as was the rate of public order offences (5.2 per 1,000 residents vs 9.3 per 1,000 residents) and the rate of violence with injury (6.1 per 1,000 residents vs 9.6 per 1,000 residents).

It is important to note that the categories can be overlapping and are non-additive.

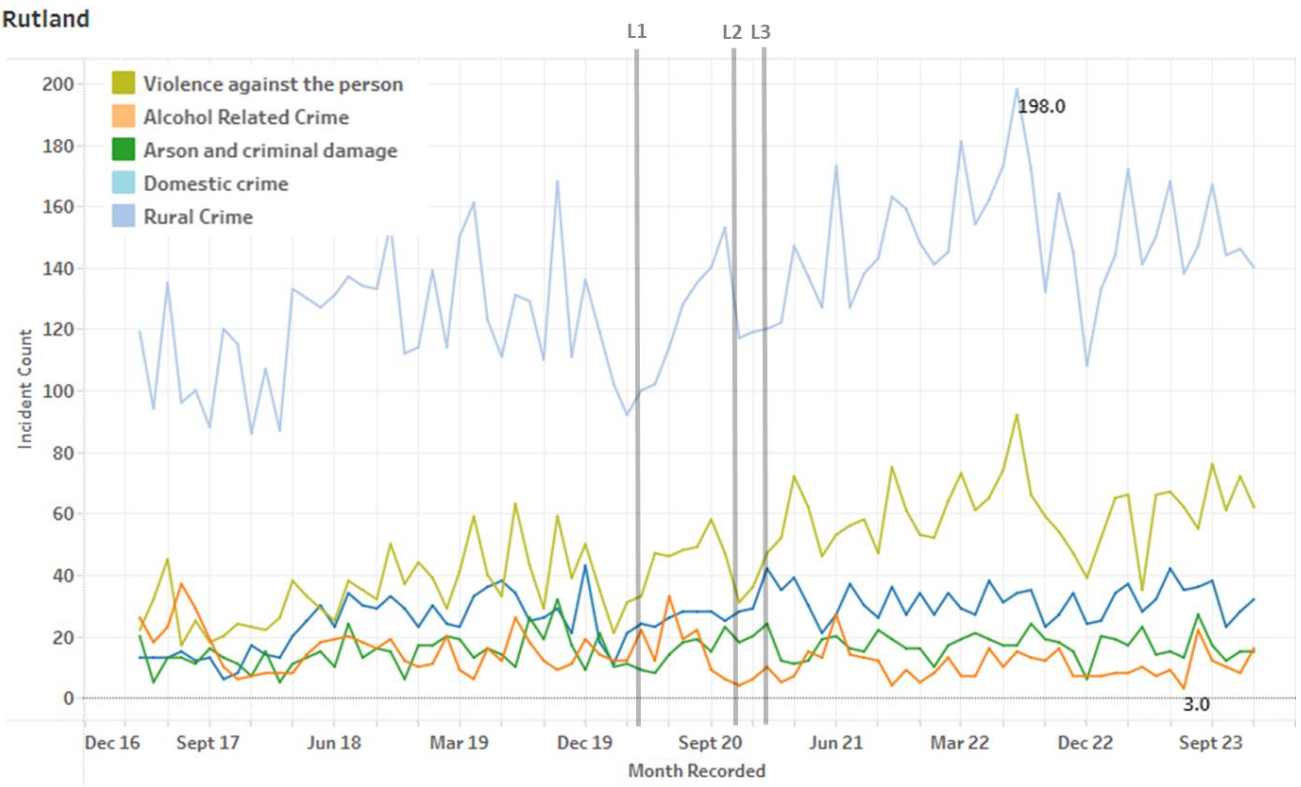
Table 5. Most common categories of reported crime in Rutland in 2023

	Number	Rate per 1,000
Rural Crime	1788	44.2
Violence against the person (VAP)	690	17.1
Violence without injury	442	10.9
Domestic crime	270	6.7
Domestic crime & incidents	270	6.7
Violence with injury	248	6.1
Theft	226	5.6
Public Order	209	5.2
Alcohol Related Crime	205	5.1

(Source: Leicestershire County Council Crime Dashboard, 2023 – Leicestershire Police Crimsec4 Statistics, ONS Mid-2020 population estimates)

Figure 17 presents the time trends in the most commonly reported crime categories with the inclusion of L1-L3, indicating approximate COVID-19 lockdown dates. Although the counts of incidents vary over time, the graph suggests an increase in violence against person and, to a smaller extent, of rural crime since 2017.

Figure 17. Recent trends in reported crime in Rutland. L1–L3 COVID-19 lockdowns (approximate placement) – July 2016 to December 20238



(Source: Leicestershire County Council Crime Dashboard, 2023 – Leicestershire Police Crimsec4 Crime Statistics)

3.9.4. Disrupted social ties

Disrupted social ties, such as the loss of social connections or the breakdown of relationships, can have a significant and negative impact on mental health. Individuals may experience a range of mental health challenges, including loneliness and isolation, depression, anxiety, loss of self-esteem and increased stress. Unresolved grief as result of a loss of close relations can lead to mental health issues such as complicated grief or depression. Substance abuse may become an unhealthy coping mechanism, as can overeating, or self-harm. Disrupted social ties can also have physical health consequences, as they are linked to higher levels of stress hormones, immune system dysfunction, and a higher risk of certain health conditions.

Mental health challenges resulting from disrupted social ties can interfere with daily functioning, including work, relationships, and overall quality of life[79].

3.9.5. Social care

Looking after a family member with a health problem, particularly a mental health issue, can significantly affect carers' mental health. Mental health problems of carers include emotional stress,

depressive symptoms and, in some cases, clinical depression [80]. More than two-thirds (71%) of carers have poor physical or mental health[81].

The results of the 2021 Census showed that 15.9% of Rutland's population were disabled under the Equality Act, significantly below the national average of 17.3%. 3.5% of Rutland's population declared themselves as having bad or very bad health which was significantly smaller than the percentage in England (5.2%).

As of the 2021 Census 8.0% of the Rutland population aged 5 and over reported providing unpaid care, this was a smaller proportion than the national figure (8.8%).

3.9.6. Students

The mental health of students can be impacted by various factors, leading to increased risks of developing mental health problems, such as high academic expectations, workload, performance pressure and fear of failure can all contribute to stress and anxiety. Many students face financial challenges, including tuition fees, living expenses, and student loan debt. Financial strain can lead to anxiety, depression, and difficulty accessing basic needs, such as food and housing. Transitioning to university or college can be socially isolating for some students, particularly if they are away from home or have difficulty making friends. Students who move away from home may have difficulty adjusting to a new environment. Relationship problems, breakups, social conflicts, and feelings of loneliness can exacerbate existing mental health issues. Some students may engage in substance use, such as alcohol, drugs, or prescription medications, as a coping mechanism for stress or to socialize. Perfectionistic tendencies, self-criticism and fear of failure can contribute to anxiety, depression, and burnout among students. Some students may face barriers to accessing mental health services, such as long wait times, limited availability of resources, or stigma surrounding help-seeking behaviour.

In 2021/22, 119,500 of UK students said they had a mental health condition, which represents 5.5% of all home students. The number saying they had a mental health condition was three and a half times as high as in 2014/15, and five times higher than in 2010. Higher rates of mental health conditions were reported among women, undergraduates, full-time students and those in their second or later years[82].

According to the 2021 Census 18.0% of Rutland's population aged five or over were classified as 'schoolchildren and full-time students', significantly below the national average of 20.4%. The 2021 Census suggests that 2.3% of Rutland's population aged 18 and over (763 adults) are full-time students, significantly below the national average of 5.2%.

3.9.7. Armed forces personnel and veterans

There are many risks to the mental health of armed forces personnel. Exposure to combat situations can lead to post-traumatic stress disorder (PTSD), anxiety, depression, and other mental health

conditions. Deployments, whether in combat zones or other operational environments, can be stressful and disruptive, leading to feelings of isolation, separation from family, and adjustment difficulties upon return. The demands of military operations, including long hours, frequent deployments, and high-pressure environments, can contribute to chronic stress, exhaustion, and burnout among personnel. Physical injuries sustained during military service, such as traumatic brain injuries, amputations, and chronic pain, can have significant psychological impacts, including depression, anxiety, and PTSD[83].

There may be an increased risk of substance abuse, including alcohol and prescription drug misuse, as a coping mechanism for stress, trauma, or adjustment difficulties. Deployments and frequent moves can place strain on relationships and family dynamics, leading to increased stress, conflict, and challenges in maintaining social support networks. Some individuals may enter military service with pre-existing mental health conditions, such as depression, anxiety, or PTSD, which may be exacerbated by the demands and stressors of military life.

Stigma surrounding mental health issues within the military culture may prevent personnel from seeking help for mental health concerns, leading to delays in diagnosis and treatment, while logistical barriers, concerns about career repercussions, and limited access to mental health services may further hinder help-seeking behaviours[84].

Transitioning from military to civilian life can be challenging, as personnel may face difficulties adjusting to civilian roles, finding employment, accessing healthcare, and reintegrating into their communities.

In 2021 (Census), a total of 2,015 residents aged 16 and over in Rutland reported to have served in the UK regular armed forces, with a further 283 having served in UK reserve armed forces and 83 having served in both regular and reserve UK armed forces.

The proportion of Rutland's population aged 16 and over that reported previously serving in the UK armed forces (6.9%) was significantly higher than the proportion in England (3.8%). This information was collected in the 2021 census after consultation with a range of stakeholders, including the Ministry of Defence. Uses of the information include ensuring adequate careers provision for ex-armed forces personnel, statutory responsibilities to provide housing for up to 5 years after leaving the forces and commissioning health services which may differ from the wider population, for example counselling services[85].

Two British Army barracks are located in Rutland, Kendrew Barracks in Cottesmore and St George's Barracks in North Luffenham. The data presented below examines summary statistics on the number of serving UK Armed Forces personnel and entitled civilian personnel with a Defence Medical Services (DMS) registration. UK armed forces includes Regulars, Gurkhas, Officer Designates and Full Time Reserve Service (FTRS) personnel. Entitled civilian personnel include contractors, service personnel family dependents and Ministry of Defence (MOD) employed civilian personnel

who are entitled to care at MOD primary care facilities. Personnel with a DMS registration have their primary care (GP services) provided by the MOD rather than the NHS.

This data suggests that in April 2022, the armed forces personnel accounted for 5.1% of the resident population in the county. The military population is younger and has a higher proportion of males compared to the resident population of Rutland. In April 2022, there were 2,110 Armed Forces personnel and entitled civilian personnel registered in Rutland. 1,550 individuals (73%) were in the Armed Forces and 560 individuals (27%) were entitled civilian personnel. Of the total, 1,530 were male and 580 female, with 1,330 males in the UK Armed forces and 220 females.[86] Since this data was collated, the 1st Battalion of the Royal Anglian Regiment has arrived from Cyprus to Kendrew Barracks in Rutland, potentially marking a significant demographic change for personnel and families.

Rutland Armed Forces Health and Wellbeing Survey 2023

Rutland Armed Forces Health and Wellbeing Survey was live between 12 April 2023 and 2nd June 2023. The target population of the survey was personnel, families and veterans located in Rutland and 1st Battalion in Cyprus due to move to Rutland at the time (this move has since occurred). In total, 69 participants completed the online survey, 65% of whom were females and 93% were white. Only 13% (N=9) of the surveyed sample were serving members of the armed forces, with 57% family members and 28% veterans. Due to small numbers, conclusions have to be treated with caution, but the results suggest that a larger proportion of veterans or family members (both 79%) felt their mental health was negatively influenced than among the small group of members of the armed forces (33%).

Conclusions drawn from the survey around mental health were that the relatives of service members endure challenges which should not be overlooked. While many respondents reported that life in the Armed Forces negatively impacts mental health, only 22% accessed mental health services in Rutland, and just 10% reported they would feel comfortable doing so. This suggests that mental health services should be linked into other channels that they would feel comfortable accessing. 6% of participants would like to see counselling available directly at Kendrew and St George's. Results also suggested that respondents do not feel very involved in the Rutland community and there is demand from serving members, families and veterans for different social and exercise groups. For all support services, including mental health, respondents would like to access them face-to-face at the barracks or in Rutland.

3.9.8. Homelessness

Homelessness is strongly associated with increased risks to mental health. Common mental health conditions among the homeless population include depression, anxiety disorders, post-traumatic stress disorder (PTSD), schizophrenia, and substance use disorders. Many homeless individuals have experienced significant trauma and adverse life experiences, such as childhood abuse, neglect,

domestic violence, or traumatic events while living on the streets. These experiences can contribute to the development of mental health disorders and exacerbate existing symptoms[87].

Substance abuse is prevalent among homeless individuals, and there is a high rate of co-occurring mental health and substance use disorders (dual diagnosis). Substance abuse can exacerbate mental health symptoms and make it more challenging for individuals to access and engage with mental health services. Homelessness is often accompanied by physical health challenges, including inadequate access to healthcare, poor nutrition, exposure to harsh weather conditions, and an increased risk of infectious diseases.

Homeless individuals often face social isolation, stigma, and discrimination, and the stigma surrounding mental illness and negative past experiences with healthcare providers may deter individuals from seeking help.

In addition, there is an increased risk of experiencing violence, victimization, and exploitation. These traumatic experiences can have profound effects on mental health and contribute to the development of PTSD and other mental health disorders.

Homelessness and mental illness often form a vicious cycle, where mental health issues can contribute to homelessness, and homelessness can exacerbate mental health challenges. Breaking this cycle requires comprehensive support services addressing housing, healthcare, employment, and social integration.

The *Annual Rough Sleeping Snapshot in England*[88], reported on the numbers of people sleeping rough[‡] on one night in autumn in 2023. Across England there were nearly 3,898, which has risen for the second year in a row (by 27%) but remains lower than the peak in 2017, and 9% lower than pre-pandemic (2019) figures. The general national trend showed an increase up to 2017 with some reduction in 2018 and 2019. The East Midlands region followed a similar trend, with total or rough sleepers counted in 2020 at 187.

In Rutland there were 0 people rough sleeping on the snapshot night.

The *Statutory Homelessness Statistics* for 2022/23 (Department of Levelling Up, Housing and Communities) show that across Rutland there were an estimated 54 homeless households (owed a relief duty) and 80 households threatened with homelessness (owed a prevention duty). Overall, this equates to 134 households owed a duty under the Homelessness Reduction Act which is a rate of 7.6 per 1,000 households which is significantly better (lower) than the rate in England (12.4 per 1,000 population).

[‡] The snapshot records only those people seen, or thought to be, sleeping rough on a single night and may exclude many groups, such as those in shelters.

Looking at their composition, homeless households (those owed a relief duty) were most commonly single adult male's (35%), followed by single adult females' (28%) and single female parents with dependent children (24%).

For households threatened by homelessness (those owed a prevention duty), the most common household compositions were that of single female parents with dependent children (28%), followed by single female households (25%) and single male households (21%).

3.9.9. Multiple disadvantage

Multiple Disadvantage or Severe and Multiple Disadvantage (SMD) refers to people facing two or more of the following issues – mental health issues, homelessness, offending and substance misuse. SMD can include other sources of disadvantage, for instance poor physical health, domestic/sexual abuse, community isolation, undiagnosed brain injuries, autism and learning disabilities. In England, 2.3 million adults (5.2% of the population) face two or more of these primary domains in a single year[89].

A closely related term is that of multiple complex needs (MCN), a broad definition including severe and multiple disadvantage and multiple exclusion in a population experiencing co-occurring issues of homelessness, substance use, crime and mental health problems; overlapping vulnerabilities associated with extreme health inequalities[90]

SMD has a higher degree of stigma and dislocation from societal norms when compared to other social inequalities. People affected by SMD are predominantly young white men, aged 25–44, often with long-term histories of economic and social issues and, in most cases, childhood trauma of various kinds, very poor family relationships and/or educational experience[91]

Despite having very high levels of morbidity and mortality, people with SMD encounter significant barriers to accessing healthcare and have lower patient enablement and they are more likely to have negative experiences of healthcare, including stigma and discrimination. GP appointment systems are often incompatible with their help seeking behaviours and the majority of general practice does not effectively include them[92]

An analysis, published by Lankelly Chase Foundation in 2015[93] and based on data for 2010 and 2011, estimated that an 'average' local authority might expect to have about 1,470 SMD (as defined by involvement in two out of the three relevant service systems) cases per year, however this would vary across the country. Specific rates were calculated for all local authority areas using data on homelessness (Supporting People), drug misuse (NDTMS) and offender data (Offended Assessment System). Rutland (and Leicestershire) were both placed among the 20 lowest prevalence areas, with a score of 47 (against the national average of 100), ranging from 21 (Wokingham) to 306 (Blackpool). Based on this one can broadly estimate the number of adults with SMD at 140 for Rutland.

4. Mental Health Needs

4.1. Mental Well-being and Mental Health Conditions

Mental well-being, also referred to as mental health and emotional well-being, encompasses a person's emotional, psychological, and social state of being. It reflects an individual's overall mental and emotional health and their ability to cope with life's challenges. While there is no universally agreed-upon definition, mental well-being is often characterized by emotional resilience, positive emotions, self-acceptance, autonomy and self-determination, positive relationships, personal growth and development, mental and emotional stability, quality of life and respect for others[94].

The World Health Organisation states that "mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes". It also defines mental health conditions as "mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm" [95].

It is important to note that mental well-being is not a fixed state but a dynamic and evolving aspect of a person's life. It can be influenced by various factors, including genetics, environment, life experiences, and personal choices. Additionally, mental well-being is not the absence of all negative emotions or challenges but the ability to navigate and overcome them in a healthy and adaptive way. Although people with mental health conditions are more likely to experience lower levels of mental well-being, this is not always or necessarily the case.

4.2. Common Mental Health Disorders (CMD)

Common mental health conditions include a variety of, often overlapping, disorders such as depression, anxiety, phobias, obsessive-compulsive disorder (OCD) and panic disorder. Although they do not affect cognition, they may cause a significant level of distress and disability. They are relatively common and often undiagnosed, hence the importance of population-based estimates[96].

4.2.1. Wider determinants

Common mental disorders are influenced by a wide range of factors, including both individual and wider determinants. The wider determinants of mental disorders refer to the broader social, economic, environmental, and cultural factors that can affect an individual's mental health and well-being. These determinants often interact with individual-level factors to shape mental health outcomes.

The socioeconomic factors play a significant role in mental health. Unemployment, income inequality, and lack of access to basic resources (e.g., housing, healthcare, education) can contribute

to stress and increase the risk of mental disorders. The nature of employment, job security, and workplace stress can impact mental health. High-stress jobs, job insecurity, and workplace discrimination can contribute to mental disorders. Strong social support systems and positive social relationships are protective factors for mental health. Loneliness, social isolation, and lack of social connections can increase the risk of common mental disorders [97].

Adverse childhood experiences, including trauma, abuse, neglect, and household dysfunction, can have long-lasting effects on mental health and increase the risk of mental disorders in adulthood. Education and literacy levels are associated with mental health outcomes. Higher levels of education are often linked to better mental health, as they can provide greater access to resources and opportunities.

Access to safe and stable housing, as well as the quality of the neighbourhood environment, can influence mental health. Unsafe or unstable housing and exposure to neighbourhood violence can be detrimental. Access to mental healthcare services, as well as general healthcare, is crucial. Barriers to accessing healthcare, including stigma, cost, and availability, can hinder early intervention and treatment.

Cultural factors, social norms, and stigma related to mental health can affect individuals' willingness to seek help and access services. Experiences of discrimination, racism, homophobia, or other forms of marginalization can contribute to stress, depression, and anxiety among affected individuals. Health behaviours, such as diet, physical activity, substance use, and sleep patterns, can impact mental health. Unhealthy behaviours may increase the risk of mental disorders. Availability and accessibility of social services, including social welfare, housing support, and community programs, can provide important resources for individuals facing mental health challenges.

Communities with high levels of social capital, characterized by trust, social cohesion, and civic engagement, tend to have better mental health outcomes for their residents [98]. Environmental factors, such as exposure to pollution, natural disasters, or extreme weather events, can contribute to stress and affect mental health.

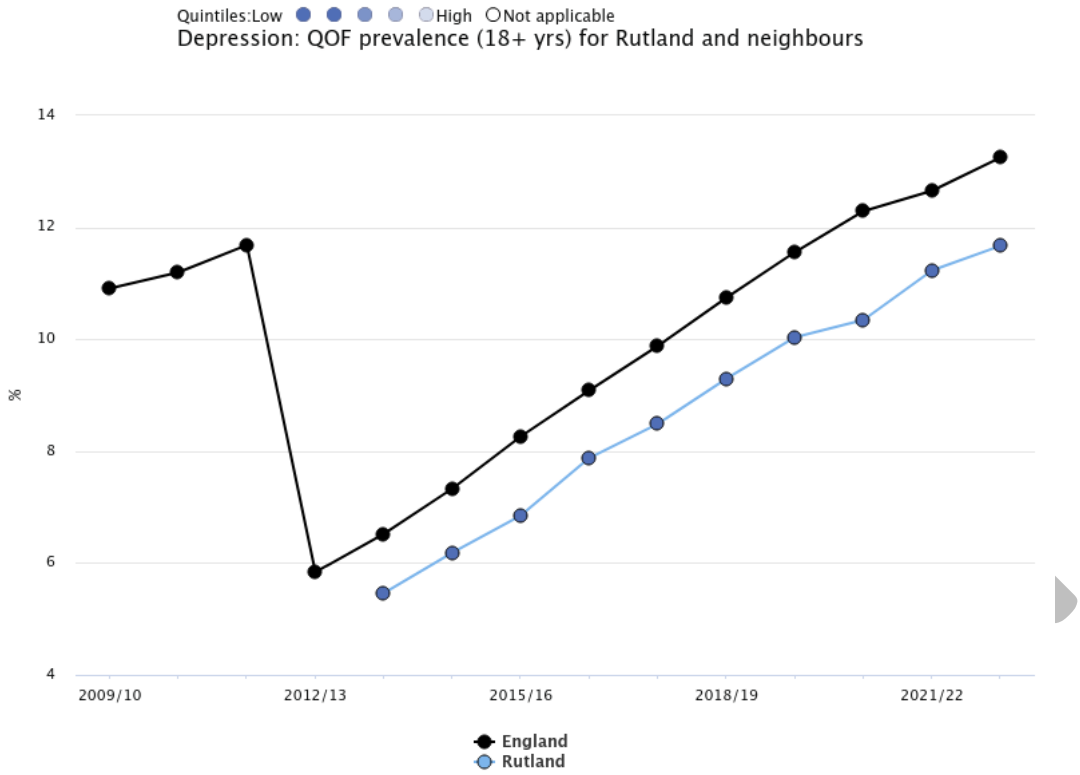
Addressing the wider determinants of common mental disorders requires a comprehensive, multisectoral approach involving government policies, social programs, community support, and individual interventions. Efforts to reduce social and economic inequalities, improve access to healthcare, promote positive social relationships, and reduce stigma can all contribute to better mental health outcomes for individuals and communities [99].

4.2.2. Prevalence

In 2022/23 the prevalence of depression among adults registered at GP practices across Rutland was 11.7%, which is significantly lower than the national average of 13.2%. In 2022/23 Rutland had the second lowest prevalence when compared to its 14 CIPFA comparators. The prevalence of depression among adults registered at GP practices across Rutland and England has shown a

significant and increasing trend over the most recent five time periods (Figure 18).

Figure 18. Trend in the prevalence of depression (GP registered population) in Rutland and England 2009/10 – 2022/23



(Source: Office for Health Improvement and Disparities, Fingertips)

The incidence of depression in 2021/22 in adults registered with GP practices in Rutland (1.2%) was significantly lower than the national value of 1.5%. Rutland had the fourth lowest prevalence when compared to its 14 CIPFA comparators in 2021/22.

The estimated prevalence of common mental conditions for those aged 16 and over in 2017 in Rutland is 3,925 cases, with around 750 cases among those aged 65 and above. In 2017, the estimated prevalence of common mental disorders in those aged 16 and over and 65 and over in Rutland was significantly better (lower) than the value for England.

In Rutland in 2019/20 the rates of attended contacts with community and outpatient mental health services and new referrals to secondary mental health services were significantly below the national average. There were over 19 thousand attended contacts with community and outpatient mental health services per 100,000 population in Rutland in 2019/20 (N=7,755) and there were around 2,220 new referrals to secondary mental health services in the same time period.

The rate of inpatient stays in secondary mental health services in Rutland in 2019/20 (102 per 100,000 population, 40 stays) was significantly lower than the national average (241 per 100,000 population) and the lowest of Rutland's CIPFA comparators (Table 6).

Expressed as comparative rates, the measured prevalence indicators were below the national

averages and low when compared with Rutland's CIPFA comparators.

Table 6. Common mental health conditions in Rutland– estimated prevalence, incidence and rates of contact with services

Indicator	Time Period	Rutland		CIPFA value range	England value
		Value	Count		
Depression: QOF Prevalence (18+ years)	2022/23	11.7% ↑	3,944	11.2% - 15.7%	13.2%
Depression: QOF incidence (18+ years) – new diagnosis	2021/22	1.2% →	401	0.9% - 2.2%	1.5%
Estimated prevalence of common mental disorders: % of population aged 16 and over	2017	11.9	3,925	11.9-17.5	16.9
Estimated prevalence of common mental disorders: % of population aged 65 and over	2017	7.8	754	7.8-11.4	10.2
Attended contacts with community and outpatient mental health services, per 100,000 (All Ages)	2019/20	19,238	7,755	16,928-34,554	30,674
New referrals to secondary mental health services, per 100,000 (All Ages)	2019/20	5,477	2,220	4,321-9,262	6,897
Inpatient Stays in secondary mental health services, per 100,000 (All Ages)	2019/20	102	40	102-291	241

Recent trend over most recent five time periods:
↑ Increasing
→ No significant change

Significantly better than the national average	
Significantly below the national average	

(Source: Office for Health Improvement and Disparities, Fingertips)

Prevalence modelling using APMS data and current population estimates

The *Adult Psychiatric Morbidity Survey (APMS)* aims to provide information and analyses on both treated and untreated psychiatric disorders in the population aged 16 and over in England, as well as provide trend data through comparison with earlier surveys in the series. It is run every seven years, with the last published survey data from 2014. Because of the COVID-19 pandemic, the current survey edition was earmarked for 2022/23, this data has not been published yet.

APMS 2014 surveyed the symptoms of depression and anxiety, to estimate the prevalence of depression, generalised anxiety disorder (GAD), phobias, panic disorders, obsessive-compulsive disorder (OCD) as well as symptoms not otherwise specified (CMD-NOS), which mixed anxiety and depression and cannot by classified within any of the specific types mentioned. The revised Clinical Interview Schedule (CIS-R) was used - an interviewer assessed 14 non-psychotic symptoms of CMD, scoring them according to their severity. A CIS-R score of 12 and above was the threshold applied

to indicate that a level of CMD symptoms was present such that primary care recognition is warranted.

The Survey indicated a sex difference, CMD being more common in women (21%) rather than men (14%), significant socioeconomic differences (CMD three times more common in people out of work or in receipt of financial support), the role of social isolation (a third of all adults under 60 living alone vs 17% overall rate) and ethnicity - prevalence higher among black or mixed groups (22%).

Applying the Survey results to the ONS 2022 Rutland Mid-Year Population Estimates, around 5,480 people could be suffering from any CMD, with approximate estimates for specific conditions as follows: GAD 1,910, depression 1,080, phobias 720, OCD 400, panic disorder 200, with other (not specified conditions) accounting for additional 2,530 cases.

APMS also surveyed for PTSD and trauma. Trauma was defined as experience that either put a person or someone close to them at risk of serious harm or death. The results suggested that in England over a third of adults aged 16 and over (31%) have had a traumatic event in their lifetime and may go on to develop PTSD. Overall, just over 4% of adults screened positive for PTSD in the past month, with similar rates for men and women, the rate was highest among younger women (16–24-year-olds - 13%), declining sharply with age. The risk was higher in people under 60 living alone, those not in work and among benefit recipients. Only 13% of those screening positive for PTSD had already been diagnosed by a health professional. These findings can indicate about 1,190 people with possible PTSD across Rutland.

Of course, these estimates need to be treated with caution.

4.2.3. People Accessing NHS Talking Therapies

Formerly known as IAPT (Improving Access to Psychological Therapies), NHS Taking Therapies are NHS-funded, evidence based, psychological therapies for depression and anxiety. In 2022, nearly 1.22 million people accessed the service in England and 1.9 million should be able to access it in 2023/24.

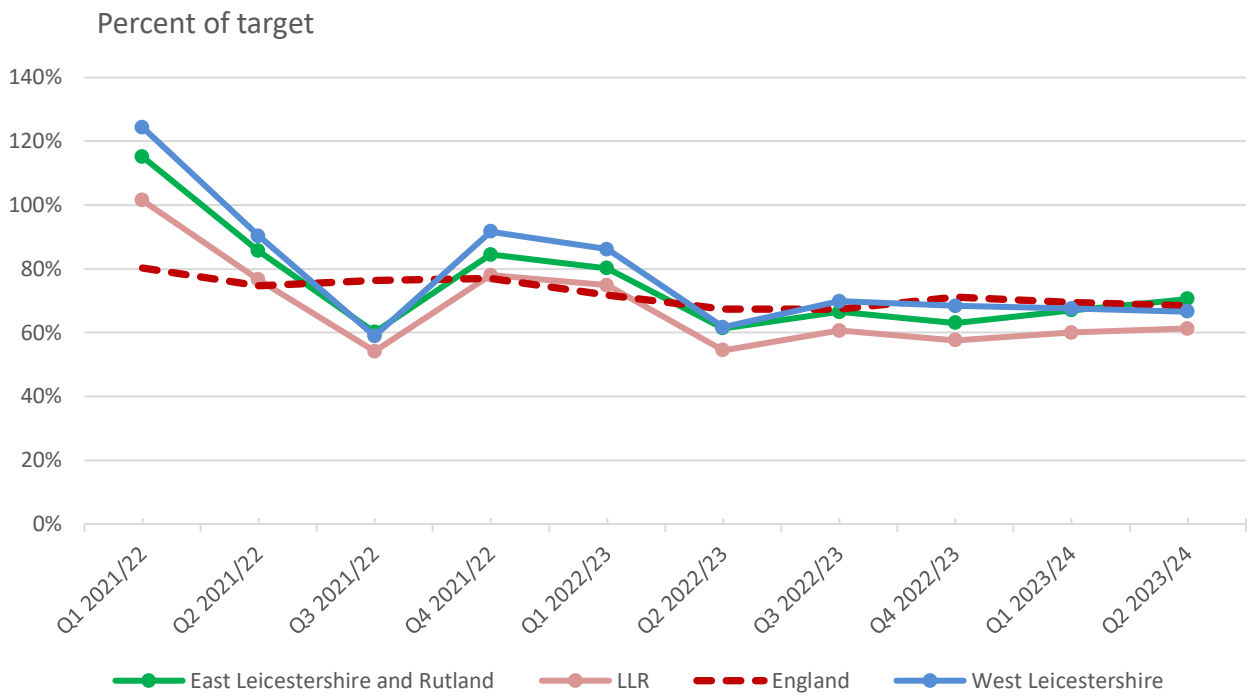
Published data indicate that in 2022/23 12,950 people accessed these services in Leicestershire and Rutland. Although the access rates to this service are similar to the national average for both East Leicestershire and Rutland and West Leicestershire, they are below the target set for these services, at 68% and 67%, respectively (Figure 19).

In quarter 2 of 2023/24 just over six percent (6.5%) of all referrals were for patients aged 65 and above in West Leicestershire and 8.9% in East Leicestershire and Rutland, against the 6.9% national average, which can be explained by age structure differential.

There are no financial sub-ICB data for 2022/23, but in 2021/22 the total spend on NHS Talking Therapies was over £5.6 million in two Leicestershire and Rutland CCGs, an increase from £4.3

million in 2017/18. As a percentage of planned spend, the rate for the whole of LLR was just 82% of the target 2022/23, compared to 90% in the previous year (Figure 20).

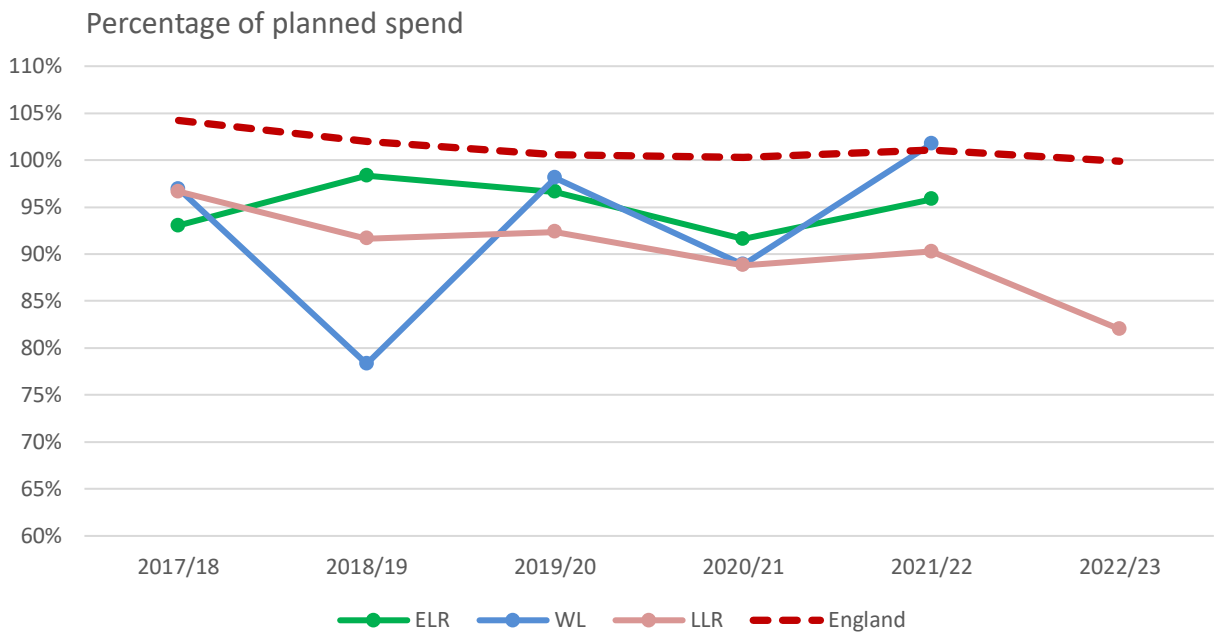
Figure 19. Talking Therapies – quarterly access rate as a percentage of target between April 2021/22 and September 2023/24



Note: rates for Q1 2023/24 were not available and are imputed.

(Source: NHS Mental Health Dashboard - February 2024)

Figure 20. Talking Therapies – actual against planned annual spend since 2017/18 (note: no sub-ICB financial data after 2021/22)

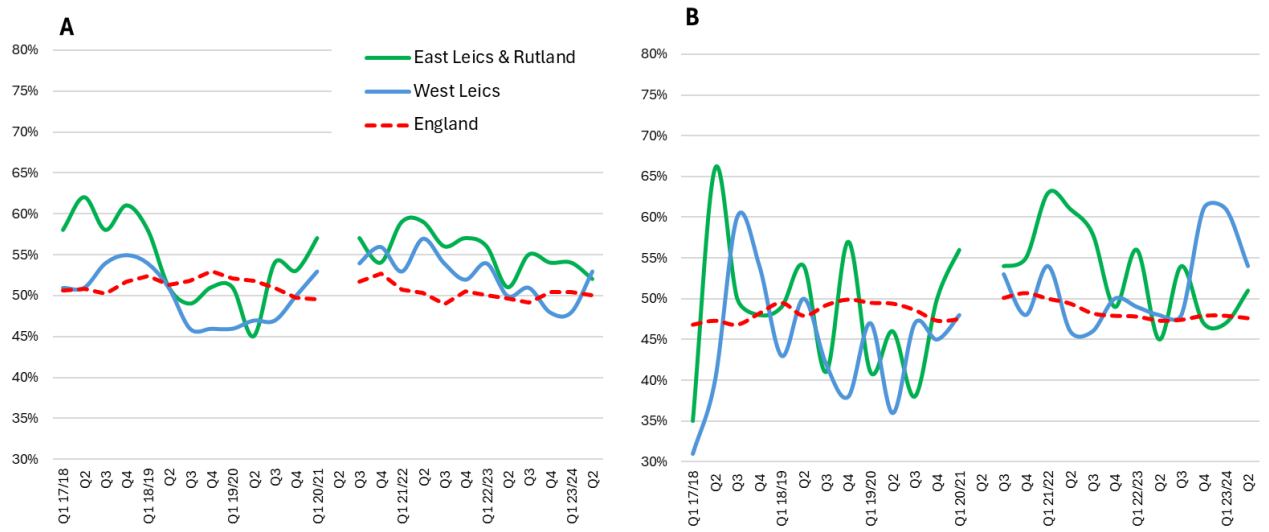


(Source: NHS Mental Health Dashboard - February 2024)

Recovery rates

Nationally, the Talking Therapies recovery rates were consistently around 50%, including those for ethnic minority populations. On a background of substantial variation, particularly for ethnic minorities, from 2020/21 the local recovery rates seemed to be somewhat higher than the national average (Figure 21).

Figure 21. Recovery rates (proportion of people who attended at least two treatments contacts and are moving to recovery. A = all groups, B = ethnic minority groups (Black, Asian or other)

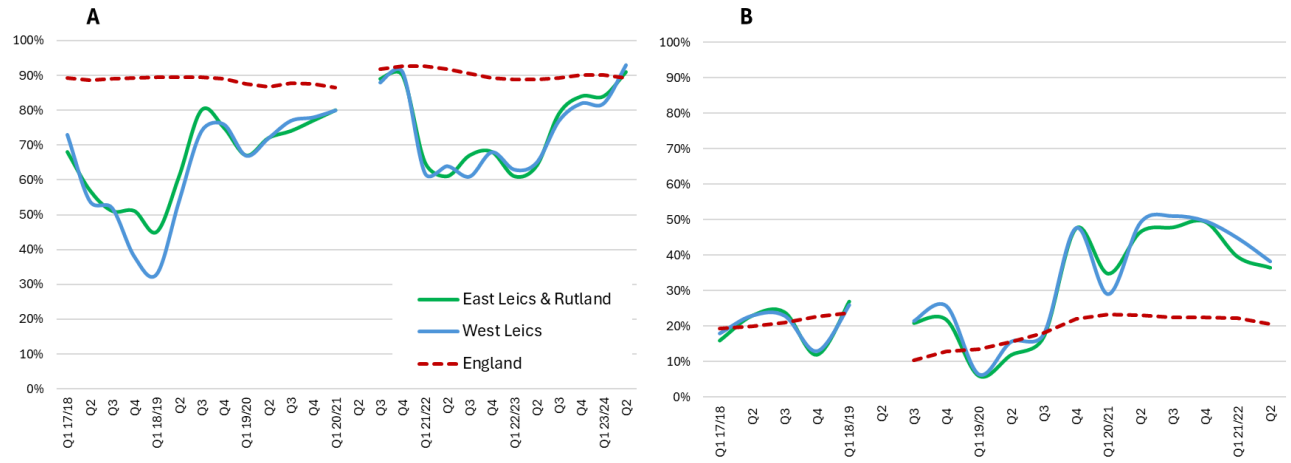


(Source: NHS England, NHS Mental Health Dashboard, February 2024)

Waiting times

Over the last five years, people tended to wait longer for their first appointment locally. For those waiting for their first appointment, the latest figures (for period July-September 2023) for East Leicestershire and Rutland show that the waits improved, with 91% accessing services within 6 weeks (national average 89%) and 100% within 18 weeks (vs 98% across England). Recently more than a third (36% in July-September 2023) of those in treatment were waiting more than 90 days between their first and second appointment, against the national average of 21%, although this rate is decreasing (Figure 22).

Figure 22. Talking Therapies waiting times. A = Proportion of people receiving their first treatment appointment within 6 weeks of referral (denominator: those who finished treatment in reporting period). B = In-treatment pathway waits over 90 days.



(Source: NHS England, NHS Mental Health Dashboard, February 2024)

4.2.4. Depression

Depression is a highly prevalent mental health condition globally. In 2019, an estimated 280 million people, including 5% of all adults and more than 10% of women in the perinatal period, experienced depression. Depression is a major contributor to loss of productivity, together with anxiety it is estimated that nearly 1 trillion US dollars are lost each year due to lost productivity worldwide[100].

Around one in five people (20%) across the world will experience depression at some point in their lives and the annual prevalence is somewhere between 5 and 10%. Depression is a major risk factor for suicide.

Although depression can affect both men and women it is more common among females, and there is evidence to suggest that the rates are higher among adolescents and young adults.

The prevalence of depression varies across regions, a variety of cultural, socio-economic and health care access factors can influence these patterns. The COVID-19 pandemic had a negative impact on the prevalence of depression - apart from the psycho-social effects of the pandemic on the whole society, infection with COVID-19 was shown to lead to increased rates of major depression and anxiety in those infected by the virus[101].

Data on the prevalence of depression in Rutland is summarised in Table 6, section 4.2.2.

4.2.5. Dementia

This section presents data for groups at risk, risk factors, prevalence (estimated and diagnosed), outcomes and mental health services, specifically for dementia. It is important to stress that dementia shares many underlying factors and treatment pathways with other common mental conditions, the discussion below concentrates on those which were investigated specially for dementia.

Background

The term dementia refers to several diseases that affect thought, memory, and the ability to perform daily activities. The illness mainly affects older people and gets worse over time. Dementia is caused by many different diseases or injuries that directly and indirectly damage the brain. Alzheimer's disease is the most common form and may contribute to 60–70% of cases, other forms include vascular dementia, dementia with Lewy bodies, and a group of diseases that contribute to frontotemporal dementia. Dementia may also develop after a stroke or in the context of certain infections such as HIV, as a result of harmful use of alcohol, repetitive physical injuries to the brain (chronic traumatic encephalopathy) or nutritional deficiencies. The boundaries between different forms of dementia are indistinct and mixed forms often co-exist.

Dementia is currently the seventh leading cause of death worldwide and is a major cause of disability and dependency among older people. Women are disproportionately affected, directly and indirectly, by the social and economic costs from dementia, because they provide 70% of care hours for people living with dementia and experience more disability-adjusted life-years and mortality caused by it[102].

Alzheimer's disease primarily affects older adults, the majority of cases are diagnosed in individuals over 65 years old (known as late-onset Alzheimer's disease). Although less common, the early onset cases (under the age of 65 at diagnosis) are often linked to genetic factors. Alzheimer's disease tends to affect women more than men, partly because women tend to live longer. Some research suggests that hormonal and genetic factors may also play a role[103]. The prevalence can vary by region and country. Some regions, like North America and Western Europe, have higher rates compared to others. These variations may be due to differences in lifestyle, genetics, and healthcare access.
Several risk factors have been identified, including genetics (family history), age, cardiovascular health, and lifestyle factors such as diet, exercise, and cognitive stimulation.
With the aging population worldwide, the number of people affected by Alzheimer's disease is projected to increase significantly in the coming decades. This will pose substantial challenges to healthcare systems and caregivers. Alzheimer's disease has a substantial economic impact due to the costs associated with healthcare, long-term care, and lost productivity. It places a significant burden on individuals, families, and societies[104].

The symptoms of Alzheimer's disease can vary in severity and typically worsen over time. Memory

loss is one of the earliest and most noticeable signs, including trouble remembering recent events, names, and appointments. Other common symptoms include difficulty with problem solving, difficulty concentrating and taking longer to do tasks, confusion with time or place, difficulty with familiar tasks, misplacing items and being unable to retrace steps to find them. These are usually followed by language problems, decreased judgement, loss of initiative, behavioural changes such as mood swings, irritability, or withdrawal from social activities. Patients have difficulty recognizing familiar faces and problems with spatial awareness, as well as often finding it challenging to learn or remember new information or tasks[105].

Risk factors and prevention

Particular demographic groups are more at risk of developing dementia, the demographic breakdown of Rutland's population is discussed above in section 3.1. Dementia is known to affect more women than men. Black, Asian and Minority Ethnic communities are also at greater risk of developing dementia, as are those with learning disabilities, particularly those with Down's syndrome[106,107,108]. Dementia is a growing problem within prisons. A study by Sutin in 2018 also found that loneliness is associated with increased risk[109]. The increased risk of dementia with increases in age is of most note for Rutland. As discussed previously in section 3.1, a larger proportion of Rutland's population are in the older age groups than nationally. This, alongside the projected rise in Rutland's older population highlights the importance of considering the future needs of Rutland's population with regards to dementia.

Behavioural factors such as alcohol misuse, obesity and high body mass index (BMI), physical inactivity and smoking are all linked to increased risk of developing dementia[110,111,112]. Other risk factors associated with increased risk of dementia include hypertension, diabetes, depression, coronary heart disease (CHD) and stroke[113,114,115]. Publicly available data on alcohol misuse in Rutland is limited, often suppression is applied due to small counts.

The population of Rutland overall demonstrate a relatively low prevalence of the range of health behaviour risk factors for dementia in comparison to England. In 2021/22, the percentage of adults aged 18 and over classified as obese was significantly lower (20.2%) than the national average (25.9%); also, in 2022/23 the percentage of patients aged 18 or over with a BMI over 30 recorded on GP disease registers was significantly lower (10.2%) than the national average (11.4%). The percentage of physically inactive adults was not significantly different to the national average of 22%. The percentage of patients recorded as current smokers on GP registers in Rutland in 2022/23 was significantly below the national percentage, with a significant decreasing trend.

For other risk factors, the prevalence of hypertension, as recorded on GP registers, was significantly higher was than the national figure (18.5% vs. 14.4%), with a significant increasing trend over the most recent five years. A systematic review identified midlife hypertension as a significant risk factor

for the later development of both Alzheimer's disease and vascular dementia[116]. The prevalence of diagnosed CHD in Rutland was significantly higher than the prevalence in England in 2022/23 (3.4% vs. 3.0%). The proposed mechanism is that pathological changes in CHD reduce blood flow to the brain along with the formation of blood clots which may damage brain cells may increase the risk of vascular dementia. Furthermore, the prevalence of diagnosed stroke was 2.3%, significantly higher than the prevalence in England (1.8%). Strokes and transient ischaemic attacks (TIAs) are two known causes for vascular dementia[117]. However, the diagnosed prevalence of diabetes mellitus in Rutland was 6.7%, significantly lower than the national prevalence of 7.5%.

In summary, the prevalence of many of the health conditions which can increase the risk of dementia is higher than the national average, while lifestyle risk factors are generally lower.

Table 7. Prevalence of risk factors for dementia in Rutland

Indicator	Time period	Rutland			CIPFA value range	England value
		Value	Count	Recent Trend		
Health behaviours						
Obesity: QOF prevalence (18+years)	2022/23	10.2%	3,464	→	10.1%-13.4%	11.4%
Percentage of adults (aged 18+) classified as obese	2021/22	20.2%	-	-	20.2%-32.0%	25.9%
Percentage of physically inactive adults	2021/22	20.8%	-	-	13.7%-24.3%	22.3%
Smoking: QOF prevalence (15+ years)	2022/23	10.0%	3,606	↓	10.0%-15.1%	14.7%
Other risk factors						
Hypertension: QOF prevalence (all ages)	2022/23	18.5%	7,808	↑	13.1%-19.3%	14.4%
Diabetes: QOF prevalence (17+ years)	2022/23	6.7%	2,316	→	5.6%-8.4%	7.5%
Coronary Heart Disease (CHD): QOF prevalence (all ages)	2022/23	3.4%	1,453	-	2.6%-4.8%	3.0%
Stroke: QOF prevalence (all ages)	2022/23	2.3%	986	-	1.7%-2.8%	1.8%

Significantly lower than the national average	
Not significantly different to the national average	
Significantly higher than the national average	
Significantly better than the national average	

Recent trend over most recent five time periods:
→ No significant change
↑ Increasing
↓ Decreasing
\- Cannot be calculated

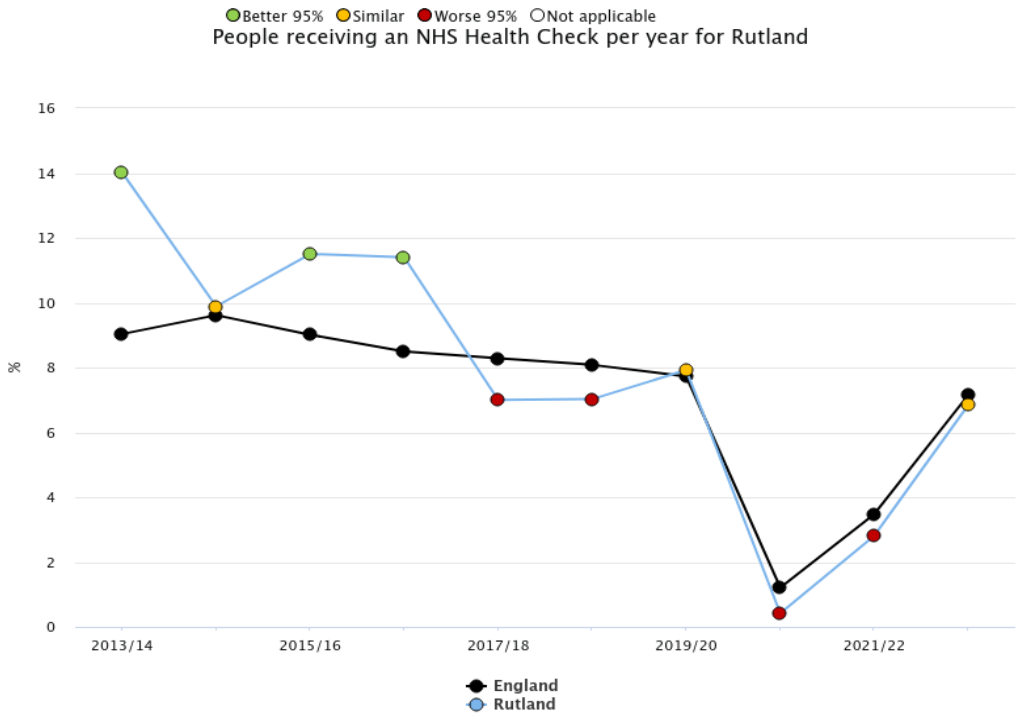
(Source: Office of Health Improvement and Disparities, Fingertips)

One way to help prevention of dementia is early diagnosis and treatment of the contributing conditions described above. The NHS Health Check Programme aims to help prevent heart disease,

stroke, diabetes and kidney disease. A high take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions. The NHS Health Check is also used to promote opportunities in mid-life to reduce the behavioural risk factors for dementia by providing advice on dementia to the relevant age group[118].

In 2022/23, 6.8% of people (aged 40 to 74) in Rutland who were eligible for an NHS Health Check, received a health check. This coverage rate is not significantly different to the national average of 7.2%. In the pre-pandemic years, the performance of the programme was variable, with relatively high coverage up to 2016/17, followed by two low-uptake years and an expected trough due to COVID-19 pandemic (Figure 23).

Figure 23. Percentage of people receiving an NHS Health Check per year for Rutland and England, 2013/14 to 2022/23



(Source: Office for Health Improvement and Disparities, Fingertips)

Prevalence

In 2019, it was estimated that 55 million people were living with dementia worldwide (with 10 million new cases every year), a number that is expected to increase to 78 million by 2030 and 139 million by 2050[119]. Dementia puts a substantial burden on the healthcare system; in 2018 the cost of dementia was estimated at US $1 trillion and is estimated to surpass US $2 trillion by 2030[120], about half of these costs are attributable to care provided informally.

The recorded dementia prevalence provides an indication of the concentration, within a population,

of the number of people who have been diagnosed and who are living with the condition. This indicator can be used to inform local service planning as to the scale of services required to provide treatment, care and support as needed, so that those with dementia can live well with the condition[121].

The Quality Outcomes Framework (QOF) data published by OHID (Table 8) are only available up to 2021/22. The diagnosed prevalence of dementia in Rutland in 2021/22 was 0.9% (358 individuals) which was significantly higher than the national average of 0.7%. There was no significant change in this prevalence across the five most recent time periods (Figure 24). The more recent data available through NHS Digital shows that in 2022/23 the prevalence of dementia in patients registered with GP practices in Rutland was 0.8% (352 patients), this was significantly higher than the national average of 0.7%. This could be explained by the older population profile of Rutland - as there are more older people in Rutland and the prevalence of dementia increases with age, Rutland has a higher prevalence of dementia than England which has a smaller proportion of older people than Rutland.

However, the percentage of patients aged 65+ with dementia recorded on GP practice disease registers in Rutland in 2020 was 3.4%, this was significantly lower than the national average of 4.0%.

In Rutland, less than half (48.5%) of those aged 65 years and above estimated to have dementia are on the GP register with a diagnosis, indicating that another 370 patients could be without a diagnosis or access to treatment. Not only is this significantly below the benchmark of 66.7%, but it is also below the national average of 63% and it is the lowest figure across Rutland's CIPFA comparators.

Dementia is considered 'young onset' when it affects people under 65 years of age, this is also referred to as 'early onset' or 'working age' dementia[122]. The crude recorded prevalence of dementia in those aged under 65 years registered at GP practices in Rutland in 2020 (2.37 per 10,000 population) was not significantly different to the prevalence in England (3.05 per 10,000 population). The proportion of people aged under 65 years with dementia registered at GP practices in Rutland in 2020 was 2.0%, this was not significantly different to the value of 3.5% for England - Rutland had the lowest proportion of its CIPFA neighbours (Table 8).

Table 8. Dementia prevalence and diagnosis for Rutland and England, 2020-2023

Indicator	Time Period	Rutland			CIPFA range	England value
		Value	Count	Recent Trend		
Dementia: QOF prevalence (all ages) (%)	2021/22	0.9%	358	⇨	0.7% - 1.1%	0.7%
Dementia: Recorded prevalence (aged 65 years and over) (%)	2020	3.38%	348	-	3.38% - 4.33%	3.97%
Dementia: Crude Recorded Prevalence (aged under 65 years) per 10,000 population	2020	2.37	7	-	1.99 - 4.91	3.05
Dementia (aged under 65 years) as a proportion of total dementia (all ages) (%)	2020	2.0%	7	-	2.0% - 4.0%	3.5%
Estimated dementia diagnosis rate (aged 65 and older) (%)	2023	48.5%[1]	346	⇨	48.5% - 67.9%	63.0%

Significantly below the national average	
Not significantly different to the national average	
Significantly worse than the benchmark goal	

1 Benchmarking against goal: > 66.7% (significantly) | similar to 66.7% | < 66.7% (significantly)

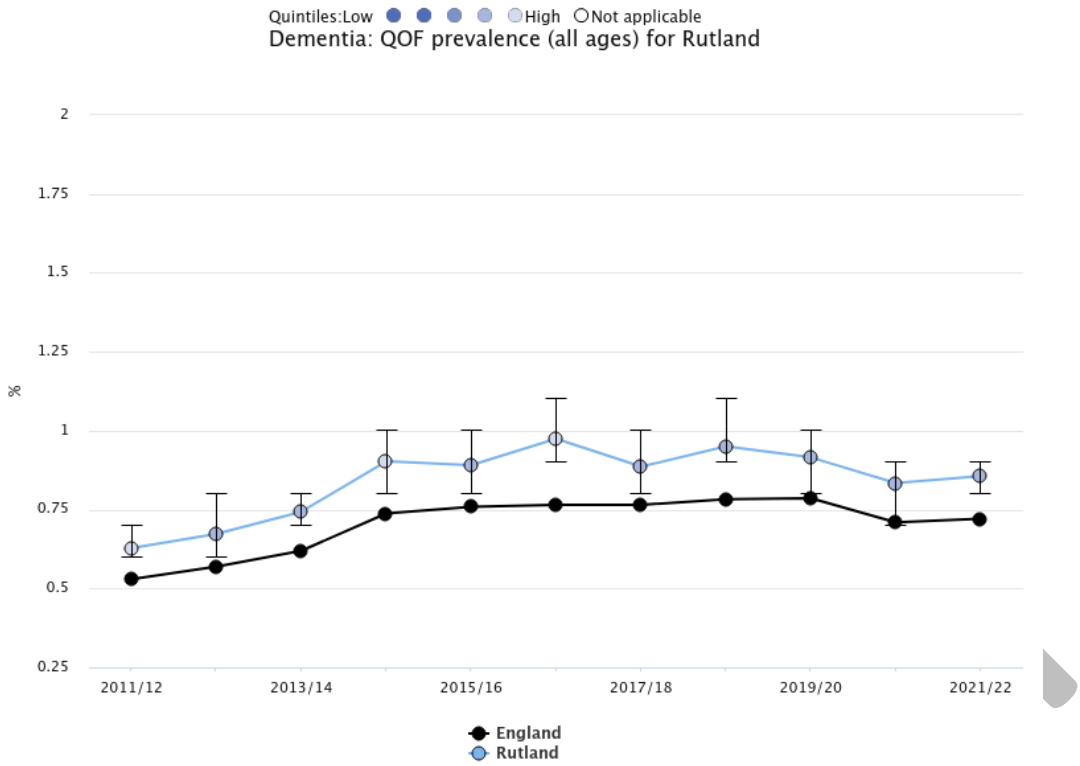
Recent trend over most recent five time periods:

⇨ No significant change

\- Could not be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

Figure 24. Dementia QOF prevalence (all ages) for Rutland and England (%), 2011/12 – 2021/22



(Source: Office for Health Improvement and Disparities, Fingertips)

Projected prevalence

As age is a major unmodifiable risk factor for dementia and the older population is expected to increase in size, so is the number of people living with dementia. Overall, between 2023 and 2040 the number of people aged 65 and over in Rutland with dementia is estimated to increase from 830 to 1,233, an increase of 48.6%. While in persons aged 85 years and over, the increase is expected to be 70.3% (from 370 to 630). The largest increase is predicted to be in males aged 85 years and over which is projected to increase by 86.9% from 107 to 200 people with dementia (Table 9).

Table 9. Current and projected estimates of dementia in Rutland population aged over 65 years and over 85 years for males, females and persons, 2023-2040

	2023	2025	2030	2035	2040	% change 2023 to 2040
Males 65 and over	313	327	382	438	475	51.8%
Males 85 and over	107	107	138	192	200	86.9%
Females 65 and over	516	536	573	690	758	46.9%
Females 85 and over	263	263	283	394	430	63.5%
Persons 65 and over	830	864	955	1,129	1,233	48.6%
Person 85 and over	370	370	421	586	630	70.3%

Source: Projecting Older Peoples Populations Information, (POPPI), 2023

In Rutland the estimated numbers of early onset dementia in each of the males aged 30-39, 40-49, 50-59, 60-64 and the females of the same age groups were below 5 for all of the 2023, 2025, 2030, 2035 and 2040 predictions. The total number of males aged 30-64 predicted to have early onset dementia in Rutland 2023 was 7, the prediction for 2040 was also 7. The total number of females aged 30-64 predicted to have early onset dementia in Rutland in 2023 was 5, the prediction for 2040 was also 5[123].

Primary Care

This section outlines data about people with dementia in East Leicestershire and Rutland Sub-ICB, including ethnicity, sex and age breakdown. Data at county/district level are not available[124].

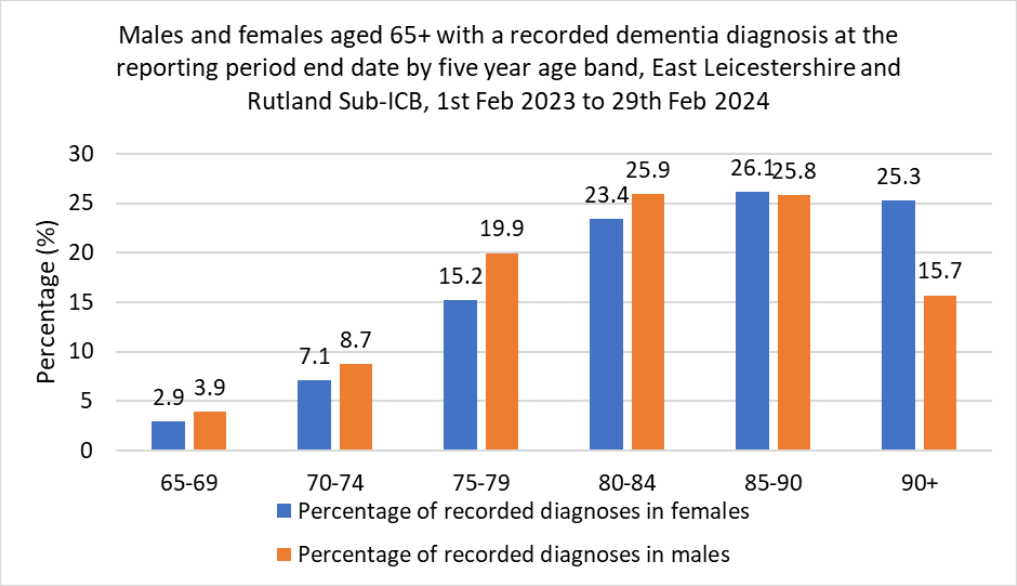
Data for February 2023 to February 2024 show that in East Leicestershire and Rutland out of 3,385 patients with a recorded diagnosis of dementia, 72% had their latest ethnicity recorded as in the white, 3% as in the Asian or Asian British, 0.3% as other, 0.3% as 'mixed or multiple' and 0.1% as black/African or Caribbean/black British. The remaining 21% of patients did not have their ethnicity recorded. Of patients aged 65 or over in that period, almost half (47.6%) were aged 85+ and a further 41.4% were aged 75 to 84 years, 61% were females and 39% were males. A detailed age/sex breakdown is given in Figure 25.

Based on data for April 2023 to February 2024, the recent type of dementia recorded was most commonly Alzheimer's disease (41%), 16% of cases were vascular dementia and 8% mixed dementia (diagnosed as having more than one type of dementia), with the remaining 35% classified as 'other' dementia[§]. [**]

[§] Any other dementia types than Alzheimer's disease, vascular dementia or mixed dementia.

[**] Dementia type data was rounded to the nearest 5.

Figure 25. Age breakdown of males and females aged 65+ with a recorded dementia diagnosis in February 2024, East Leicestershire and Rutland



Source: NHS England

Caution should be taken when interpreting this data as it has not been standardised against the demographic profile of the population.

Memory Services

Community based memory services teams assess people who have memory and other cognitive difficulties that might indicate a form of dementia, aiming to ensure early diagnosis and access to treatment.

In Rutland there were 270 open referrals to these services in 2022/23, and 740 contacts, of which 77% were attended. This related to 210 individuals in that year; expressed as a rate this equates to 2.0 individuals per 1,000 among older population (65 and above). This rate is slightly higher than the national rate of 1.9/1,000 or that across Leicestershire (1.7/1,000)[††].

Living with dementia

This section presents a selection of comparative indicators collected in primary and secondary care, summarising the use and quality of care for people with dementia. Unfortunately, the data have a significant time lag and are heavily affected by COVID-19 pandemic.

The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-

[††] NHS Mental Health Bulletin 2022/23

to-face review in the preceding 12 months in Rutland in 2020/21 was 27.7%, this was significantly below the percentage of 39.7% in England. This is an important measure in place to help improve the quality of life for the patient and/or carer. This indicator was likely heavily affected by the pandemic as the figure for 2019/20 was 84.6% and significantly above the national average.

The rate of emergency hospital admissions for people aged 65 and over with a mention of dementia or Alzheimer's in any of the diagnosis code positions in Rutland in 2019/20 (2,311 per 100,000 population) was significantly lower than the rate in England (3,517 per 100,000 population). In 2020, the percentage of assessed residential care and nursing home beds suitable for those aged 65 years and over with dementia in Rutland (79.9%) was significantly worse than the national figure (96.2%). In Rutland in 2020, this equated to 60 beds that were not assessed. Non-assessed beds can occur when new residential care homes and nursing homes are registered in the area or it may indicate a localised assessment issue[125]. The percentage of residential care home and nursing home beds, suitable for a person aged 65 and over with dementia, which were rated as 'good' or 'outstanding' by the Care Quality Commission (CQC) in Rutland in 2020 was 79.9%, this was significantly higher (better) than the percentage of 74.1% in England.

The percentage of assessed residential care and nursing home beds suitable for those aged 65 and over with dementia, indicates that each bed that was assessed in Rutland in 2020 received a 'good' or 'outstanding rating by the CQC (Table 10).

Table 10. Living with Dementia indicators for Rutland and England 2019-2021

Indicator	Time Period	Rutland			CIPFA range	England value
		Value	Count	Recent Trend		
Dementia care plan has been reviewed in the last 12 months (denominator includes Personalised Care Adjustments) (%)	2020/21	27.7%	93	-	23.0% - 48.9%	39.7%
Dementia: Direct standardised rate of emergency admissions (aged 65 years and over) – per 100,000 population	2019/20	2,311	245	-	2,138 – 3,602	3,517
Dementia: Quality rating of residential care and nursing home beds (aged 65 years and over) (%)	2020	79.9%	239	-	53.1% - 85.7%	74.1%
Dementia: Percentage of assessed residential care and nursing home beds (aged 65 years and over) (%)	2020	79.9%	239	-	79.9% - 99.9%	96.2%
Dementia: Residential care and nursing home bed capacity (aged 65+) (%)	2020	85.9%	299	-	59.0% - 121.6%	75.3%

Significantly below the national average	
Significantly better than the national average	
Significantly worse than the national average	

Recent trend over most recent five time periods:

- Cannot be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

Mortality

In 2019 in the UK, mortality from Alzheimer's and other dementias was the most common cause of death for females and the second most common cause for males (preceded only by IHD), with rates for women almost twice as high as for men[126]. In 2022, there were 62,118 deaths due to dementia and Alzheimer's disease in England, almost two-thirds of these were in women. Over two-thirds of Rutland's deaths due to dementia and Alzheimer's disease in 2022 were in females - there were 71 deaths in total, 23 of these were in males and 48 were in females. In Rutland in 2022 the mortality rates from dementia and Alzheimer's disease in persons, males and females were not significantly different to the national rates. In Rutland in 2019 the rate of mortality in people aged 65 and over with a recorded mention of dementia or Alzheimer's (747 per 100,000 population) was not significantly different to the rate in England (849 per 100,000 population). The proportion of all dementia and Alzheimer deaths which took place in the individuals usual place of residence in Rutland in 2019 was 75.3%, this was not significantly different to the proportion in their usual place of residence in England (70.3%) (Table 11).

Table 11. Dementia mortality in Rutland and England, 2019 and 2022

Indicator	Sex	Time Period	Rutland			CIPFA range	England value
			Value	Count	Recent Trend		
Mortality rate from dementia and Alzheimer's disease, all ages – directly standardised rate, per 100,000 population	Persons	2022	123.7	71	⇨		111.7
	Male	2022	91.2	23	⇨		100.2
	Female	2022	144.6	48	⇨		118.1
Direct standardised rate of mortality: People with dementia (aged 65 years and over) – per 100,000 population	Persons	2019	747	79	-	674-905	849
Deaths in Usual Place of Residence: People with dementia (aged 65 years and over) (%)	Persons	2019	75.3%	58	-	68.2% – 83.7%	70.3%

Not significantly different to the national average

Recent trend over most recent five time periods: ⇨ No significant change

\- Could not be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

4.2.6. Neurodevelopmental Disorders

Autism Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) are neurodevelopmental disorders which can coexist, particularly in children. Although adults can have both ADHD and ASD, the combination is less common. While ASD is considered a lifelong disorder, long-term studies have shown that in one-third to two-thirds of children with ADHD, symptoms last into adulthood.

ASD is characterised by impaired social interaction and communication, severely restricted interests, and highly repetitive behaviours, while ADHD, classically considered a disorder of childhood, is characterized by core symptoms of attention, impulsivity, and hyperactivity[127]. These symptoms persist into adulthood in about 40–60% of cases and even persist into later life, with around 3% of adults aged 50 and older reporting clinically significant ADHD symptoms[128].

Estimated prevalence

The *Adult Psychiatric Morbidity Survey (APMS)* in 2014 screened for ASD and ADHD. The prevalence of ASD in the English adult (aged 16 and over) population was estimated to be around 0.8%, (0.5% and 1.3%, 95% confidence interval); higher in men (1.5%) than women (0.2%) and higher among people with no qualifications.

Nearly 10% of adults in England screened positive for ADHD, with higher rates in younger adults, those living alone, people without educational qualifications, the unemployed and those who are economically inactive. Only 2.3% of those screened positive had been diagnosed by a professional.

For Rutland this is equivalent to an estimated 290 adults with ASD (between 120 and 730, 95% confidence interval) and 3,090 adults with ADHD (2,840 to 3,370, 95% confidence interval). Please note the high level of uncertainty in the autism estimate in particular.

Access to services

The national data[129] show a significant rise in the number of referrals for autism assessment – the number waiting in April 2019 was just over 17,400 in England, compared to 172,000 in December 2023 (almost a ten-fold rise).

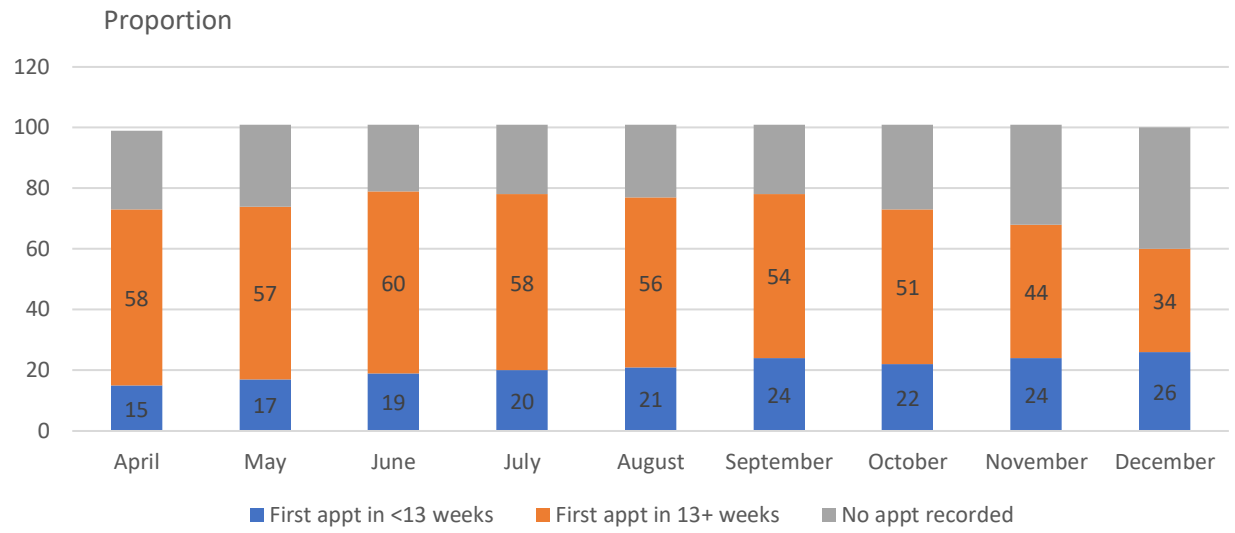
The available data at the sub-ICB level show that in December 2023 there were 165[‡‡] adults from East Leicestershire and Rutland with an open referral for suspected autism. Among those, 90 (55%) were waiting for more than 13 weeks. This proportion is lower than the national 87% average.

In 2023, there were on average 35 new and 31 closed autism referrals for adults across East Leicestershire and Rutland.

While nationally only 5.2% of adults waiting had their first appointment within the recommended 13 weeks in December of 2023, this indicator is higher in East Leicestershire and Rutland at 26% (N=25). The monthly progress since April 2023 is shown on Figure 26.

[‡‡] All numbers rounded to nearest 5

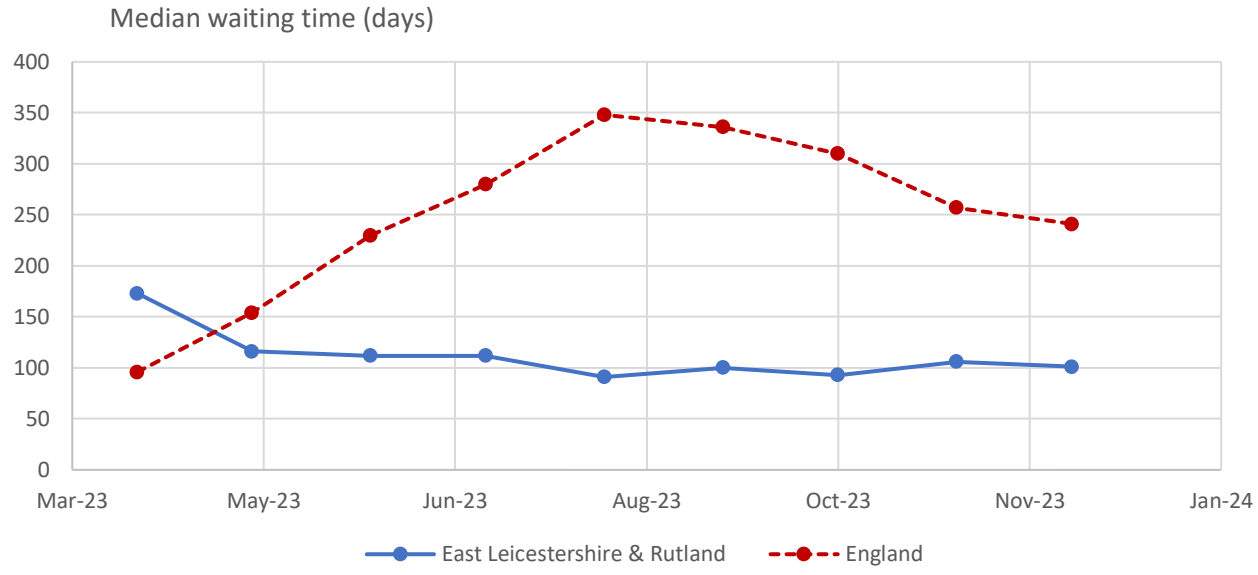
Figure 26. Adults with open autism referral in East Leicestershire and Rutland receiving their first appointment between April and December of 2023



(Source: NHS Digital, Autism Waiting Time Statistics)

Nationally, the median waiting time for children and adults has risen from 92 days in April 2019 to 281 days in December 2023. In 2023, the local waiting times for adults seemed to be significantly shorter than the national average, more similar to national pre-pandemic figures (Figure 27).

Figure 27. Median waiting time for a first appointment (adults only) for suspected autism, April-December 2023



(Source: NHS Digital, Autism Waiting Time Statistics)

It is important to stress that the NHS Autism Waiting Time Statistics are classified as experimental and have to be treated with some caution. It does not, for example, include data collected by the community services, where mental health diagnosis also happens. The data rely on Mental Health Services Dataset (MHSDS) only; the number of providers submitting data to MHSDS has increased over time which can affect the published time trends.

4.2.7. Medically unexplained symptoms (MUS)

The term 'Medically Unexplained Symptoms' (MUS) is used for 'persistent bodily complaints for which adequate examination does not reveal sufficiently explanatory structural or other specified pathology'. Other terms used for physical or bodily symptoms that cause distress or impairment but do not have a clear medical or organic cause are 'functional symptoms', 'somatoform disorders', or 'somatic symptom disorders'. For a proportion of patients with MUS, the symptoms may be part of a poorly understood syndrome, such as chronic fatigue syndrome (CFS), also known as ME, irritable bowel syndrome (IBS) or fibromyalgia (pain all over the body)[130].

Common examples of medically unexplained symptoms include chronic pain, fatigue (often profound tiredness and exhaustion), digestive symptoms such as abdominal pain, bloating, or diarrhoea, neurological (dizziness, headaches, weakness, or sensory disturbances), cardiovascular symptoms (palpitations, chest pain, or shortness of breath) or non-epileptic seizure (seizure-like episodes that are not associated with the abnormal electrical brain activity seen in epilepsy). While these symptoms are real and experienced by the individual, they cannot be attributed to a specific medical condition or disease through standard medical examinations or tests.

Medically unexplained symptoms can be challenging to diagnose and manage because they often lack clear physiological markers or abnormalities that can be identified through medical tests or imaging. However, it is important to note that individuals experiencing these symptoms are genuinely suffering, and their symptoms can have a significant impact on their quality of life and daily functioning.

Some individuals with MUS may receive a diagnosis of a somatic symptom disorder (excessive focus on and distress about physical symptoms) or a related condition, such as illness anxiety disorder (hypochondriasis) or conversion disorder (functional neurological symptom disorder).

Treatment for individuals with MUS often involves a multidisciplinary approach, including psychological interventions (counselling, cognitive behavioural therapy or psychotherapy), medication (particularly for co-occurring depression or anxiety), education and supportive care[131].

It is important to approach individuals with medically unexplained symptoms with empathy, understanding, and a collaborative approach to care. A thorough evaluation is needed to rule out any underlying medical conditions before arriving at a diagnosis of MUS or a related disorder.

4.3. Severe Mental Illness (SMI)

People with severe mental illness are more likely to be in treatment, thus the prevalence recorded through GP registers is more likely to be a true representation of the numbers in the population.

4.3.1. Risk factors

Potential risk factors for SMI may be genetic (certain genetic variations or predispositions may make individuals more susceptible to conditions such as schizophrenia, bipolar disorder, or major depressive disorder), biological (e.g., abnormalities in dopamine and serotonin levels have been implicated in schizophrenia and depression, respectively), adverse childhood experiences, environmental (e.g., high levels of stress, exposure to traumatic events, chronic illness, substance abuse, or environmental toxins), substance abuse, and socioeconomic factors[132].

Cultural factors, including stigma surrounding mental illness, can also impact help-seeking behaviours and treatment outcomes. Certain chronic medical conditions, such as neurological disorders, autoimmune diseases, or endocrine disorders, may increase the risk of developing serious mental illnesses or exacerbate existing symptoms.

Certain personality traits, such as high levels of neuroticism, introversion, or impulsivity, may increase the risk of developing serious mental illnesses. However, personality traits alone are unlikely to cause mental illness but may interact with other risk factors.

It is essential to note that the development of serious mental illnesses is often multifactorial, with interactions between genetic, biological, psychological, and environmental factors playing a role. Additionally, having one or more risk factors does not necessarily mean that an individual will develop a serious mental illness, as protective factors and resilience can also influence outcomes. Early identification, intervention, and support can help mitigate the impact of risk factors and improve outcomes for individuals with serious mental illnesses.

4.3.2. Prevention

Prevention can be primary (preventing a disease from occurring), secondary or tertiary, after the onset of disease, providing earlier diagnosis and treatment, or reducing adverse symptoms, complications or long-term disability.

Factors that promote positive wellbeing and resilience are key in preventing mental illness and improving outcomes in those with mental illness[133]. Childhood and adolescence are the critical periods for setting growth and wellbeing for the adult life; empowering youth with life skills and opportunities to reach their full potential in adult life has been shown to have a positive effect on both physical and mental health outcomes. For severe mental disease, early identification and interventions are of key importance and have been shown to be highly cost-effective.

Although prevention of severe mental illness may not be possible, particularly in those with genetic

predisposition, there are many strategies to help manage risk factors, such as early intervention (e.g. treatment of symptoms, cognitive behavioural therapy), providing supportive environments, healthy nutrition and maintenance of good physical health, and stress reduction. Avoidance of substance misuse, particularly drugs like cannabis or hallucinogens, which have been linked to the development of SMI is also important.

4.3.3. Prevalence

WHO estimates a global prevalence of all mental disorders at 12.5% of the population[134].

There are different clinical criteria and diagnostic practices for SMI across various countries, thus local estimates may not be comparable, particularly between more or less developed countries. Rates will also vary depending on various socio-economic and cultural factors.

In the Unites States, for example, the published estimate for 2020 (Substance Abuse and Mental Health Services Administration, SAMHSA) is 5.6% of all adults aged 18 or over. The estimated prevalence of psychotic disorders (a subset within SMI) is around 0.7%, bipolar disorder 2% and 4.4% screen positive for symptoms of PTSD [135].

Estimated prevalence

The *Adult Psychiatric Morbidity Survey (APMS)* in 2014 found that 2% of the surveyed English adult population (aged 16 and over) screened positive for bipolar disorder; which was more common in younger age-groups (3.4% of 16–24-year-olds), in those not in employment or living alone. Over 3% of adults under 65 screened positive for ASPD, which was more common in men than women with 2.4% positive for BPD. The Survey also screened for 'any personality disorder', and found 14% of adults as positive, with similar rates in men and women. Screening positive on all three measures of personality disorder was more common among younger people, those living alone, and those not in employment or in receipt of benefits. Over 6% of people screening positive for ASPD and 13% for BPD believed that they have had a personality disorder (vs 1% of the screen-negative cohort); in the majority this group also had a diagnosis of personality disorder from a professional.

In addition, APMS attempted to screen for *probable psychotic disorder* in the surveyed English adult population (aged 16 and over). The overall prevalence was low (0.7%); however, the rate was higher in black men (3.2%) and the socioeconomic factors are strongly linked – people who were economically inactive or on benefits (in these groups prevalence could reach 13%), or those in social isolation. Around four-fifths of people identified with psychotic disorder were in receipt of treatment.

Applying APMS rates to Rutland's population (ONS Mid-Year Estimates 2022) one can broadly estimate about 570 (95% confidence interval 460 to 710) people with bipolar disorder and 4,330 (95% confidence interval 4,030 to 4,650) with any personality disorder. It is also estimated that there could be around 220 people with psychotic disorder in Rutland.

These estimates have to be treated with caution, as they are based on the 2014 survey and not fully adjusted for important socio-economic factors.

Diagnosed prevalence

In 2022/23 the number of people on practice disease registers across Rutland with a diagnosis of schizophrenia, bipolar disorder and other psychoses is just over 310 (0.74% of the total practice list size). This is significantly lower than the national average of 1.00%. The prevalence in Rutland is the second lowest of its CIPFA comparators in 2022/23. There has been no significant change in the prevalence of severe mental illness in Rutland over the most recent five years.

The registered total of around 312 is also below the estimated 790 (bipolar disorder plus other probable psychotic disorders) from APMS (see above).

Despite the caveats relating to APMS estimates described above, there could still be a substantial gap in the diagnosis of SMI in primary care in Rutland.

4.3.4. People accessing community mental health services

Across England, the rates of access to community mental health services for adults with SMI are strongly correlated to deprivation, with the rate under 560 per 100,000 population in the most affluent decile compared to 1,460 per 100,000 population in the most deprived one, equivalent to 2.6 ratio. The average rate in England was 900 per 100,000 population, with higher rates for males (1,029 per 100,000 population) than females (719 per 100,000 population) in 2022/23. The highest rates were among those aged 85 and over (over 1,600 per 100,000 population). National rates were highest among those of mixed or multiple ethnicity (over 1,000 per 100,000 population) and black ethnicities (980 per 100,000 population) compared to just over 570 per 100,000 population in the Asian or Asian British population, and under 790 per 100,000 population in white residents.

Rates of contact in Leicestershire and Rutland were slightly higher than the England average (Table 12), with total of 7,630 adults with serious mental illness accessing those services in 2022/23.

Table 12. People accessing community mental health services (adults or older adults only) with serious mental illness who received 2 or more contacts within 2022/23.

	Number	Rate per 100,000 population
East Leicestershire and Rutland	3,235	937
West Leicestershire	4,395	1,077
England	508,214	900

(Source: NHS Digital MHB 2022/23)

4.3.5. Outcomes

People with SMI are more likely to have adverse physical outcomes, with higher rates of premature mortality.

In the three years between 2018 and 2020, premature mortality in adults with SMI in Rutland (55.9 per 100,000 population) was significantly better (lower) than the national average (103.6 per 100,000 population) - with Rutland having the lowest rate of its CIPFA neighbours.

In Rutland in 2018-20, the risk of premature mortality in adults with SMI was almost 4.5 times higher than in adults without SMI, the excess risk in Rutland was not significantly different to the national value of almost 4 times higher. Premature mortality due to cancer in adults with severe mental illness contributes to this higher risk, with around 15 premature deaths between 2018-20 and a 1.5 times higher risk of premature mortality due to cancer than adults without SMI (Table 13). Mortality from other common causes (cardiovascular, liver and respiratory disease) in those with SMI in Rutland is too low to report a value.

Table 13. Mortality among those with severe mental illness in Rutland and England (2018-20)

Indicator	Time Period	Rutland			CIPFA range	England value
		Value	Count	Recent Trend		
Premature mortality in adults (18-74 years) with severe mental illness (SMI) – directly standardised rate, per 100,000 population	2018-20	55.9	55	-	55.9-111.0	103.6
Excess under 75 mortality rate in adults with severe mental illness (SMI) – excess risk (%)	2018-20	445.8%	-	-	269.2-615.1	389.9%
Premature mortality due to cancer in adults with severe mental illness (SMI) – directly standardised rate, per 100,000 population	2018-20	13.9	15	-	11.1-23.4	20.2
Excess under 75 mortality rate due to cancer in adults with severe mental illness (SMI) – excess risk (%)	2018-20	157.1%	-	-	51.0-241.6	125.8%

Not significantly different to the national average	
Significantly better than the national average	

Recent trend over most recent five time periods:

- Cannot be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

4.3.6. SMI and physical health

People with SMI are at higher risk of poor physical health, with higher levels of obesity, asthma, diabetes, COPD and CVD. Smoking prevalence is twice as high in those experiencing SMI when compared to the general population [136]. Improving the coverage of physical health checks was part of the NHS Long Term Plan, with a 390,000 minimum target to be achieved by 2023/24. The six health checks include alcohol, blood glucose levels, blood lipids, blood pressure, BMI and weight, and smoking. Nationally, the rate of health checks in people with SMI has increased since 2018/19 from 25% to over 50% in 2023/24. The rates were lowest during the COVID-19 pandemic.

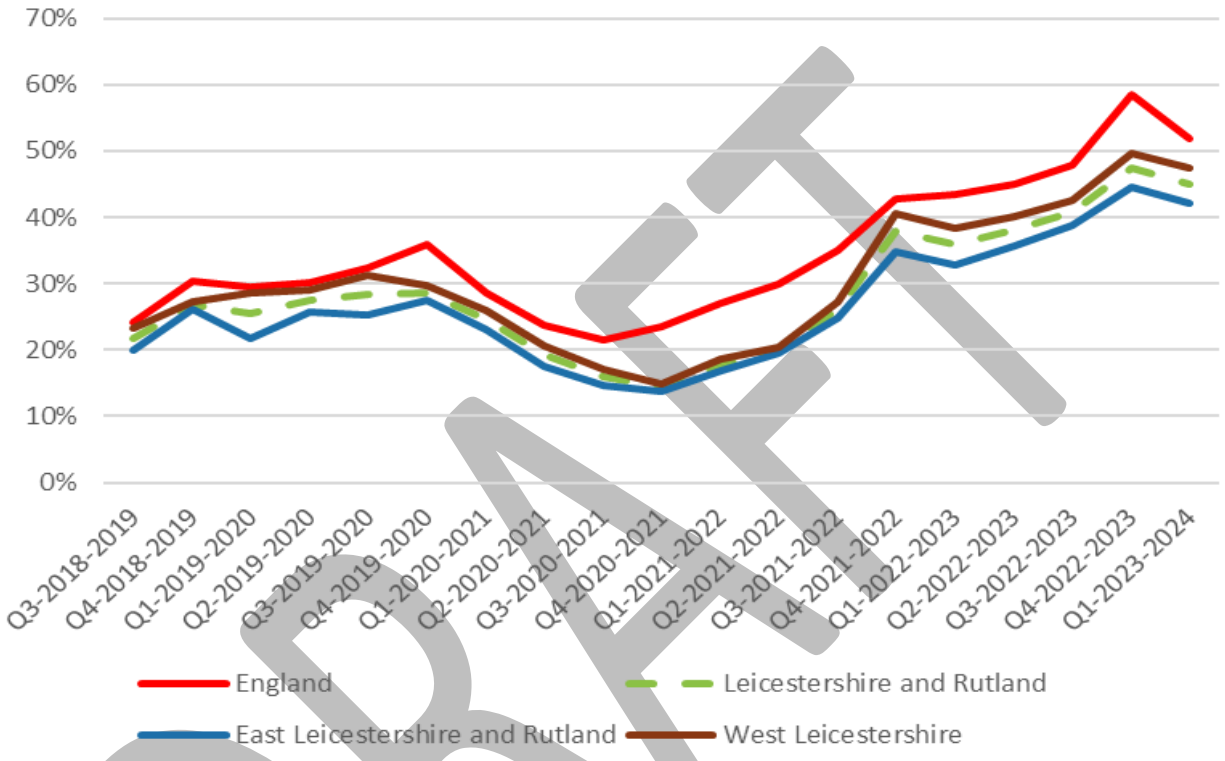
Although the rates in Leicestershire and Rutland have been lower than in England, the trends have been similar (Figure 28).

Caveats include completeness of trend data (2018/19 included only checks done in primary care and are more comprehensive since then) and its coverage across England.

Latest data for June 2023 (Q1 of 2023/24) indicates that 45% of people registered with SMI across

Leicestershire and Rutland had a full check in the previous 12 months (2,897 of 6,424 registered on 30th of June). This is lower than the 62% in Leicester, 52% nationally and 55% across the Midlands region.

Figure 28. Trends in health checks coverage for people with SMI (% of people registered with SMI getting all six checks in the previous 12 months), Q3 2019/2019 to Q1 2023/2024



(Source: NHS England NHSMH Dashboard)

4.3.7. SMI and cancer screening

Cancer screening programmes are designed to help early diagnosis and to improve the likelihood of successful treatment. Currently there are three NHS programmes - cervical screening, breast and bowel screening. The latest comparative screening coverage figures quoted here are for year 2022/23[§§].

Cervical screening – all women aged 25 to 49 are invited for screening every 3 years, and those aged 50 to 64 every 5 years. In 2022/23, the overall coverage in England for the younger and older age groups was 67% and 75%, respectively, with the corresponding rates in East Leicestershire and Rutland (ELR) significantly higher than the national average, 73% and 78%, respectively.

Breast screening through a mammogram is offered to women from the age of 50 to their 71st

[§§] Source: OHID 2024 (Fingertips: Cancer Services)

birthday, or at earlier age for those at higher risk of breast cancer. The coverage of the breast screening programme in England was 65% in 2022/23, with a significantly higher rate in ELR (70%).

Bowel screening aims for an early diagnosis of bowel cancer, as 90% of cases can be treated successfully when discovered early. It is offered to people aged 60 to 74 years of age. In 2022/23, the coverage for this screening programme across England was 72%, with significantly higher levels locally – 76% in ELR.

The most recent (end of December 2023) data for cancer screening coverage for people with SMI in East Leicestershire and Rutland indicate that the cervical screening rate is lower than in the general population locally (70% vs. 73-78%), while bowel screening coverage is higher in this group (over 87% vs. 76%).

However, breast cancer screening coverage for women with SMI is low, approximately half of the previous national or local rates in the general population (34% vs 72%) (Table 14).

Table 14. Cancer screening coverage for people with SMI – Q3 2023/24

	Period	Number Screened	Total Eligible	% Screened	ELR uptake (general population)
East Leicestershire and Rutland					
Cervical screening (women 25-64)	60 months	794	1135	70.0%	73 - 78%
Breast screening (women 50-70)	36 months	386	1129	34.2%	72%
Bowel screening (men & women 60-74)	24 months	664	757	87.7%	76%

(Source: Leicestershire Health Informatics Service 2024)

4.4. Suicide and Self-Harm

Suicide is a global public health issue. According to the World Health Organization (WHO), approximately 700,000 people die by suicide each year worldwide[137]. This number represents a significant but preventable loss of life. Understanding the distribution, causes, risk factors, and trends related to suicidal behaviours within populations is crucial for developing effective prevention and intervention strategies.

Suicide rates vary by age and gender. In many countries, suicide rates are higher among males than females. However, suicide attempts are more common among females. The highest suicide rates tend to occur in older adults (especially in males) and young individuals (especially in females) [138].

The choice of suicide method varies by region and culture. Common methods include hanging, poisoning, firearms, and jumping from heights. Access to lethal means, such as firearms, can significantly increase the risk of fatal suicide attempts [139].

Suicide rates vary widely by country and region. Factors contributing to these variations include

cultural norms, access to healthcare, social support systems, and economic conditions.

A significant proportion of individuals who die by suicide have a diagnosable mental health condition, such as depression, bipolar disorder, or substance use disorders. However, not all individuals who die by suicide have a known mental health diagnosis.

Suicide attempts are far more common than completed suicides. Many individuals who attempt suicide do not go on to complete it. Non-fatal suicide attempts are often a strong predictor of future suicide risk.

In addition to a history of previous suicide attempts, risk factors include family history of suicide, access to lethal means, social isolation, chronic illness, exposure to trauma or abuse, and stigma associated with seeking help. Conversely, protective factors against suicide include access to mental healthcare, strong social support networks, coping skills, and a sense of belonging and purpose.

Suicide prevention efforts involve a combination of public health initiatives, mental health promotion, crisis helplines, gatekeeper training, and access to mental healthcare services. Reducing access to lethal means, such as restricting firearm access, can be an effective suicide prevention strategy.

Ongoing surveillance and data collection are essential for monitoring trends in suicide rates and evaluating the effectiveness of prevention efforts.

It is important to note that suicide is a complex issue with multiple contributing factors, and it often involves the interplay of individual, societal, and cultural elements. Prevention efforts should encompass a holistic approach, addressing both the immediate risk factors and the broader social determinants of suicide. Increased awareness, education, and the destigmatisation of mental health issues are crucial components of suicide prevention strategies.

Rates of self-harm, suicide and undetermined injury are a broad indicator of the underlying mental health of the population. Because of the relatively small numbers of suicides, it is often difficult to show significant differences between areas or establish the significance of trends over time.

4.4.1. Rates of self-harm and suicide in Rutland

There were 45 emergency hospital admissions due to intentional self-harm in Rutland in 2021/22. This equates to a rate of 106.4 per 100,000 population which was significantly better (lower) than the national figure of 163.9 per 100,000 population. Rutland had the second lowest rate out of its CIPFA comparators. Of the 45 emergency hospital admissions due to intentional self-harm in Rutland in 2021/22, 25 were in those aged 10 to 24 years – of these, 10 were in those aged 10-14 years and 10 were in those aged 15-19 years.

In 2022/23, the rate of hospital admissions as a result of self-harm in those aged 10-24 years in Rutland (241.9 per 100,000 population) was not significantly different to the national figure of 319.0 per 100,000 population (Table 15). The Rutland rate equates to 15 admissions.

Between 2020 and 2022 there were 7 suicides in Rutland.

Table 15. Hospital admissions for Intentional Self-Harm in Rutland and England, 2021/22 and 2022/23

Indicator	Time Period	Rutland			CIPFA range	England value
		Value	Count	Recent trend		
Emergency hospital admissions for intentional self-harm, directly standardised rate per 100,000 population	2021/22	106.4	45	-	102.9 – 279.3	163.9
Hospital admissions as a result of self-harm (10-24 years), directly standardised rate per 100,000 population	2022/23	241.9	15	⇨	216.4 – 662.3	319.0

Not significantly different to the national average	
Significantly better than the national average	

Recent trend over most recent five time periods:

⇨ No significant change

\- Could not be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

The *2014 APMS* assessed the prevalence of suicidal thoughts, attempted suicide and self-harm through both the face to face and self-completion of a survey in a population sample of adults aged 16 and over in England. Younger women (16-24) were more likely to self-harm (26%) than men of the same age (10%), or older women; the gap between young men and young women has grown over time.

Over 5% of adults reported suicidal thoughts in the past year, a significant increase on the 3.8% reporting this in 2000. Groups more likely to report these thoughts and behaviours included those who lived alone or were out of work (either unemployed or economically inactive). The survey found that two-thirds of Employment and Support Allowance (ESA) recipients had suicidal thoughts (66.4%) and approaching half (43.2%) had made a suicide attempt at some point.

For Rutland, these findings can be translated into estimates of around 6,590 people with suicidal thoughts, 2,100 of suicidal attempts and 2,100 people self-harming. These are broad estimates and need to be treated with caution.

This data demonstrates that it is important to acknowledge that there may be more people in need of mental health services and support in Rutland than the number of suicides and hospital admissions suggests, with many more people estimated to be experiencing suicidal attempts and self-harming.

4.4.2. Suspected Suicide Surveillance

A near to real time suspected suicide surveillance system (nRTSSS) was launched on 30 November 2023[140]. It is designed to act as an early warning system for changes in patterns of deaths by suicide to enable appropriate intervention.

It collects data on all suspected suicides, where cause of death was not yet confirmed by coroners' inquest. In all cases of 'sudden and unexpected' deaths, a suspected cause is assigned by the attending police officer, which is followed by a review based on the NPCC (National Police Chiefs' Council) guidance. Any suspected suicide assignation is provisional. The whole of England is not yet covered - not all PFA (police force areas) are participating. Overall, a coverage of 75% of the population of England aged 10 and above is currently covered.

The national report (based on nearly 5,000 deaths, around 75% of which were men) presents statistics for the most recent 15-month period (June 2022-August 2023). It describes monthly suspected suicide rates by age group and sex to show any variations, and 3-month aggregated data to describe suspected suicide methods.

Generally, the rates were three times higher for men than for women, except for the month of October within which the rate for men was four times higher. The rate was highest in June (13.1 per 100,000 population) and lowest in February (10.1 per 100,000 population), although monthly variations were not statistically significant. Rates were highest among 45–64-year-olds (14 per 100,000 population) and lowest for those 65 and above (6.5 per 100,000 population). The most common method of suicide was hanging, strangulation and suffocation (more than half of all deaths), followed by poisoning (20%).

Some detailed results indicate higher rates of suicide in the summer, for both men and women, with seasonal variation among younger adults (those aged 25-44). In the older group (65 years of age and above) the rates are increasing, with a recommendation to be monitored. There is also an indication of changes in the method of suicide, with an increase in jumping/lying in front of moving objects, as well as in drowning.

Sub-national data have not been published.

4.5. Substance misuse and smoking

It is estimated that 86% of people who access alcohol services experience mental health problems and 70% of those accessing drug misuse treatment have a mental illness. A 30-year-old concept of 'dual diagnosis'.

More than a third of people with mental health problems and more than two-thirds of people in psychiatric units smoke tobacco[141].

Both substance misuse and smoking contribute to morbidity and mortality among those with mental

health issues but there are problems with access to appropriate services as substance misuse and mental health services are provided separately.

In 2021-22 in Rutland, 68% of adults who entered drug, and 62% of those entering alcohol-only treatment were identified as having a mental health need, for reasons other than substance misuse. The local numbers are too low for robust comparison to the national rate, but they are in the same ballpark (70% for both groups nationally). The rates were higher for women than men (86% vs 61% and 67% vs 59%, for drugs and alcohol, respectively). In the alcohol-only group, over three-quarters were receiving treatment for their mental health, mainly through their GP or CMHT (Community Mental Health Team)[142].

In Rutland in 2021/22 the rates of admission episodes for mental and behavioural disorders due to the use of alcohol, according to the broad definition, were significantly better (lower) than the national figures for persons, males and females.

According to the GP Patient Survey, in 2022/23 8.3% of the adult population in Rutland classify themselves as current smokers (either occasional or regular smokers). Data from the same survey shows that of adults reporting a diagnosed long term mental health condition, 25.7% classify themselves as current smokers. The percentage of adults classifying themselves as current smokers in Rutland is significantly higher in those reporting a diagnosed long term mental health condition, with those reporting a mental health condition three times as likely to be current smokers. The smoking prevalence in adults with a long-term mental health condition in Rutland according to the GP Patient Survey (25.7%) is not significantly different to the national average (25.1%) (Table 16).

Table 16. Substance misuse and smoking in those with mental health conditions in Rutland and England

Indicator	Time Period	Rutland			CIPFA range	England
		Value	Count	Recent Trend		
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad) (Persons) – per 100,000 population	2021/22	142	59	-	142-467	404
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad) (Male) - per 100,000 population	2021/22	202	43	-	202-626	587
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad) (Female) -per 100,000 population	2021/22	86	16	-	86-371	233
Smoking prevalence in adults with a long-term mental health condition (18+) – current smokers (GPPS) (%)	2022/23	25.7%	-	-	17.1-33.0	25.1%
Smoking prevalence in adults (18+) – current smokers (GPPS) (%)	2022/23	8.3%	-	-	8.3-13.7	13.6%

Not significantly different to the national average	
Significantly better than the national average	

Recent trend over most recent five time periods:

- Cannot be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

4.6. Eating Disorders

Eating disorders are relatively common mental health conditions, with estimates suggesting that they affect millions of individuals worldwide. The most prevalent eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder [143].

Eating disorders disproportionately affect females compared to males, with rates typically higher among women and girls. However, it is important to recognize that males also experience eating disorders, though they may be less likely to seek treatment or receive a diagnosis. Eating disorders can develop at any age, but they often emerge during adolescence or young adulthood.

Various risk factors contribute to the development of eating disorders, including genetic predisposition, psychological factors (e.g., low self-esteem, perfectionism), sociocultural influences (e.g., media portrayals of body image), interpersonal factors (e.g., history of trauma or abuse), and biological factors (e.g., alterations in brain chemistry) [144].

Eating disorders frequently co-occur with other mental health conditions, such as mood disorders (e.g., depression, anxiety), substance use disorders, and personality disorders. Individuals with eating disorders may also experience medical complications related to their disordered eating behaviours. Eating disorders can have serious consequences for physical health, including

nutritional deficiencies, electrolyte imbalances, gastrointestinal problems, cardiovascular complications, and bone density loss. They also impact psychological well-being and quality of life.

Due to the stigma surrounding eating disorders and barriers to accessing care, many individuals may not seek treatment or receive a formal diagnosis. As a result, the true prevalence of eating disorders may be underestimated. While eating disorders are recognized as a global health concern, prevalence rates may vary between countries and cultures due to differences in sociocultural norms, access to healthcare, and awareness of eating disorders [145].

4.7. NHS Secondary Mental Health Service Use

Although health service use data are not a direct representation of mental health needs in a population, being representative of demand for care rather than of need, they do contribute to the understanding, prevention and control of diseases. Under careful analysis, they can provide crucial information on prevalence, incidence, patterns of disease, inequalities, health care utilisation, risk factors and populations at risk, health care costs and effectiveness, and patient behaviour and preference, among others.

Published annually, the NHS England *Mental Health Bulletin* (MHB) provides the most detailed picture available of people who used NHS funded secondary mental health, learning disabilities and autism services in England[146]. At the time of writing, the latest data are for financial year 2022/23 (April 2022 to March 2023).

While some of the MHB data are available at a local level, there is also a wealth of contemporary national-level intelligence providing useful insights into the current trends and inequalities in access to mental health services (some selected ethnic and deprivation examples are presented below) and, as proxy, in the prevalence of mental health conditions in the population. It is important to stress that the subset of the population in contact with specialist mental health services are already at a health disadvantage, nationally their mortality rate that is 3.6 times higher than the general population [147].

This section aims to report on the recent local trends and broader, national, patterns of inequality in access to specialist mental health services.

4.7.1. Contact and admission rates

Broadly, the 2022/23 data show rising rates with 6.3% of people (5.2% of all males and 6.1% of females) in England in contact with secondary mental health, learning disabilities and autism services in 2022/23, compared to 5.8% in 2021/22 and 5.0% in 2020/21– a 16% year on year rise.

3.6% of adults (aged 18 and above) in contact with services spend time in a hospital, less than in the previous (2021/22) year (4.2%). Prior to 2021/22, this proportion fluctuated between 4.2% and 5.1%. The year on year rise across England was 10% between 2021/22 and 2022/23, less than the

16.2% between 2020/21 and 2021/22. Across Rutland the trend was higher (14.2%) (Table 17).

Table 17. Number of people in contact with NHS funded secondary mental health, learning disabilities and autism services for residents in Rutland and England (all ages)

	In contact 2022/23 *	Admitted 2022/23 **	% of contacts admitted 2022/23	In contact 2021/22	Trend (%) ***
Rutland	2,055	40	1.9	1,800	14.2
England	3,582,864	91,945	2.6	3,256,659	10.0

* Number of people in contact with NHS funded secondary mental health, learning disabilities and autism services

** Number of people admitted as an inpatient while in contact with NHS funded secondary mental health, learning disabilities and autism services

*** Proportional increase in the number between 2021/22 and 2022/23

(Source: NHS Digital MHB 2022/23)

The Mental Health Bulletin provides demographic data down to sub-ICB (previously CCG) level, where people are classified using their GP registration status rather than their residence. Data presented here are for East Leicestershire and Rutland (03W, ELR).

Table 18. Number of people in contact with mental health services, access and admission rates for GP registered population in East Leicestershire and Rutland, by population group, 2022/23

	East Leicestershire & Rutland			
	In contact	**Contact rate (% of population)***	**Admitted****	**% Admitted**
All	19,515	5.7	450	2.3
Age:				
<18	3,915	5.6	10	0.3
18+	15,600	5.7	440	2.8
Sex:				
Male	8,100	4.6	250	3.1
Female	11,240	6.6	195	1.7
Ethnicity:				
Asian or Asian British	935	2.9	40	4.3
Black or Black British	150	3.5	5	3.3
Mixed	350	4.3	10	2.9
White	14,850	5.0	340	2.3
Other Ethnic Groups	145	2.5	10	6.9
Not Stated	2,510	-	35	1.4
Not Known	320	-	5	1.6
Unknown	260	-	0	0.0
Deprivation:				
01 Most deprived	220	3.5	10	4.5
02	2,205	8.8	70	3.2
03	3,695	6.7	80	2.2
04	5,895	5.9	105	1.8
05 Least deprived	7,430	5.2	160	2.2

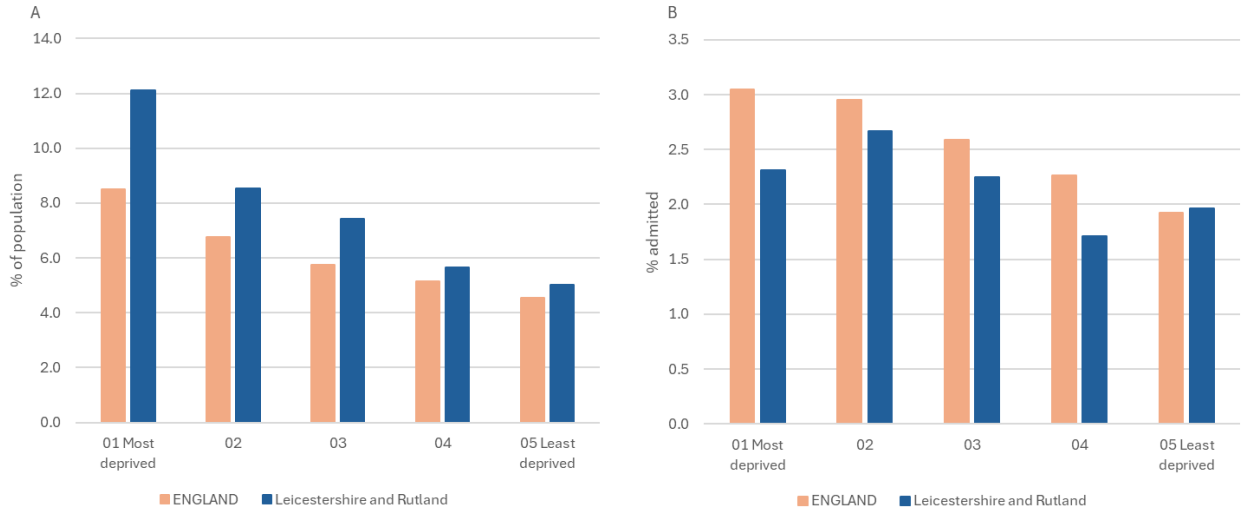
* Calculation for ethnicity excludes 'not stated', 'not known' or 'unknown' – rates to be treated with caution as for 15% of people in contact ethnicity was not known

** Number of people admitted as an inpatient while in contact with NHS funded secondary mental health, learning disabilities and autism services

(Source: NHS Digital MHB 2022/23)

Across East Leicestershire and Rutland in 2022/23, women were 39% more likely to be in contact with secondary mental health services than men, although also 45% less likely to be admitted as in-patients. Although there is some evidence of gradient across social deprivation categories, this is not consistent. The rates of contact were highest among white and mixed ethnicity population groups (Table 18 and Figure 29).

Figure 29. Rates of access to secondary mental health service (A) and proportion of admitted to hospital (B) across Leicestershire and Rutland in 2022/23, by deprivation quintiles

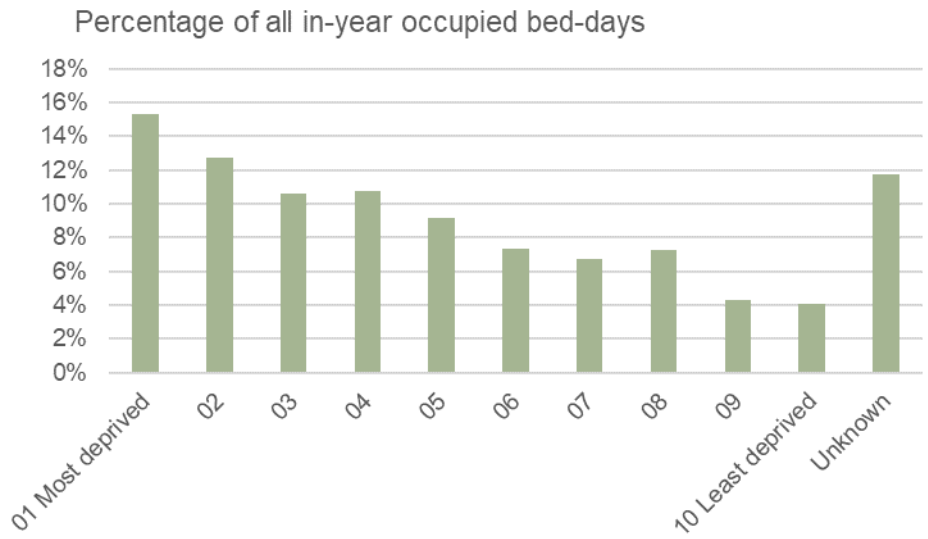


(Source: NHS Digital MHB 2022/23)

4.7.2. Bed Occupancy

Bed occupancy in mental services is strongly linked to socio-economic deprivation. Across England, the most deprived quintile of deprivation contributed 28% of all occupied bed-days, while the least deprived just 8% (Figure 30).

Figure 30. Bed occupancy by Indices of Multiple Deprivation, England 2022/23



(Source: NHS Digital MHB 2022/23)

The Leicestershire rate of bed occupancy, expressed as the number of in-year bed days in NHS funded secondary mental health service per 1,000 population (all ages) was about 38% lower than

the national average (105 vs 168 per 1,000) and was even lower in Rutland (65 per 1,000).

For comparison, the registered population East Leicestershire and Rutland CCG had a relatively high rate of 162/1,000, with a clear, three-fold difference between the most deprived and affluent areas.

Table 19. In-year occupied bed days in 2022/23 across Leicestershire, Rutland and England

	Number of in year bed days	Rate (per 1,000)	Rate Q1 (most deprived)	Rate Q5 (least deprived)
East Leicestershire and Rutland*	53,425	161.7	367.5	125.9
West Leicestershire *	42,210	109.6	288.4	72.0
Rutland	2,660	64.6	-	-
Leicestershire	75,750	104.9	-	-
England	9,512,771	168.4	269.2	75.4

(Source: NHS Digital MHB 2022/23)

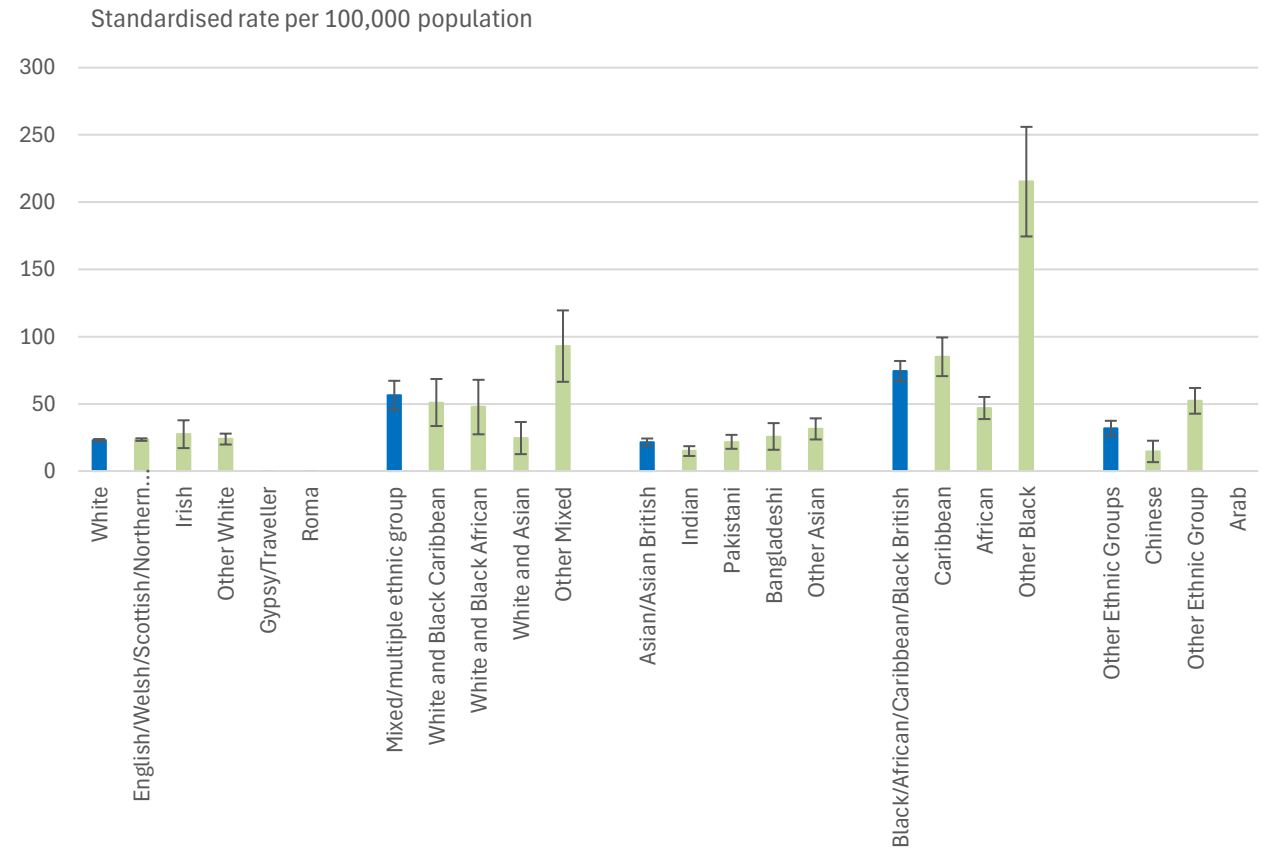
4.7.3. Inequalities at the national level

This section presents some of the more notable examples of ethnic differentials for adult patients in the NHS secondary mental health services in England in 2023. Although local data were not available, the national picture can give a useful indication of potential groups at higher risk. The underlying data were sourced from the 2022/23 NHS Digital Mental Health Bulletin.

For example, for adults aged 18-64 the highest rates of *long hospital stays* (60 days or more) in 2022/23 were for the 'other black' ethnic category (331/100,000 population) and 'other mixed' category (92/100,000), compared to the overall 32/100,000 and 25/100,000 in white population. It follows that these groups can be at significantly higher risk of long-term hospital stays. It has to be stressed that for 14% of cases in the national set ethnicity was poorly recorded ('not known', 'not stated' or 'other ethnic group') and these figures need to be treated with some caution.

The rates of *restrictive intervention* also varied significantly across ethnic groups with highest rates among those classified as 'other black' with over 200 interventions per 100,000 population compared to just over 21/100,000 in those from Asian or Asian British background, differing almost ten-fold. 'Other mixed' group and those of Caribbean descent also had relatively high rates (a five-fold differential with Asian groups) (Figure 31).

Figure 31. Rates of people subject to a restrictive intervention per 100,000 population, England 2022/23



(Source: NHS Digital MHB 2022/23)

Although the link between long hospital stays and restrictive interventions to deprivation was less pronounced, there were twice as many restrictive interventions in the most deprived quintile than in the most affluent one. And a three-fold gradient in the rates of long stays (60+ days) for adults in England in 2022/23.

4.7.4. Outpatients

Across England, the main groups of people in contact with services, but not admitted as inpatients, were with Core Community Mental Health (38%), followed by activity in general hospitals (11%) and Crisis & Acute Mental Health Activity in Community Settings. Notably a large proportion (over a half) of activity is described as 'other services', a further 8% were not classified.

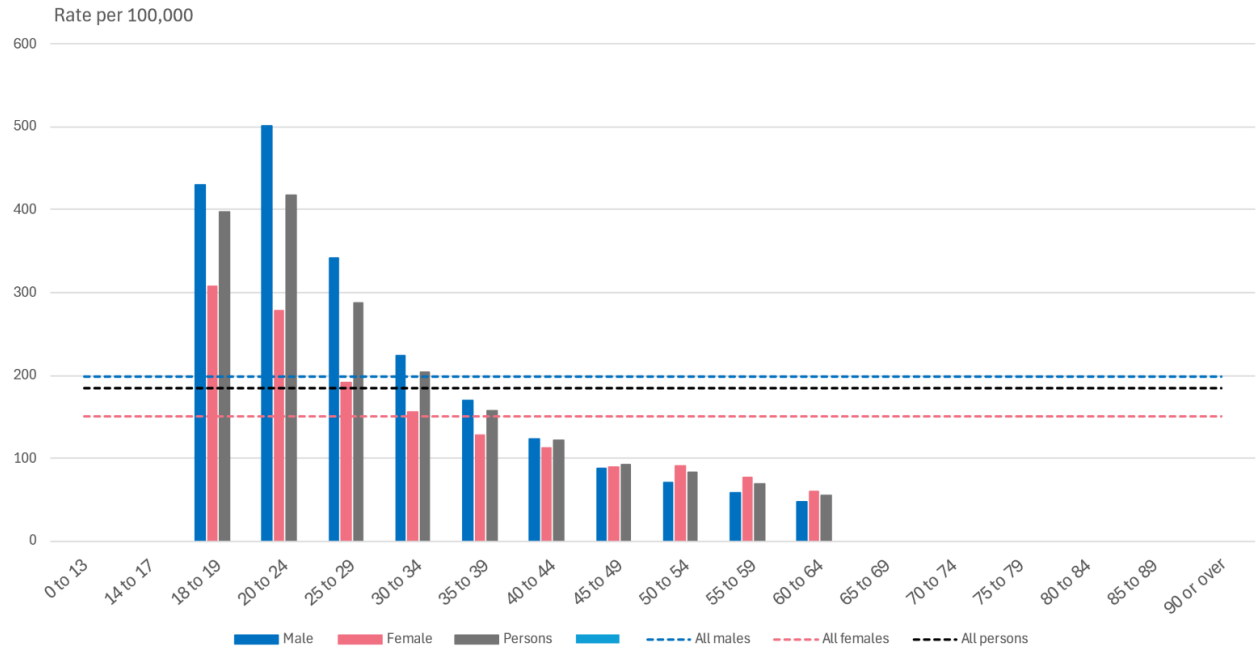
4.7.5. Early Intervention for Psychosis (EIP) pathway

Evidence suggests that early intervention for psychosis can lead to better long-term outcomes, including reduced hospitalisation rates, improved symptom control, higher rates of employment

and educational engagement[148]. Individuals experiencing psychosis for the first time have multifaceted needs, which necessitates rapid access to treatment, integrated service delivery (across psychiatric treatment, psychological therapies and work-based and family support), psychoeducation and support, medical management and psychological therapies, e.g. cognitive-behavioural therapy (CBT).

The national data show that the majority of all active referrals are for younger adults 18 and 34, with higher rates for men (by about a third) and with very few referrals among those aged 65 or above; the difference between men and women reduces with age (Figure 32).

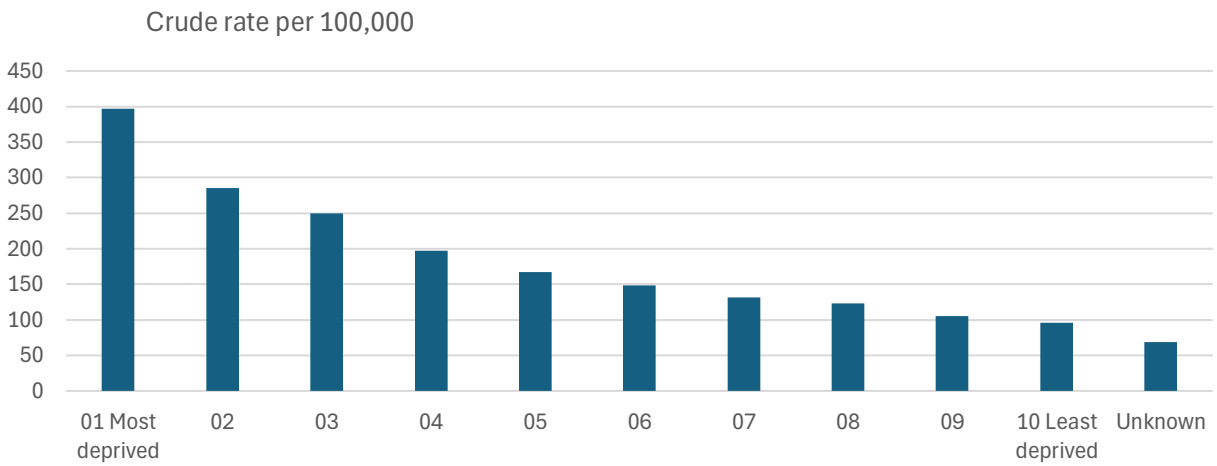
Figure 32. Referrals on EIP pathway in England in 2022/23 by age and sex (Source: NHS Digital MHB)



(Source: NHS Digital MHB 2022/23)

In England, there is a strong correlation between the rates of referral and deprivation, with rates over four times higher in the most deprived quintile of the population when compared to the most affluent quintile in England (Figure 33).

Figure 33. Referrals on EIP in England in 2022/23 by deprivation



(Source: NHS Digital MHB 2022/23)

Specialist Perinatal Mental Health Community Services

Are described in section 3.2.4, page 23 (Pregnancy and Maternity)

Memory Services for People with Dementia

Are described in section 4.2.5, page 58 (Dementia)

5. Impacts

5.1. COVID-19 Pandemic

The COVID-19 pandemic has had a significant impact on mental health worldwide, affecting individuals of all ages and backgrounds. Some of the mechanisms include increased stress and anxiety (through fear of contracting the virus, financial concerns, and social isolation), depression and loneliness (distancing measures, lockdowns, and restrictions on gatherings) and in some cases grief and loss, due to the loss of loved ones due to COVID-19, as well as disruptions to important life events such as weddings, graduations, and funerals, leading to feelings of grief and bereavement[149].

The economic impact of the pandemic, including job losses, reduced income, and financial insecurity, has contributed to stress, anxiety, and depression for many individuals and families. The disruption to daily routines, including work, school, and leisure activities, has led to feelings of uncertainty and a loss of purpose for some individuals, which can impact mental well-being.

The prolonged nature of the pandemic, combined with ongoing uncertainty and stress, has contributed to feelings of fatigue and burnout for many people, impacting their mental well-being.

Certain populations, including healthcare workers, older adults, people with pre-existing mental health conditions, and marginalized communities, may be disproportionately affected by the mental health impacts of the pandemic due to various factors such as increased exposure to stressors and barriers to accessing support. There is evidence of widening inequalities as result of the pandemic. In England, COVID-19 mortality rates were higher in the more deprived parts of the country[150], although the same evidence emerged from other parts of the world, the Americas, Europe, Africa and the Western Pacific[151].

Although in the main an overwhelmingly negative experience for most, it should be acknowledged that for some the pandemic had positive impacts on their mental health. For example, more time away from commuting and office work opened up time for mindfulness, family time and getting exercise and exposure to community outdoor spaces which can have positive impacts for physical and mental health[152].

5.1.1. The workplace

The COVID-19 pandemic has had a significant impact on the mental health of people in employment and those on furlough, at its worst in November 2020 to January 2021, with some improvement reported since then. The level of this improvement depends on the type of industry, particularly how fast a sector has bounced back after the pandemic.

It is estimated that the total estimated cost of mental ill-health has increased by 25% since 2019 and – reaching £53-56 billion in 2020/21, contributed to by presenteeism (attending work while ill), higher turnover of staff, and, to a lesser degree by absenteeism. Mental health of younger workers

and those from ethnic minorities was more affected by the pandemic, while the key workers were under more pressure than non-key workers, due to an increased risk of infection, pressure at work and wider pandemic-related stresses[153].

5.2. Employment and economy

Work is generally good for both physical and mental health and wellbeing and is a key part of the recovery process. There is a complex, two-way relationship between mental health and employment, with poor mental health decreasing the likelihood of meaningful employment and unemployment affecting mental health negatively. Getting back into employment increases the likelihood of improved health (from poor to good) almost threefold, and boosts quality of life almost twofold. People living with mental illness have employment rates of just 16% to 35%, a significant gap to general population [154].

One of the forms of support for people with disability or health conditions affecting their ability to work is ESA (Employment and Support Allowance). At the national level, the rates of claiming ESA for mental or behavioural disorders are strongly linked to deprivation, with rates in the most deprived decile 2.5 times higher than in the least deprived.

In 2022/23 in Rutland, the percentage of the population with a physical or mental long term health condition that was in employment (aged 16 to 64) was 73.8%, this was not significantly different to the national figure of 65.3%. In 2022/23 there was a 10.4% gap in employment between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate in England. The gap in Rutland (3.3%) was not significantly different to the national figure. The rate of Employment and Support Allowance (ESA) claimants for mental and behavioural disorders in 2018 in Rutland (12.0 per 1,000 population) was significantly better (lower) than the national average (27.3 per 1,000 population). Rutland had the lowest rate of claimants of its CIPFA comparators. The rate in Rutland has shown a significant increasing and worsening trend over the most recent five time periods.

In 2021/22 in Rutland, the percentage of the population who were in contact with secondary mental health services that were in paid employment (18-69 years) was not significantly different to the national figure (4.0% vs. 6.0%). The gap in the employment rate for those who were in contact with secondary mental health services and the overall employment rate in Rutland in 2021/22 (71.9 percentage points) was not significantly different to the national figure (69.4 percentage points).

The proportion of adults in contact with secondary mental health services who lived in stable and appropriate accommodation in Rutland in 2020/21 was not significantly different to the national average (34.0% vs. 58.0%) (Table 20).

Table 20. Differentials in employment and economic factors for those with mental health conditions in Rutland

Indicator	Time Period	Rutland			CIPFA range	England
		Value	Count	Recent Trend		
The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64)	2022/23	73.8%	-	-	50.8 – 76.0	65.3%
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate (Gap-percentage points)	2022/23	3.3	-	-	3.0 – 16.7	10.4
ESA claimants for mental and behavioural disorders: rate per 1,000 working age population	2018	12.0*	270	↑	12.0-37.1	27.3
The percentage of the population who are in contact with secondary mental health services that are in paid employment (18-69 years)	2021/22	4.0%	13	-	1.0%-14.0%	6.0%
Gap in the employment rate for those who are in contact with secondary mental health services and the overall employment rate (Gap – percentage points)	2021/22	71.9	-	-	66.2-76.4	69.4
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Proportion - %)	2020/21	34.0%	-	-	34.0%-84.0%	58.0%

Significantly better than the national average	
Not significantly different to the national average	

Recent trend over most recent five time periods:
↑ Increasing and getting worse

(Source: Office for Health Improvement and Disparities, Fingertips)

5.3. Return on Investment

In 2019 mental health conditions are estimated to have accounted for 7% of all ill-health with the cost to the UK's economy estimated at nearly £118 billion per year (5% of UK GDP), with the majority of this cost falling outside of the health care system – through lost employment and informal care costs [155].

Of the total, £101 billion is attributed to England. More than half of the estimate (56%) is for ages 15-49, with 27% for those aged 50-69. The largest components by condition are for depression (23%), anxiety (18%) and bipolar disorder (17%). Thus, prevention of depression and anxiety would have the most significant impact.

Evidence indicates that there is a positive return of around £5.30 on every £1 spent on mental health interventions in the workplace [156] [157].

Although important, and easier to quantify, the workplace is not the only setting where prevention is likely to have economic impact, others include[158]:

- Perinatal depression prevention (health visiting)
- Parenting programmes
- School and education – antibullying programmes, exercise and physical activity
- Early identification in young adults
- Psychological interventions in those living with long-term conditions
- Prevention in older people – measures to reduce social isolation, increase physical activity, for example

As with other public health interventions, these are likely to have long-term effects, often difficult to quantify through, typically shorter-term, research.

5.4. Dementia

Dementia is progressive in nature with patient's needs changing over time, which has implications for service planning at an individual and at population level. It has significant impact on the life of the patient, with loss of independence and mental capacity, but also on wider circle of family and friends, who often provide care. These carers may experience negative effects including increased mental health issues, physical ill health, social isolation and financial hardship. It is therefore important they are considered as 'second patients' who require support alongside the person with dementia[159]. It was estimated in 2019 that dementia sufferers and their families in the UK spend around an estimated £8.3 billion pound on paid for care, whilst also contributing around £13.9 billion in unpaid care[160].

Dementia not only affects someone's mental health but also their emotional wellbeing. Dementia diagnosis can cause a range of emotional responses and can cause the person to be treated differently by others. It can also contribute to the person feeling isolated or lonely which in itself has health consequences. Diagnosis can also trigger other mental health conditions in particular anxiety and depression. These additional conditions can negatively affect the patient's health even further than the original dementia[161]. These additional mental and emotional health issues add to the burden placed on the person with dementia but also those caring for them, the wider community they live in and the services they access.

Up to a quarter of hospital inpatients at one time in the UK may have a diagnosis of dementia, contributing a large amount to the burden on our acute hospitals. In 2014 the NHS spent around £4.9 billion on dementia care. Whilst social care spent around £15.7 billion on care for people with dementia, with £4.5 billion of this coming from local authorities and the remaining cost coming from families paying for state funded care. With these costs expected to rise[162].

6. Current Services

6.1. Summary of Adult Mental Health Services in England

Mental health services for adults in England are provided through the National Health Service (NHS) and other community organizations. The NHS services are traditionally grouped as primary, secondary, and tertiary care, but under the NHS Long Term Plan, transformation is ongoing to create integrated community mental health services.

- General practitioners (GPs) are often the first point of contact for individuals seeking mental health support. They can provide assessments, referrals to specialist services, and prescribe medication.
- Talking Therapies (previously Improving Access to Psychological Therapies, IAPT) program offers therapies like cognitive behavioural therapy (CBT) for common mental health issues such as depression and anxiety. It aims to provide timely and evidence-based interventions.
- Community Mental Health Teams (CMHTs) consist of various professionals, including psychiatrists, psychologists, social workers, and community psychiatric nurses. They provide comprehensive support to individuals with severe and enduring mental health problems.
- Crisis Resolution and Home Treatment Teams (CRHT) offer intensive support to individuals experiencing a mental health crisis, aiming to prevent hospital admissions and support individuals in their homes.
- Inpatient Services are offered to individuals requiring more intensive support, there are psychiatric hospitals and units available across England. These provide care and treatment for acute mental health conditions.

In addition, there are specialized services for specific mental health needs, such as eating disorders, personality disorders, and psychosis. These services offer tailored interventions and support.

Increasing emphasis is placed on recovery-oriented approaches, promoting individuals' independence, resilience, and social inclusion. Many organizations offer peer support and self-help groups where individuals with lived experience of mental health problems can connect, share experiences, and support each other's recovery. There's a growing emphasis on digital mental health services, including online therapy platforms, apps, and helplines, providing accessible support options for those who may not access traditional services. Efforts are made to integrate mental health services with social care and other support services to provide holistic support for individuals with complex needs.

Most services are commissioned locally by Integrated Care Boards (ICBs); however, some specialist services are commissioned by NHS England. NHS England is in the process of delegating responsibility for commissioning specialised mental health, learning disability and autism services

to NHS-Led Provider Collaboratives[163].

6.2. Local Mental Health Services for Adults

Most of mental health services for adults in Rutland are commissioned and operate across Leicester, Leicestershire and Rutland (LLR).

This section provides only a summary of current local services – for a more comprehensive description please see the separate **Appendix.**

For urgent mental health support, people may contact the **Mental Health Central Access Point**, a 24/7 freephone, operated by Leicestershire Partnership Trust and Turning Point, **NHS111 service** or a **Crisis Café**.

6.2.1. Mental Health Central Access Point

The phone line is staffed by recovery workers from Turning Point, who, after an assessment, can transfer callers to an appropriate staff member at Leicester Partnership NHS Trust (LPT).

6.2.2. Neighbourhood Mental Health Cafés

(https://www.leicspart.nhs.uk/service/neighbourhood-mh-cafes/

The cafes are drop-in centres operated by supportive, trained staff.

For non-urgent mental health support people can contact their general practice or the **NHS Talking Therapies**, a self-referral, free confidential service provided by Vita Minds (Vita Health part of Spire Healthcare).

6.2.3. NHS Talking Therapies

Formerly known as IAPT (Improving Access to Psychological Therapies), NHS Taking Therapies are NHS-funded, evidence based, psychological therapies for depression and anxiety. It is provided by Vita Health Group (VitaMinds) for all adults who live and are registered with a GP in Leicester, Leicestershire and Rutland (https://www.vitahealthgroup.co.uk/nhs-services/nhs-mental-health/leicester-leicestershire-rutland .

6.3. Leicestershire Partnership NHS Trust

LPT provides the following inpatient, outpatient and community services:

6.3.1. The Bradgate Mental Health Unit

The Bradgate Mental Health Unit (Glenfield Hospital, Leicester) is an acute mental health admissions unit with six recovery-focused general psychiatry wards, two psychiatric intensive care wards and one low-secure ward.

6.3.2. Adult Community Mental Health Teams

There are eight community multidisciplinary mental health teams providing a secondary care, planned assessment and treatment service. This might involve psycho-social interventions, medical prescribing or, if eligibility criteria are met, social care commissioning of services. They aim to provide support with mental health needs, all aspects of daily life such as self-care, well-being and health promotion.

6.3.3. Forensic Mental Health Services

This is both an inpatient and a community service for people with a history of offending who also suffer from mental ill health. It operates from the Herschel Prins Centre, Glenfield Hospital in Leicestershire.

6.3.4. Perinatal Mental Health Service

A team of health professionals at Bradgate Mental Health Unit, Glenfield Hospital, providing personalised and specialist care to people with moderate to severe mental health problems relating to pregnancy, childbirth and the first year following a child's birth (also known as the perinatal period).

6.3.5. Maternal Mental Health Service

Based at Prince Philip House, St Matthews Health & Community Centre, Malabar Road, Leicester this is a psychology-led, trauma-informed service, helping women and birthing people with moderate to severe difficulties related to birth trauma, baby loss, and tokophobia.

6.3.6. Psychosis Intervention & Early Recovery (PIER) Team

Based at Merlyn Vaz Health and Social Care Centre, Leicester, the team offers support to people recovering from a psychotic episode. The service offers help to people aged 14 – 64 years who are experiencing first symptoms of psychosis, as well as providing help to their families.

6.3.7. Mental Health Liaison

This is a multidisciplinary team of liaison professionals providing assessment and treatment for people who experience mental health problems as a result of physical illness. The service provides a specialist *Chronic Fatigue Syndrome (CFS) service*.

6.3.8. Mental Health Services for Older People (MHSOP)

MHSOP provides inpatient, outpatient and memory services for older people. *MHSOP Inpatients* operates across two sites, The Evington Centre and the Bennion Centre, with three wards. Working closely with community intensive teams, community mental health teams and outreach services for older people with functional and organic mental health problems. *MHSOP Memory Service*

operating from Evington Centre, provides diagnostic assessment and treatment for people with dementia within a clinic setting, care home or their own home. People of all ages with possible dementia can be referred, while the *MHSOP Outpatient Service* provides assessment and treatment for people over 65 years with moderate/complex functional mental health issues in clinics held across Leicester, Leicestershire and Rutland.

There is also an *MHSOP In-reach Team,* based at Neville Centre*,* Leicester General Hospital Site, helping patients who live in a care, residential or nursing home, and are experiencing difficulties due to their dementia and require specialist support and advice.

6.3.9. Mental Health Wellbeing and Recovery Support Service (MHWRSS)

This service is aimed at providing a first point of access for people who need mental health support. P3 (https://www.p3charity.org) provides this service for Rutland and Leicester City.

6.3.10. Crisis Resolution and Home Treatment Team

This team provides a rapid assessment of people who are experiencing a mental health crisis and would otherwise require a hospital admission to an acute mental health ward, due to mental health crisis which impacts on the person's ability to cope with day-to-day activities.

6.3.11. Adult Eating Disorders Service

Is an outpatient service for patients from LLR and a regional inpatient service for the East Midlands for adults aged 18 and over who have eating disorders such as anorexia nervosa, bulimia nervosa, binge eating disorder and other diagnosable eating disorders.

6.3.12. Therapy Services for People with Personality Disorder (TSPPD)

The service provides psychotherapy programmes drawn from a number of different models of psychotherapy for people age 18+ who have been assessed for the group therapy service and discussed it with their referrer.

6.3.13. Severe and Enduring Mental Illness Rehabilitation

These are rehabilitation inpatient units providing multidisciplinary care for patients who have severe and enduring mental illness.

6.3.14. Acute Recovery Team

Is providing specialist care, including an ECT clinic and Clozapine clinic, blood tests and monitoring.

6.3.15. Clinical Neuropsychology

Based at the Leicester General Hospital, the team serves both inpatients and outpatients who are having cognitive difficulties as a result of a neurological condition, providing neuropsychological

assessment and advice, intervention, rehabilitation, and training.

6.3.16. Leicestershire Psycho-oncology Service (LPOS)

Helping those with emotional and mental difficulties following a diagnosis of cancer, providing a range of interventions in hospital or in patient's home.

6.3.17. Huntington's Disease Inpatient and Community Service

Is a community inpatient unit for people with Huntington's disease for patients with severe and enduring mental health needs and require complex care due to physical, psychiatric, behavioural and psychological needs or rehabilitation. The community team is also based there.

6.3.18. Assertive Outreach (AO) Service

The service is provided within a multidisciplinary team approach, predominantly delivered within people's homes. The service offers a range of therapeutic interventions. It has been specifically set up to work in partnership with people with long-standing mental health needs which are 'psychotic' in nature.

6.3.19. Central Referral Hub/Unscheduled Care service

All referrals into Mental Health Services for Older People from across Leicester, Leicestershire and Rutland are received by the Central Referral Hub. People of all ages with probable dementia and adults over the age of 65 with depression, anxiety or psychotic illnesses.

6.3.20. Criminal Justice and Liaison Diversion

The service assesses people's mental health needs who have had any contact with the criminal justice system or police for any reason, victim, suspect, defendant, witness or bystander, who it is felt would benefit from mental health intervention.

6.3.21. Employment Support Service

The service is delivered to adult patients (17 and above) open to community mental health teams, psychosis intervention and early recovery (PIER) and assertive outreach, providing information, advice, guidance and support to find paid work, as part of an individualised recovery plan. Currently operates employment clinics in nine locations across Leicester, Leicestershire and Rutland (LLR).

6.3.22. Homeless Mental Health Service

The Homeless Mental Health Service is a multi-disciplinary team offering engagement, mental health assessment and referral to mainstream mental health and support services – for people age 16 and over, who are homeless or staying in temporary accommodation. The team is made up of three full-time mental health practitioners, a part-time psychiatrist, part-time clinical psychologist

and a part-time secretary.

6.3.23. Leicestershire Recovery College

Based at the Mett Centre, Leicester, this is an NHS college offering a range of recovery-focused educational courses and resources for people aged 18 and over who have lived experience of mental health challenges, along with their friends, family and LPT staff.

6.3.24. Medical Psychology

A service for adults who are having difficulties with managing the impact of medical/physical health problems on their psychological well-being or are finding that their mental health is having a direct impact on their physical health. The service can offer assessment and treatment to adult patients from all medical specialities. Referrals only from University Hospitals of Leicester (UHL) Consultants (or a member of their team).

6.3.25. Mental Health Urgent Care Hub

A team of mental health practitioners with the expertise to treat people of all ages; this includes mental health nurses, support workers, and consultants. It is specifically for people with mental health needs that don't need any physical health support from an emergency department.

People are referred to the hub by emergency services, social care or health professionals.

6.3.26. Op Community

Op Community is a telephone line for the armed forces community (including veterans, reservists, serving personnel, families and the wider armed forces community) to offer support and guidance around navigating NHS services and advice regarding other services that can support with issues.

6.3.27. Outreach Team for Adult Learning Disabilities Service

The Outreach Team works with adults aged 18 years + with a diagnosed learning disability and their carers where the person with a learning disability has challenging behaviours that might mean they cannot continue to be supported in the community/at home.

6.3.28. Psychological Awareness of Unusual Sensory Experiences (PAUSE)/At Risk Mental State (ARMS)

Planned to launch in Autumn 2023, initially in a targeted geographical area rather than across Leicester, Leicestershire and Rutland. To offer NICE-recommended psychological and psychosocial interventions to people aged 14 – 35 years who may be experiencing the early signs of psychosis.

6.3.29. Reconnect

The service offers care to those aged 18 and above with identified vulnerabilities after a custody

service. Provides up to 12 weeks pre-release and six months post-release person centred support, including assertive outreach, digital guidance, system navigation, signposting to support from wider health and wellbeing services.

6.3.30. The Involvement Centre and Café

The Involvement Centre is an information, IT and social resource, open to inpatients, outpatients, service users, carers and visitors.

6.3.31. Arts in Mental Health

The team delivers a range of artistic projects for mental health service users whilst supporting service users.

6.3.32. The Mett Centre

A mental health day resource centre in Leicester city centre, offering recovery-focused support, through individualised programmes of meaningful activities, physical and mental health promotion, social inclusion and therapeutic interventions.

6.4. PAVE Team (Pro-Active Vulnerability Engagement)

This is a partnership between police, mental health practitioners, and substance misuse practitioners providing targeted support for people who intensively use health and police services. The aim is to reduce the number of people with mental ill health being held inappropriately in police cells. The multi-disciplinary team includes police officers, mental health practitioners, and substance misuse Recovery Workers. In addition clinical support is available as required from a Consultant Psychiatrist.

6.5. Voluntary and Community Sector Services

In Rutland, voluntary and community based services include:

Norton Housing Support (http://nortonhousingandsupport.org.uk/) provides support and accommodation to adults with ongoing mental health needs and/or learning disabilities.

Leicestershire Action for Mental Health Project (LAMP) (https://www.lampadvocacy.co.uk/) provides independent mental health advocacy (IMHA).

The Singing Café (https://thesingingcafe.co.uk) is a charity initiative run by Without Walls to address the needs of vulnerable members of Leicestershire population, seeking to address loneliness and mental health conditions. Can be found in Melton and Wigston.

The Carers Centre (https://www.claspthecarerscentre.org.uk/) aims to support unpaid carers across the diverse communities of Leicester, Leicestershire and Rutland.

Living Without Abuse (https://lwa.org.uk/) offers information and advice to anyone experiencing

domestic abuse and/or sexual violence.

Voluntary Action Leicester (VAL https://valonline.org.uk/) is an active part of the local voluntary, community and social enterprise (VCSE) sector, providing advice, support and training to charities and community groups across Leicestershire. They are a source of information on other voluntary initiatives for people with mental health across LLR.

6.6. Local Authority and Other Mental Health Services

The working age adults mental health care pathway supports recovery and reablement, aimed at maximising people's independence, and their ability to self-manage. Service provision includes;

6.6.1. Mental Health Reablement Teams

The service provides the first offer to the majority of people who are eligible for support for their mental health problems (excluding safeguarding, and urgent crisis/complex work). These teams provide short term solution focused support to promote recovery and increase independence. These teams are staffed by Mental Health Social Workers.

6.6.2. Community Mental Health Teams

The teams include Social Workers, and Mental Health Social Workers, and most also include an Approved Mental Health Professional (AMHP). The teams provide a service to all service users in their locality. In addition to the locality based teams there are countywide services providing more specialised support and interventions.

6.6.3. Mental Health Wellbeing and Recovery Service

Commissioned jointly between, Leicestershire County Council, Leicester City Council, Rutland County Council, and the three CCG's and currently provided by three different providers, the service offers support networks focused on wellness and recovery, encouraging independence and developing own personal support networks.

6.6.4. Specialist Substance Misuse Treatment Services

Specialist substance misuse services for Leicestershire and Leicester City are jointly commissioned by Leicestershire County Council (Public Health) and Leicester City Council (Adult Social Care) with additional funding by the Office of Police + Crime Commissioner (OPCC) and NHS England. It is currently provided by the Turning Point. There are close working arrangements with inpatient psychiatric wards, and weekly clinics/drop-ins attended by the Dual Diagnosis Senior Recovery Worker. In addition there is a weekly mental health drop-in session at the main service hub in the city centre, but available for any service user.

6.6.5. Local Authority Public Health Services

The Public Health Department approach involves finding ways to improve the mental wellbeing of the population in Leicestershire, through assessing health needs, assessing evidence base for interventions, direct commissioning/contracting of services, and working with other departments and partners. The department leads the Leicestershire, Leicester City and Rutland wide Suicide Audit and Prevention Group. In addition to the suicide prevention work, currently the department commissions and/or contributes to a number of local initiatives aimed at improving mental wellbeing and supporting recovery:

First Contact + offers access to a range of low level preventative services through a single point of contact. This is an online service ensuring that people can access information, advice and support across a range of issues.

Local Area Co-ordinators (LAC's) is a community based intervention delivered in specific areas by Local Area Co-ordinators. The team work on an asset-based model to increase individual and community capacity, preventing people reaching crisis, and thereby reducing demand on public services. Whilst not a specific mental health service, much of the work undertaken supports improving people's mental wellbeing and addresses issues that impact on individual mental health.

Other services include:

6.6.6. Getting Help in Neighbourhoods

This service is commissioned by the ICB and in partnership with Leicestershire County Council this service offers drop-in sessions offering a listening ear and short-term support based on the needs of the individual. It is available to anybody aged 18, the sessions are running across Leicester, Leicestershire and Rutland

6.6.7. Student Mental Health

The ICB is leading on a workstream focussing on the needs of the student population across the universities in Leicester and Leicestershire in conjunction with the university health and wellbeing services.

6.6.8. Mental Health Practitioner/Facilitators

Is a Primary Care based service for patients with more severe and enduring mental illness such as schizophrenia and bipolar disorder.

6.6.9. Mental Health central Access Point

Is a 24/7 self-referral service for people in need of mental health support for themselves or others, commissioned by the ICB and staffed currently by Turning Point , this is an all-age service that provides signposting, assessment and intervention.

6.6.10. Place of Safety

This is the Section 136 (S136) suite at the Bradgate Mental Health Unit. This suite is used for emergency psychiatric assessment by an AMHP detained by police, under S136 of the MHA. S136 is used on an exceptional basis, although when it is appropriate to be used, it is preferable for the individual to be detained in a healthcare setting rather than a criminal justice setting.

6.6.11. Triage Car

Leicestershire Police and a mental health nurse from LPT respond to people with mental health problems in public places

6.6.12. Transition work

The ICB is leading on services and pathways for those aged 18-25.

6.6.13. Upcoming service to Rutland: Women's Hub

Rutland are in the process of mobilising a women's hub to provide social, emotional and health support including sexual health, menopause and social prescribing.

6.7. Additional Dementia Services

Admiral Dementia Nurse Service – includes specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia. The service is available to people living in Rutland and will work with family carers as their prime focus, promote best practice in person centred dementia care, pre diagnostic support, support through transitions in care and bereavement support.

Rutland Dementia Support Service, LeicesterShire & Rutland Age UK – Supports people who are living in Rutland and who are awaiting or living with an early diagnosis of dementia. The service offers, personalised information and advice, emotional support as well as access to a range of group activities that promote wellbeing.

Dementia Friendly Leicestershire, Care Choices – A practical guide to living with dementia in Leicester, Leicestershire and Rutland which explores all aspects of living with dementia. The guide is available here: https://www.carechoices.co.uk/publication/leicestershire-dementia-guide/

The Hub of Hope, Chasing the Stigma – This mental health support signposting tool brings local, national, peer, community, charity, private and NHS mental health support and services together into one place.

Dementia carers Support Age UK - Dementia advisors support friends and family of those with dementia with information and advice about navigating local services and applying for benefits.

7. Identified Needs and Gaps in Provision

- Rutland has a faster than national demographic growth among older adults which has direct implications for future health needs, levels of morbidity and multimorbidity, including mental health conditions.
- The numbers of women accessing community perinatal mental health services in Leicestershire and Rutland are increasing, following the national trend.
- There is some evidence of rising local crime rates, including rural crime and violence against the person, and further analysis of the impacts on mental health would be recommended.
- Although some work to understand the health and wellbeing needs of Rutland's armed forces population has been undertaken recently, the small numbers of respondents make it difficult to draw conclusions on the wider needs of this population, particularly that this population has recently changed.
- The proportion of people waiting for NHS Talking Therapies for a long time was higher than expected in previous years but shows improvement recently (91% seen within 6 weeks across East Leicestershire and Rutland).
- The prevalence of dementia in patients registered with GP practices in Rutland has been consistently higher than the national average, however the proportion of patients with their care plan reviewed in the last 12 months was relatively low in 2020/21. This could be the result of the COVID-19 pandemic, as in prior years this indicator was above the national average; when available, the later data could show post-pandemic recovery.
- The estimated prevalence of severe mental illness (SMI) in Rutland is 790, whilst there were just 312 patients registered with SMI on GP registers. This suggests that a substantial number of patients are not accessing treatment.
- Comparative data show higher rates of premature mortality among people with SMI, with a suggestion this is largely due to cancer mortality in Rutland, although the numbers are too low to draw a statistically valid conclusion.
- Only half of people with severe mental illness receive full physical health checks (45% in Leicestershire and Rutland), against the current 60% performance target – a preventative measure that could be improved.
- Due to the small numbers of suicides in Rutland we are unable to report details on these figures within this report. However broad estimates suggest that there are around 4,000 people self-harming and/or attempting suicide in Rutland. Surveillance of suspected suicide is on-going.
- Dementia prevalence is projected to increase – between 2023 and 2040 the number of

people aged 65 and over in Rutland with dementia is estimated to increase by 48.6%, while in persons aged 85 years the increase is expected to be 70.3%. Plans will need to take the projected growth into account to ensure that the capacity of dementia services is increased to meet this level of need in the future.

- People with personality disorders (PD), estimated to account for at least 4,000 in Rutland, experience considerable stigma, and, as was previously assumed, less chances of effective recovery. However, there is evidence that treatment for PD can be effective; a trauma-informed understanding of PD would consider it as complex trauma. Currently, care for PD is fragmented with gaps in service provision offering a compassionate understanding about PD and treatment.
- There is a lack of flexible mental health outreach for people who sleep rough and may have dual diagnosis with substance misuse.
- It is recognised that 50% of mental health problems are established by age 14 and 75% by age 25, and although one in ten children and young people aged 5-16 have a clinically diagnosable condition, 70% have not had appropriate interventions at a sufficiently early age (MH Foundation 2024).
- There are gaps in the continuity of care for people self-harming, attending Emergency Department and returning back to locality Primary care and local services, particularly for those at university who may be at a part-time address.

8. Recommendations

- To seek opportunities for prevention and early detection of mental health conditions, including raising awareness of the risk factors of dementia and prevention measures for these.
- To monitor and improve uptake of physical health checks, particularly among those with serious mental illness or dementia.
- As Rutland is predominantly rural, issues of access to services and hidden pockets of deprivation should be recognised and addressed at a local level, through improved joint working. Needs of some at risk groups such as prisoners, travellers and armed forces personnel should assessed at a local level.
- To improve the transition from children's services such as CAMHS into adult services, with a focus on prevention. The ICB is leading on this piece of work and the system plays a key part in shifting the focus from separate children and adult services into considering children's mental health as part of the adult preventative offer across the life course. A comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults could deliver an integrated approach across health, social care, education and the voluntary sector, and offer person-centred and age-appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.
- To develop prevention services for carers of people with mental health difficulties to provide support before that person reaches a crisis.
- To improve access to mental health services particularly in communities where there may be a stigma attached to living with a mental health problem.
- To develop flexible mental health outreach for people who sleep rough and may have dual diagnosis with substance misuse (primarily Leicestershire and Leicester).
- To enhance continuity of care for self-harm, including emergency services, primary and social care and other local services.
- To develop a local Prevention Concordat with a prevention-focused approach (primarily Leicestershire).
- To improve access to effective treatments for personality disorders (PD).
- To implement the recommendations of the on-going gambling-related harm workstream for suicide prevention alongside the work on cost of living pressures.
- To enhance engagement with the voluntary and community sector.
- To enhance local data collection on mental health inequalities, prevention and services, including mapping of services and patient pathways, particularly for vulnerable groups such as pregnant women and armed forces populations.

- The effectiveness of the Rutland Women's Hub service currently being mobilised should be assessed and monitored to ensure that this service is meeting the needs of women in Rutland.
- Further modelling of the impact of current demographic trends on future mental health needs and demand for health care would be recommended, particularly for dementia.

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