APPENDIX D

RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

MENTAL HEALTH OF ADULTS

DECEMBER 2018

Strategic Business Intelligence Team
Leicestershire County Council

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Rutland
County Council

Public Health Intelligence

Strategic Business Intelligence Team
Strategy and Business Intelligence
Chief Executive's Department
Leicestershire County Council
County Hall, Glenfield
Leicester LE3 8RA

Tel 0116 305 4266
Email phi@leics.gov.uk

Produced by the Strategic Business Intelligence Team at Leicestershire County Council.

FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To 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.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs 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 has reviewed the population health needs for the people of Rutland in respective of an adult's mental health, substance abuse, sexual violence and domestic violence. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting the population, and the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG 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, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- The Annual Population Survey 2015/16 estimates that over three-quarters (76.6%) of Rutland's population report a high happiness score. This is higher than the England average of 74.7%. In 2016/17, just over one fifth (21.8%) of Rutland's residents reported a high anxiety score, this is similar to the England value of 19.9%.

- The Quality Outcomes Framework shows the recorded prevalence for depression in the GP registered population aged 18 or over has increased year on year both nationally and locally since 2013/14. The latest data in 2016/17 shows the recorded prevalence for depression in the GP registered population aged 18 or over is 7.9% for Rutland's population. This is significantly lower than the England average of 9.1%.

- The Adult Psychiatric Morbidity Survey 2014 found mixed anxiety and depression to be the most prevalent common mental health condition in England, with 7.8% of the population estimated to be affected by it in any given week. The IAPT service data shows that in 2016/17, 34.1% of the referrals entering treatment for ELR CCG were diagnosed with mixed anxiety and depression, accounting for 1,145 people. This was the most common recorded diagnosis for ELR CCG.

- The latest data for Rutland shows that the percentage of people with severe mental illness (0.69%) on GP Practice registers is significantly lower than England (0.92%) in 2016/17. Nationally the trend over time is increasing, whereas locally the trend has stabilised. Acute mental health admissions recorded at Leicestershire Partnership Trust are significantly lower than England average; however acute mental health bed days are significantly higher than the England average. This suggests that although less people are going into hospital compared to the England average, those that do go in stay there for longer than average. This may be associated with the significantly low percentage of Rutland's adults who were in contact with secondary mental health services and lived in stable and appropriate accommodation (23.0%) compared to nationally (54.0%).

- The latest data for hospital admissions for self-harm shows Rutland performs significantly better than the national rate. Since 2014/15, the rate of admissions for intentional self-harm in Rutland have decreased year on year, while the national rate has fluctuated.

- In Rutland, a similar proportion of the population are dying by suicide compared to England. As seen in national trends, the rate of suicides in males is at least three times higher than the rate of suicides in females.

CONTENTS

List of Tables

1. Who is at risk?

Almost 1 in 4 people in the UK experience at least one mental health problem each year, with 1 in 6 experiencing a common mental health problem, such as anxiety or depression, in any given week. The proportion of disease burden, as measured by the number of years lived with disability due to mental disorders and self-harm, is 30.3% in the UK. This means, on average, people will spend almost a third of their life living with a mental health condition. This figure is thought to be a significant underestimate as it excludes several mental disorders.

1.1. Protected characteristics

1.1.1. Long term health problems or disabilities

It is suggested that people with a long-term health problem or disability are two to three times more likely to develop mental health problems, particularly anxiety and depression.

According to the 2011 Census, 15.5% of Rutland's population were found to have a long-term health problem or disability that limited their day-to-day activities. This is lower than the England average of 17.6%.[1]

1.1.2. Learning disabilities

Adults with a learning disability are estimated to experience double the risk of depression and a three-fold increase in the risk of schizophrenia.[1] The Quality Outcomes Framework (QOF) indicates that in 2016/17, 2.03% of Rutland's population were recorded on a GP register as having a learning disability. 60.7% of eligible adults with a learning disability received a GP health check. This is similar to the England proportion of 48.9%.[2]

1.1.3. Gender reassignment and sexual orientation

Research indicates the increased likelihood of certain mental health problems occurring in the lesbian, gay, bisexual, transgender or others that do not feel they fit into any traditional categories of gender or sexuality (LGBT+) population. For example, LGBT+ people are 1.5 times more likely to develop depression and anxiety compared to the rest of the population.[3] They are also more likely to self-harm.[4]

When comparing all the common sexual identity groups, bisexual people were found to have increased risks of depression, anxiety, self-harm and attempting suicide.[5] When comparing to the rest of the population, gay and bisexual men were found to be four times more likely to attempt suicide across their lifetime.[3] For females, suicidal thoughts and self-harm were

also more prevalent in the lesbian and bisexual women populations compared to the general population.[6] When considering age groups in the LGBT+ population those aged under 26 were found to be more likely to attempt suicide and self-harm compared to older populations.[7]

A transgender mental health study showed that 88% of transgender people had experienced depression and 84% had thought of ending their life.[8]

Despite research showing the link between mental health and the LGBT+ population, it is difficult to estimate what percentage of the population this effects. This is because there has been no definitive data collection on numbers of the population who identify as LGBT+. However, the Office for National Statistics produced experimental statistics on sexual identity in the UK by region, and estimates that those people identifying as LGB make up 1.6% of the East Midlands population in 2016. When considering the UK population, those aged 16 to 24 were most likely to identify as LGB with 4.1% doing so. Males were also more likely to identify as LGB than females at 2.3% compared to 1.6% respectively.[9]

1.1.4. Race

The 2011 Census shows 2.9% of the population in Rutland are from black and minority ethnic (BME) backgrounds. Examining the population by each ethnic group shows in 2011 in Rutland there were 389 residents from Mixed ethnic group (1.0%), 365 from Asian ethnic group (1.0%), 251 from Black ethnic group (0.7%) and 63 residents from Other ethnic group (0.2%). Research indicates mental health problems are more prevalent in BME populations. For example, rates of schizophrenia are 5.6 times higher in the black Caribbean population, 4.7 times higher in the black African population and 2.4 times higher in Asian groups.[10] Black populations have the highest rates of Post-Traumatic Stress Disorder (PTSD), suicide attempt, psychotic disorder and any drug use/dependence while white populations have highest rates for suicidal thoughts, self-harm and alcohol dependence.

1.1.5. Pregnancy and maternity

Perinatal mental health is defined as the antenatal period (during pregnancy) and the postnatal period (up to one year after childbirth). Mental health issues that arise during the perinatal period can vary in severity from anxiety and depression through to PTSD and postpartum psychosis. For women who have had a history of bipolar disorder, there is an increased risk of a relapse at this time. Mental health problems in perinatal women can affect the foetus, baby, family and the mother's physical health.[11] It is believed that between 10% and 20% of women will be affected by mental health problems at some point during their pregnancy or the first year after childbirth.[12] It is recognised that some fathers may also

suffer from mental health issues over this period however there is very little data available to evidence this.

1.1.6. Marriage and civil partnerships

Being happily married or in a stable relationship appears to have a positive impact on mental health. A 2008 study found that high marital quality was associated with lower stress and less depression. However, participants who were single had better mental health outcomes than those who were unhappily married.[13] The 2011 Census showed that 11.3% of Rutland's adults' marital status was separated or divorced. This is similar to the England average of 11.6%.[1]

1.2. Education, learning and development

Low levels of education can impact on stable employment and income opportunities and widen health inequalities: these are factors known to influence mental wellbeing and common mental health problems. As with other risk factors, it is difficult to determine cause and effect as mental problems during adulthood can lead to poorer outcomes in educational achievement, but lower educational achievement can lead to poorer mental health.[1415]

The 2011 Census showed that 29.9% of Rutland's population aged 16 and above had no qualifications or a low level of education. This is significantly lower than the England average of 35.8%.[1]

1.3. Childhood

Half of all lifetime mental health problems (except dementia) arise by the age of 14. This increases to over three quarters of all mental health problems by the age of 24.[16] However, only a minority of those with mental health problems (except psychosis) receive treatment during childhood and adolescence, meaning mental health problems in childhood are likely to transfer into adulthood. For children and adolescents who do receive treatment, an estimated 70% have not had appropriate interventions at a sufficiently early age.[17]

1.4. Lifestyle

Mental health problems are associated with a higher prevalence of risk taking behaviours and increased dependency on the use of substances. This includes a lack of exercise, smoking, drinking and drug use.[18]

Data from the Active Lives Survey in 2015/16 suggests that over a fifth (20.5%) of Rutland's

population aged 19 or over, were classed as inactive. Inactivity is defined through achieving less than 30 minutes of moderate intensity exercise, or equivalent, per week, as opposed to the Chief Medical Officer guidelines of above 150 moderate intensity equivalent minutes of physical activity per week. This is similar to the England average.[19]

Smokers are significantly more likely to have a mental health problems compared to non-smokers. The Annual Population Survey estimated that 12.3% of adults in Rutland smoked in 2016, significantly lower than the England proportion of 15.5%.[19]

Having a history of alcohol or drug use has been recorded in 54% of all suicides in people experiencing mental health problems with only 11% of these in touch with drug treatment services at the time of death.[20] In 2014/15, Rutland's estimated prevalence of opiate and crack/cocaine use amongst 15-64 year olds was 2.9 per 1,000 population. This is significantly lower than the England rate of 8.6 per 1000 population.[21] Data on numbers of people who have co-morbid mental health problems and substance misuse is not available, however estimate of national prevalence rates suggest 20-37% in secondary mental health services and 6-15% in substance misuse settings.[22]

1.5. **Employment and economic factors**

Unemployed individuals, benefits claimants and those living in households with lowest incomes are considered to be at increased risk of common mental health problems, such as depression.[23]

In Rutland in 2016, 2.4% of the working age population were unemployed. This is significantly lower than the national proportion of 4.8%. In August 2016, 0.12% of the working age population were classed as long term unemployed in Rutland, significantly lower than the England average of 0.09%.[1]

Out-of-work benefits include Employment Support Allowance (ESA). ESA can be claimed by those out of work due to illness or disability. The 2014 APMS also found two thirds of the working age population in receipt of ESA had a Common Mental Health Disorder (CMD) compared with one in six who were not in receipt of ESA (66.1% compared to 16.9% respectively). Of women in receipt of ESA, 81.0% had a CMD, compared to 21.1% of those who were not in receipt of ESA. For males, figures were 55.8% and 12.7% respectively.[23] Further analysis revealed that ESA claimants also had a higher prevalence of personality disorder, suicidal thoughts and suicidal attempts.

In 2017, the percentage of Rutland's working age population claiming ESA, incapacity benefit or severe disablement allowance was 3.0%, significantly better than England's average of

5.7%.[24]

Further detail on Employment in Rutland is included within the Population Chapter.

1.6. Housing

Homelessness and poor quality housing result in an increased risk of mental health problems. The national Joint Commissioning Panel for mental health estimates that 27% of homeless people have probable psychosis.[25]

In 2015/16, the rate of statutory homelessness in Rutland is 2.2 per 1,000 population. The England average is 2.5 per 1,000 population.[1]

In 2016/17, 23% of Rutland's adults who were in contact with secondary mental health services lived in stable and appropriate accommodation. This is significantly lower than England's 54%.[19]

1.7. Crime

1.7.1. Sexual violence

Perpetrators of sexual violence often either have existing mental health or substance misuse problems. The victims of the crimes can also suffer from mental health problems following the crime.

Between 2010/11 and 2016/17, Rutland has seen a significant increasing trend of sexual offences per 1,000 population. The latest data from 2016/17 shows there were 32 sexual offences reported in Rutland, this equates to a rate of 0.8 per 1,000 population. The rate for England was 1.9 per 1,000 population.[19] The directly standardised rate of hospital admissions for violent crime (including sexual violence) was 30.0 per 100,000 population during 2014/15 – 16/17 (31 violent crimes). This is better (lower) than the England rate of 42.9 per 100,000 population.[19]

1.7.2. Domestic abuse

Domestic abuse can take a variety of forms – psychological, physical, sexual, financial or emotional. Perpetrators of domestic abuse often either have mental health and/or substance misuse problems. Furthermore, the victims of the crimes may also suffer from mental health problems following the crime. The crude rate of reported domestic abuse-related incidents and crimes in Rutland in 2016/17 was 18.7 per 1,000 population, lower than the England rate of 22.5 per 1,000 population. This has increased from 2015/16, where the rate was 14.7 per

1,000 population.[19]

1.8. Vulnerable Groups

Pockets of the population can be missed in overarching statistics. These subgroups, who have not been mentioned in key statistics above, are more exposed and vulnerable to the unfavourable social, economic, and environmental circumstances encompassed in the above risk factors. They are therefore at a higher risk of mental health problems than the general population.

1.8.1. Prisoners

Prisoners suffer from mental health issues at rates in excess of those in the general population. In England and Wales, 54% of women and 34% of men in prison say they are affected by emotional wellbeing or mental health issues.[26] It is estimated that over a third of men and over half of women (33% and 51% respectively) in prison experience depression. Just over one fifth of males and just under one third of females (21% and 32% respectively) are estimated to have anxiety, whilst personality disorder is estimated to be prevalent in 14% of male prisoners, and 50% of female prisoners.[27]

Annual self-harm incidents in prison have increased by nearly two-thirds since 2011, while self-inflicted deaths have doubled in the same time period.[2829] In 2016, more than a third of all prison deaths in England and Wales were self-inflicted.[30] Released prisoners further have a significantly higher risk of suicide compared to the general population.[27]

In England in 2016/17, 9.2% of people in prison were on a care programme approach plan, hence diagnosed with a severe mental illness.[19] There is one prison in Rutland. As of December 2017, HMP Stocken in Stretton contained 841 males aged 21 and over.[31]

1.8.2. Victims of crime

Being a victim of crime, through exposure to unsafe environments, violence, or domestic abuse, increases the risk of developing mental health problems. People with mental health problems are estimated to be three times more likely to be a victim of crime than the general population and five times more likely to be a victim of assault; this increases to ten times more likely for women.[32]

Research indicates that victimisation among people with severe mental illness (SMI) is more prevalent and associated with greater psychosocial morbidity than victimisation among the general population. Women with SMI are at particularly high risk of both domestic and community violence.[33] Violence prevention for people with SMI is likely to require an

integrated response by mental health professionals, third-sector organisations and the Criminal Justice System.[33]

1.8.3. Migrants

Migrants, including refugees, asylum seekers, economic migrants, spouses and students may be at increased risk of mental health problems prior to, during or after migration to the UK. Refugees, asylum seekers and economic migrants have PTSD, anxiety, depression and phobias at rates five times higher compared to the general population.

In 2016, the rate of migrant GP registrations in Rutland was 6.0 per 1,000 population, significantly lower than the England average of 12.9 per 1,000 population.[1]

1.8.4. Carers

Research has shown that the stress and worry, lack of time for one's self, isolation, money worries, lack of sleep, feelings of frustration guilt and low self-esteem can impact on carers' mental health and wellbeing. This can lead to depression, anxiety and obsessive compulsive disorder (OCD).[34]

Results from the Personal Social Services Carers Survey show that in Rutland in 2016/17, 31.1% of adult carers had as much social contact as they would like, meaning over 2/3s of carers were not having as much social contact as they would like. The proportion having as much social care as they would like was similar to the England average of 35.5%.[19]

1.8.5. Adult social care users

The Adult Social Care Users survey estimated that 46.5% of adult social care users in Rutland in 2016/17 felt they had as much social contact as they would like. This is similar to the England average of 45.4%.[19]

1.8.6. Living alone

Whilst not all people living alone would be considered to be socially isolated, or considered lonely, the 2014 APMS showing that people of working age who were living alone were significantly more likely to have a common mental disorder compared to those who lived with others.

The 2011 Census showed that 12.0% of Rutland's population were living alone, significantly lower than the England average of 12.8%.[21]

Meanwhile, 6.26% of households in Rutland were occupied by a single person aged 65 and over. This was higher than the national average of 5.24%.[21]

1.8.7. Loneliness

Whilst 'loneliness' does not account for a specific segment of the population, it is important to acknowledge the risk loneliness plays in poor mental wellbeing. Loneliness is defined by an individual's subjective emotional state, based on their personal and subjective sense of lacking closeness, affection and social interaction with others.[35]

The Community Life Survey shows that 5.4% of people in England reported feelings of loneliness often or always in 2016/17. Variations were observed by age group, with 10% of 16-24 year olds being the highest group to report loneliness, followed by 6% of 25-34 year olds. The groups that had the lowest percentage reporting loneliness were the 65-74 and 75 and over populations with only 3% reporting feeling lonely often or always.[36] The 2014 APMS further supports this: the study found that the prevalence of CMDs in the 75+ population was half the rate of their younger counterparts.

2. Level of need in Rutland

2.1. Mental wellbeing

Data from the Annual Population Survey 2015/16 estimates that 76.6% of Rutland's population report a high happiness score. This is higher than the England average of 74.7%.[21] In 2016/17, just over one fifth (21.8%) of Rutland's residents reported a high anxiety score, this is similar to the England value of 19.9%.[19]

Data from the GP Patient Survey in 2015/16 estimated that 3.8% of Rutland's GP registered population considered themselves to have a long-term mental health problem. This is similar to the national value of 5.2%.[21]

2.2. Common mental health conditions

2.2.1. Overall common mental health conditions

Common mental health conditions, also known as common mental disorders (CMD) or neurotic disorders, encompass different types of depression and anxiety, including generalised anxiety disorder (GAD), phobias, obsessive compulsive disorder (OCD) and panic disorder. While they do not affect cognition, they do cause emotional distress and can interfere with a person's day to day life.

In 2014/15, it was estimated that 12.2% of ELR CCG's registered population, aged 16-74 had a common mental disorder.[37] The Adult Psychiatric Morbidity Survey 2014 estimates 1 in 6 people (15.7%) to have a common mental health condition in England, with 1 in 12 reporting severe symptoms of common mental health disorders. Self-reported prevalence is higher in females (1 in 5 or 19.1%) compared to males (1 in 8 or 12.2%). Over a third of respondents (35.6%) were identified by the survey as currently having a CMD, although they had never been diagnosed with one. Symptoms were most prevalent in the working age population, with them being twice as likely to have symptoms compared to those aged over 65. All anxiety disorders in the survey were more common among young women aged 16 to 24 (GAD 9%, phobias 5.4%, OCD 2.4%, panic disorder 2.2%) than in any other age-sex group. CMD symptoms peaked in the 16-24 age group for females, at a rate almost 3 times higher than males (26% compared to 9%). Symptoms remained stable for men during their working age and then tailed off after 65. However, a second although less pronounced peak for females was evident between the ages of 45-54.

Improving Access to Psychological Therapies (IAPT) is the largest national service to provide therapies for those with low level mental health conditions, notably common mental health disorders. Published data on IAPT referrals for 2016/17 shows that 6,100 referrals were received for ELR CCG. In the same time period, 3,355 referrals entered treatment for ELR CCG. Upon receipt of referral, the most common identified diagnosis was 'unspecified' making up 57.3% (3,495) of ELR CCG referrals. Upon entering treatment, 28.9% (970) of diagnosis for ELR CCG were classed as 'unspecified'.[38] For this reason, the following IAPT diagnosis data is based only upon those entering treatment.

2.2.2. Depression

Depression is characterised by persistent low mood and a loss of interest and enjoyment in things which are normally considered enjoyable. Symptoms can be emotional, physical or behavioural and can include sleep disturbance, change in appetite, loss of energy, poor concentration, low feelings of self-worth and thoughts of suicide. Depressive episodes can range from mild to severe.[39]

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. The QOF shows the recorded prevalence for depression in the GP registered population aged 18 or over has increased year on year both nationally and locally since 2013/14. Over this time period, the prevalence in Rutland has remained significantly lower than the national average. The latest data in 2016/17 shows the recorded prevalence for depression in the GP registered population aged 18 or over is 7.9% for Rutland's population. This is significantly lower than

the England average of 9.1%.

Incidence looks at the rate of new, or newly diagnosed, cases of a particular disease, illness or health problem. The QOF shows the recorded incidence for depression in the GP registered population aged 18 or over has increased year on year both nationally and locally since 2013/14. In Rutland, the recorded incidence of depression in the 18 and above age group in 2016/17 is 1.3% for Rutland. This is significantly lower than the England average of 1.5% in 2016/17.[1] This shows new cases of depression are being diagnosed at a slower rate in Rutland compared to nationally.

The IAPT service data shows that in 2016/17, 12.1% of the referrals entering treatment for ELR CCG were diagnosed with depression, accounting for 405 people. This was the third most common recorded diagnosis for ELR CCG.[38]

2.2.3. Generalised anxiety disorder (GAD)

GAD is an anxiety disorder characterised by excessive worry, with individuals experiencing difficulty in controlling that worry. Symptoms include restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep.[39]

The Adult Psychiatry Morbidity Survey (APMS) 2014 found GAD to be the second most commonly identified CMD in England, with an estimated 5.9% experiencing it in the past week. The prevalence in females is statistically significantly higher than in males (6.8% compared to 4.9% respectively). The highest age-sex prevalence group was females aged 16-24 (9.0%) followed by females aged 45-54 (8.5%), followed by females aged 35-44 (7.0%). For males the highest prevalence was in the 35-44 age group at 6.8%. The lowest prevalence for both males and females was estimated to be in the 75+ population (0.9% and 3.6% respectively).

In 2012, Public Health England estimated that GAD was prevalent in 2.8% of Rutland's population aged 16-74. There are some concerns regarding the quality of this data and it should be noted that the estimate was created as an indication of caseload for psychological therapy services, hence based on numbers likely to be diagnosable at the time.[1]

The IAPT service data shows that in 2016/17, 9.1% of the referrals entering treatment for ELR CCG were diagnosed with GAD, accounting for 305 people. This was the fourth most common recorded diagnosis for ELR CCG.[38]

2.2.4. Mixed anxiety and depression

The APMS 2014 found mixed anxiety and depression to be the most commonly identified CMD in England, with 7.8% of the population estimated to be affected by it in any given week. Prevalence is statistically significantly higher in females than males. For males, it is estimated that the highest prevalence is in the 25-36 age group, with 7.9% being affected. For females, the 45-54 age group followed by 16-24 age groups are estimated to have the highest prevalence (11.8% and 11.3% respectively), both more than two times higher than males which were 5.6% for both these age groups.

The IAPT service data shows that in 2016/17, 34.1% of the referrals entering treatment for ELR CCG were diagnosed with mixed anxiety and depression, accounting for 1,145 people. This was the most common recorded diagnosis for ELR CCG.[38]

Of the referrals received by IAPT, unspecified diagnosis was the most common. If unspecified diagnoses are removed from analysis, mixed anxiety and depression was the most commonly diagnosed disorder upon receipt of referrals for ELR CCG. For ELR CCG 1,240 of the 6,105 referrals received were for mixed anxiety and depression (20.3%).

The 2015/16 GP Patient Survey found that 8.9% of the 18+ population in Rutland felt anxious or depressed. This is lower than the England value of 12.7%.[21]

2.2.5. Panic disorder

People with panic disorder experience repeated and unexpected attacks of intense anxiety. There is a marked fear of future attacks and this can result in avoidance of situations that may provoke a panic attack. Symptoms include a feeling of overwhelming fear and apprehension often accompanied by physical symptoms such as nausea, sweating, heart palpitations and trembling.[39]

The APMS 2014 found panic disorder to have the lowest prevalence of all surveyed CMDs in England, with 0.6% reported symptoms in the past week. The youngest age group, 16-24 year olds, were estimated to have the highest prevalence (1.2%), with the majority attributed to females with 2.2% and 0.4% for males. For all other ages, prevalence remained stable between 0.3% and 0.7%. Overall, prevalence was statistically significantly higher in females than males. While panic disorder prevalence is estimated to be lower than other CMDs, of those identified with any CMD 44.6% mentioned having panic attacks. 30.2% reported this had been diagnosed by a professional, meaning almost 70% of panic attacks were not diagnosed.

In 2012, the estimated prevalence of panic disorder in 16-74 year olds in Rutland was 0.35%. This is lower than the England prevalence of 0.65%.[1]

The IAPT service data shows that in 2016/17, 2.1% of the referrals entering treatment for ELR CCG were diagnosed with panic disorder, accounting for 70 people.[38]

2.2.6. Phobias

The APMS 2014 estimated 2.4% of England's population to have phobia symptoms in any given week. Prevalence is statistically significantly higher in females than males. (3.0% compared to 1.8% respectively). Phobias were more common in the working age population in 2014 than in previous years increasing from 1.8% in 1993 to 2.1% in 2007 to 2.9% in 2014.

In 2012, the estimated prevalence of all phobias in 16-74 year olds in Rutland was 0.96%. This is lower than the England prevalence of 1.77%.[1] The IAPT service data shows that in 2016/17, 2.2% of the referrals entering treatment for ELR CCG were diagnosed with phobias, accounting for 75 people.[38]

2.2.7. Obsessive compulsive disorder (OCD)

OCD is an anxiety condition characterised by the presence of either obsessions (repetitive, intrusive and unwanted thoughts, images or urges) or compulsions (repetitive behaviours or mental acts that a person feels driven to perform), or both.

The AMPS 2014 found 1.3% of England's population to have experienced symptoms in the past week. While prevalence is higher in females than males, the difference is not statistically significant. (1.5% compared to 1.1% respectively). Only 13.2% of people who identified as having OCD had been diagnosed by a professional.

The IAPT service data shows that in 2016/17, 1.8% of the referrals entering treatment for ELR CCG were diagnosed with OCD, accounting for 60 people.[38]

2.3. Suicide and self-harm

2.3.1. Self-harm

Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. However, following an episode of self-harm, there is a significant and persistent risk of suicide.[19]

In Rutland in 2016/17, the directly standardised rate of emergency hospital admissions for

intentional self-harm for all ages was 102.8 per 100,000 population (37 admissions). This is significantly better than the England average of 185.3 per 100,000 population. Since 2014/15, the rate has decreased year on year in Rutland whereas the national rate has fluctuated.[19]

2.3.2. Suicide

Suicides and injury undetermined is seen as an indicator of underlying rates of mental ill-health. The definition of suicide includes all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over. Due to small numbers, suicide rates are measured across five year periods.

In Rutland the rate of suicides in males is almost four times higher than in females. The crude rate for suicides in males aged 35-64 years in Rutland for 2011-15 was 21.6 per 100,000 population, this is similar to that of England which had a rate of 20.8 per 100,000 population. Meanwhile, the crude rate for suicides in females aged 35-64 years in Rutland for 2011-15 was 5.5 per 100,000 population. The rate is similar to that of England which had a rate of 6.0 per 100,000 population.[40]

When considering method of suicide, UK figures for 2016 show that the most common method used was hanging/suffocation/strangulation, accounting for 58.7% percent of males' and 42.8% females' deaths. The second most common method of suicide for both males and females was poisoning, with proportions of 18.3% and 36.2% respectively.[41]

It is important to note this data is based on those who completed suicides and does not account for all suicide attempts.

2.4. Severe and enduring mental illness

2.4.1. Overall SMI

The QOF severe mental health register is a count, for each GP practice, of the total number of patients with schizophrenia, bipolar disorder and other psychoses. The percentage of people with severe mental illness on GP Practice registers was 0.69% in Rutland in 2016/17, significantly lower than England's 0.92%. Nationally the trend over time is increasing, whereas locally the trend has stabilised.[21]

The rates of adult acute mental health admissions are only published by NHS Trust. In 2015/16, Leicestershire Partnership Trust (LPT) recorded 169 acute mental health admissions per 100,000 population aged 16-64. This is significantly lower than the England average of 220 per 100,000 population. LPT also recorded 7,574 acute mental health bed days per

100,000 population aged 16-64, significantly higher than the England average of 7,063 per 100,000 population.[37] This suggests that although less people are going into hospital compared to the England average, those that do go in stay there for longer.

In the same time period, Cambridge and Peterborough NHS Trust recorded 272 acute mental health admissions per 100,000 population aged 16-64. This is significantly higher than the England average of 220 per 100,000 population. The Trust also recorded 5,624 acute mental health bed days per 100,000 population aged 16-64, significantly lower than the England average of 7,063 per 100,000 population.[37] This suggests that although more people are going into hospital compared to the England average, those that do go in stay there for a shorter time.

In 2016/17, in the Leicestershire, Leicester and Rutland Sustainability and Transformation Plan (STP) area, there were 60 detentions under the Mental Health Act giving a crude rate of 5.7 per 100,000 population. This is the lowest of all STP areas.[42] As of 31st March 2016, LPT reported 270 people subject to the Mental Health Act 1983. Of these, 190 were detained in hospital on 31st March 2016, while 80 people were subject to Community Treatment Orders.[43] There may be some data quality issues with these figures.

Evidence suggests that people with severe mental illness such as schizophrenia, die between 15 and 25 years earlier than the average for the general population. In 2014/15, the excess under 75 mortality rate in adults with a serious mental illness in Rutland was 247.8% (expressed as a percentage). This percentage is showing that deaths in the population with severe mental illness are almost two and a half times higher than that of the general population.[19]

Data from the Quality Outcomes Framework (QOF) shows that in 2016/17 50.6% of people with SMI had a comprehensive care plan in the East Leicestershire and Rutland CCG area. This is significantly lower than England average of 79.0%.[21]

2.4.2. Psychosis

The estimated incidence of new cases of psychosis in 2011 among those aged 16-74 was 17.0 per 100,000. This is significantly lower than the national rate of 24.2 per 100,000 population.[21]

2.4.3. Schizophrenia

Schizophrenia is associated with increased mortality from all disease and a reduced life expectancy of around 21 years for men and 16 years for women. It is also linked to increased risk of suicide and self-harm.[44]

In Rutland during 2009/10-11/12, the rate of emergency admissions for schizophrenia, schizotypal and delusional disorders was 12.0 per 100,000 population aged over 18 years. This is significantly lower than the England value of 57.0 per 100,000 population.[45]

2.5. **Perinatal mental health**

Perinatal mental health is defined as the antenatal period (during pregnancy) and the postnatal period (up to one year after childbirth). Mental health issues that arise during the perinatal period can vary in severity from anxiety and depression through to post traumatic stress disorder and postpartum psychosis. For women who have had a history of bipolar disorder, there is an increased risk of a relapse at this time. Although these conditions can affect anyone with mental health problems, the concern with mental health problems in perinatal women is that it can affect the foetus, baby, family and the mother's physical health.[46] It is believed that between 10% and 20% of women will be affected by mental health problems at some point during their pregnancy or the first year after childbirth.[44]

In Rutland, 312 women gave birth in 2016. Table 2 shows that in 2016, the most prevalent disorder affecting postpartum women in Rutland was adjustment disorders and distress, affecting between 16.0% - 30.4% of mothers. This equates to between 50 and 95 mothers in the county. Mild-moderate depressive illness and anxiety was the second most prevalent condition affecting between 11.2% - 16.0% of mothers in Rutland. It is estimated that severe depressive illness affected 3.2% of postpartum woman (10) in Rutland.[47] It is important to remember that failure to treat perinatal depression can result in a prolonged and harmful effect on the relationship between the mother and baby. Evidence suggests that postnatal depression "may be associated with lower cognitive and language achievements" in young children.

Table 1 Estimated number of mental health conditions of postpartum women in Rutland in 2016[47]

	Count*

Estimated number of women with adjustment disorders and distress (upper estimate)	95
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)	50
Estimated number of women with adjustment disorders and distress (lower estimate)	50
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)	35
Estimated number of women with severe depressive illness	10
Estimated number of women with PTSD	10
Estimated number of women with postpartum psychosis	5
Estimated number of women with chronic SMI	5

Source: NHS Digital, Hospital Episode Statistics

*Figures must not be added together to give an overall estimate as some women may suffer from more than one condition

Post-traumatic stress disorder can be associated with mental health disorders when experiencing birth related traumas, whether it is from a traumatic birth including complications either physically or mentally as well as stillbirth or the death of a baby or sometimes from an uncomplicated delivery. It is estimated there were 10 women in Rutland who suffered from PTSD in the perinatal period in 2015/16.[47]

3. How does this impact?

While poor mental health affects individuals, it also affects society as a whole through costs to public services, including the NHS, social care and employers. Calculations attempting to quantify costs have varied dependent on the mental health conditions and impacts considered.[4849] However, all estimations to date have "failed to take into account the additional value to society of improving mental wellbeing or the adverse effects of physical health."[50]**Error! Bookmark not defined.** Further, while studies endeavour to account for costs to mental health service usage, additional costs to other services, such as chronic illness, are not always considered, resulting in underestimation.[50]

The health, social and economic consequences of poor mental health are substantial. In England, it has been estimated that the government spends around £19 billion every year within and beyond the health system on dedicated services for people with mental health needs. The NHS alone spent almost £9.2 billion in 2015/16 on mental health problems.

In 2014 NHS England developed a programme with a set of commitments to promote parity of esteem, with the aim of 'valuing mental health equally with physical health'. One of the commitments was that CCGs should increase their mental health spending in real terms, by

at least the same proportion as their overall budget increase (Parity of Esteem funding commitment). With the publication of the Five Year Forward View for Mental Health, this funding commitment was reiterated as the 'Mental Health Investment Standard' in the NHS Operational Planning and Contracting Guidance published in September 2016. The Mental Health Dashboard shows that NHS England's actual spend on mental health was 12.5% of their total CCG budget in 2015/16, and 12.7% in 2016/17. Locally for 2017/18 the planned spend on mental health was 11.9% for ELRCCG.[51]

These budgetary costs under-estimate the full impact of poor mental health as it also increases the risks of poor physical health and poor management of pre-existing physical health problems. Studies in the UK and elsewhere indicate that people living with severe mental health problems may die up to 20 years younger than the general population.[52] [53] These impacts are also felt well beyond the health care system, mainly due to lost economic productivity as a result of reduced participation in work, education and community activities. There is also the increased risk of premature mortality mainly due to poorer physical health but also linked with self-harm and suicide.

"The economic benefits of mental wellbeing are not as well established as the costs of mental illness." However, the impacts that positive mental wellbeing can have, both on a personal and societal level, through reduced healthcare utilisation and lower morbidity and mortality, presents a strong case for investment in mental wellbeing through promotion and prevention.[50] [54]

The case for seeking to support physical and mental health in a more integrated way is compelling, and is based on four related challenges: – high rates of mental health conditions among people with long-term physical health problems – poor management of 'medically unexplained symptoms', which lack an identifiable organic cause – reduced life expectancy among people with the most severe forms of mental illness, largely attributable to poor physical health – limited support for the wider psychological aspects of physical health and illness. Collectively, these issues increase the cost of providing services, perpetuate inequalities in health outcomes, and mean that care is less effective than it could be.[55]

More information
For further information on spend by local authority or CCG, please visit:
https://www.gov.uk/government/publications/spend-and-outcome-tool-spot

2013/14 CCG Programme Budgeting Marketing Tool – showing how much CCG's spend on different healthcare conditions, please visit:
https://www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/

For further information on commissioning cost-effective services for the promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health, please visit:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640714/Commissioning_effective_mental_health_prevention_report.pdf

For further information on this analysis and return on investment through mental health promotion and mental illness prevention please visit:
https://www.gov.uk/government/publications/mental-health-services-cost-effective-commissioning

http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf

4. Policy and Guidance

4.1. No Health Without Mental Health; A cross government mental health outcomes strategy for people of all ages (2011) - Department of Health[4]

Sets out the Government's ambition to mainstream mental health, and establish parity of esteem between services for people with mental health problems and physical health problems. The strategy looks to communities as well as the state, to promote independence and choice, and a wide range of partner organisations to deliver the strategy. These include user and carer groups, service providers, including NHS providers, local government and central government departments.

The strategy sets out six shared objectives to improve mental health outcomes for individuals and the population as a whole as follows;

i) More people will have good mental health

ii) More people with mental health problems will recover

iii) More people with mental health problems will have good physical health

iv) More people will have a positive experience of care and support

v) Fewer people will suffer avoidable harm

vi) Fewer people will experience stigma and discrimination

4.2. Better Mental Health For All: A Public Health approach to mental health improvement (2016)[18] Error! Bookmark not defined.

Commissioned from the Mental Health Foundation by the Faculty of Public Health (FPH). The report is intended as a resource for public health practitioners. It focuses on what can be done to enhance the mental health of individuals, families, and communities by using a public health approach.

4.3. NICE (National Institute for Health and Care Excellence) Guidance Documents

NICE has published a number of relevant guidelines and guidance documents including;

Common Mental Health Disorders : Identification and Pathways to Care-NICE CG 123 (2011)

Depression in Adults; recognition and management – NICE CG 90 (2009)

Generalised anxiety disorder and panic disorder in adults: management NICE CG 113 (2011)

Obsessive-compulsive disorder and body dysmorphic disorder: treatment NICE CG 31 (2005)

Social anxiety disorder: recognition, assessment and treatment NICE CG 159 (2013)

Post-traumatic stress disorder: management NICE CG 26 (2005)

Antenatal and postnatal mental health: clinical management and service guidance NICE CG 192 (2014)

Transition between inpatient mental health settings and community or care home settings NICE NG27 (2016)

4.4. Five Year Forward View for Mental Health (2016) report of the Mental Health Taskforce[51]

Sets out a ten year transformation plan. It outlines priority actions for the NHS, and recommendations for wider action including decent housing, employment opportunities, and community engagement. The report focuses on tackling inequalities, recognising that mental health problems disproportionately affects people living in poverty, those who are unemployed and those who already face discrimination.

4.5. Care Act 2014 – Department of Health[56]

The Care Act sets out duties for local authorities and their partners, new rights for individuals and carers, and the requirement to integrate care and support offered by local authorities

with that of health services. There is now also a requirement to consider an individual's 'wellbeing'. This is a comprehensive and detailed document. An Easy Read version is available.

4.6. LLR Sustainability and Transformation Plan 2017 (STP) Mental Health Workstream[57]

The aspiration for mental health is to promote recovery from mental illness by developing a patient's understanding of their illness and supporting them to manage their condition more effectively. The workstream aims to support people to stay well at home and be independent but also have better access to emergency and crisis services when they need them.

4.7. Improving Physical Healthcare for People living with SMI in Primary Care: Guidance for CCG's (2018) NHS England[58]

National guidance to improve the quality of physical healthcare for people with SMI in primary care, aimed at reducing risk from preventable serious illness, including cancer, heart disease, and diabetes. The guidance details the action and collaboration required by commissioners and providers in primary and secondary care to improve access to and the quality of physical health checks and ensure appropriate follow-up care is given.

4.8. Preventing Suicide in England: third progress report HM Government (2017)[59]

The Five Year Forward View for Mental Health recommends that all local authorities have multi-agency suicide prevention plans in place in 2017. These plans should target high-risk locations and support high-risk groups, including men and people in contact with mental health services. The local plans should be reviewed annually and supported by new investment.

The All Party Parliamentary Group on Suicide and Self-Harm Prevention (2013) recommended that Health and wellbeing boards:

i. Ensure that suicide and self-harm are addressed in the Joint Strategic Needs Assessment beyond being a measure.

ii. Ensure that the local suicide prevention plan is written into the local health and wellbeing strategy and includes provision for bereaved families.

iii. Investigate opportunities for developing links with neighbouring local authorities to co-ordinate work through a regional group that could pool resources and expertise.

A Leicester, Leicestershire and Rutland Suicide Prevention Strategy and Plan 2017-20 is in

place. In addition the LLR Suicide Audit and Prevention Group (LLR SAPG) has been brought together to tackle the cause and the impact of suicide across Rutland. The LLR SAPG is a sub-group of the LLR Better Care Together Mental Health Partnership Group and it also feeds into the LLR Crisis Concordat. In addition it reports into local authority Health and Wellbeing Boards.

4.9. Other related documents

Mental Health; How do you know if your council is doing all it can to improve mental health. Local Government Association (2018)

Creative Health; The Arts for Health and Wellbeing Inquiry Report. APPG (2017)

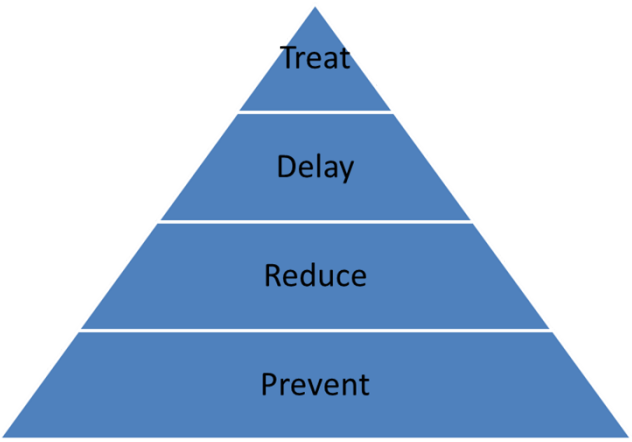
Thriving at Work; the Stevenson/Farmer review of mental health and employers. DWP/DoH+SC (2017)

5. Current Services

5.1. Overall service Provision

There is partnership work currently ongoing at a strategic level to deliver improvements across mental health services with the aim of shifting the focus to prevention and recovery, and delivering services on a locality based model. The strategic direction driven by the national Five Year Forward View for Mental Health, and the local Leicestershire Partnership Trust (LPT) Transformation Programme is to ensure the right level of care in the right place at the right time, with the emphasis on prevention and recovery.

The approach to delivering service provision is a layered approach with a continued emphasis on people being supported towards greater independence. It is summarised in the pyramid below.



Social Care works closely with GPs and inpatient facilities that treat people experiencing serious mental illness such as when they are being discharged from hospital and perhaps need residential care. Social care will always try to enable the person to go home and perhaps facilitate this by commissioning appropriate support packages such as formal carers to call in and support the person.

5.2. Leicestershire Partnership Trust

The Leicestershire Partnership NHS Trust (LPT) has three clinical directorates. The Adult Mental Health and Learning Disability Services directorate provides a range of both inpatient adult mental health services, and community mental health services.

5.2.1. Inpatient Adult Mental Health

Inpatient adult mental health services include a number of wards providing different levels of care and support depending on individual need. These are based at the Bradgate Mental Health Unit on the Glenfield Hospital site. These include;

<u>Recovery focused general psychiatric care</u>

Ashby Ward – assessment and care for men in the acute stage of their illness.

Aston Ward – female acute needs ward

Beaumont Ward – acute inpatient assessment and care

Bosworth Ward – male acute needs ward

Heather Ward – female acute needs ward

Thornton – male acute needs ward

<u>Psychiatric intensive care</u>

Belvoir Ward – male ward

Griffin Ward – female ward

<u>Low-secure environment care</u>

Phoenix Ward

5.2.2. LPT Community Mental Health Services

Community mental health services include;

Community Mental Health Team (CMHT) – the East Leicestershire and Rutland CMHTs receives referrals through a person's GP or other healthcare professional. Teams include Consultant Psychiatrists, Psychiatric Nurses, Occupational Therapists, Social Workers, and Psychologists providing a range of interventions and treatments.

Forensic Mental Health Team – single team covering Leicester, Leicestershire, Rutland (LLR). Provides specialist community (and inpatient) service for those individuals who pose a risk of harm to others in the context of their mental disorder. The multidisciplinary team includes Consultant Psychiatrists, Psychiatric Nurses, Occupational Therapists, Social Workers, and Psychologists. Access to the service is by referral from a Consultant Psychiatrist to the Referral Panel.

Crisis Resolution and Home Treatment Team – provides rapid assessment and care for people experiencing a crisis in their mental health that might otherwise result in a hospital admission. Intensive home treatment is provided for a short period before care is passed to the GP or other secondary care. Referral is primarily through a GP.

Perinatal mental health care – provides assessment, treatment and support for women experiencing severe mental illness during pregnancy and following birth of their child. This may be pre-existing conditions that recur in pregnancy, or conditions with their onset during pregnancy/following birth. The service includes a perinatal psychiatric liaison consultation service to primary care, maternity and mental health services. Service covers Leicester, Leicestershire and Rutland (LLR). The service is accessed through GP, midwife, obstetrician, mental health worker, or health visitor.

PIER team (Psychosis Intervention and Early Recovery) – provides treatment and support for people (from 14 years of age) who are experiencing their first episode of psychosis. The service supports individuals and their families to recover, and manage ongoing difficulties, and minimise the chances of relapse/recurrence. The team incudes mental health workers and support workers. Service covers LLR. Referral to the service is through GP or other healthcare professional.

Liaison Psychiatry Service – provides assessment and treatment for people who experience mental health problems in the context of their physical illness. This will usually take place on University Hospitals Leicester (UHL) hospital wards. The service covers LLR. Access is by referral only from GP, secondary care providers, clinicians from acute specialities.

Leicestershire Recovery College – based on a national model the Recovery College provides a range of recovery focused educational courses for people with lived mental health experience, their families and friends and LPT staff. Courses cover a range of mental health and wellbeing subjects. The aim is for people to recognise their own resourcefulness and skills and become experts in their own self-care. A course prospectus is available and courses are free of charge. People can attend courses by enrolling as a student with a 'satellite' hub available at Rutland Adult Learning Service, Oakham Enterprise Park, Oakham An evaluation is currently taking place of the recovery outcomes for the students of the Recovery College.

Crisis House (Turning Point) - the Crisis House provides short term intensive support for adults who need extra support when experiencing a mental health crisis. The service, provided by Turning Point, aims to avoid unnecessary hospital admissions. The house provides six beds and 24 hour care and support, including a structured recovery focused programme of activities. In addition to the Crisis House, the service provides a 24 hour crisis helpline and open access drop-in session at Turning Point in Rutland.

Employment Support (Aspiro) – provides employment support for people using specialist mental health support services

5.3. PAVE Team (Pro-Active Vulnerability Engagement)

The service 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.

5.4. Rutland Community Wellbeing Service

This service offers information, support and signposting to self-help tools, and onwards referral to a variety of community support. They provide a wide range of assistance to help people to overcome some of the factors which may have a negative impact on emotional wellbeing, such as poor housing, debt, economic disadvantage, serious illness, bullying, abuse, bereavement or isolation. This includes help to access specialist military/veteran support.

Mental Health Matters provides community based support to adults who are experiencing emotional and mental health problems, as well as their carers, by providing advice,

information and support. They offer brief interventions and support for low-level and moderate mental health issues, and support for those recovering from clinical treatment of Serious Mental Illness through both group support and one to one interventions. The service offers both drop-in and appointment based access within Rutland.

Let's Talk-Wellbeing (IAPT service) provides psychological assessment and treatment for mild to moderate common mental health problems. The service has specialised skilled and accredited practitioners who are able to provide psychological therapies (talking therapies) for people experiencing common difficulties including depression, anxiety, panic, phobias, obsessive compulsive disorder (OCD), trauma and stress.

Social care employs specialist qualified social workers and other support staff to engage with people suffering from the effects of serious mental illness in the community. Social care does not provide treatment but helps with the provision of after care and regular visits to ensure the person is being correctly supported to help them maintain good mental health after treatment. This approach helps prevent relapse of symptoms and possible return to hospital.

Health and social care services for people with more serious mental health problems are provided by staff based in the Rutland Community Mental Health Team. Services are provided on a multidisciplinary basis with input from social care staff where relevant and required. Following assessment a number of different services will be available if needed. These services range from hospital and medical services through to a range of support services to enable people to remain as independent as possible in the community.

Social Care provides specialist staff called Approved Mental Health Professional's (AMHP's) who alongside section 12 doctors assess people who are at crisis. If the person is assessed to be a risk to themselves or others they can be detained under section of the mental health act. This service is provided 24 hours a day every day of the year.

Turning Point provide integrated drug and alcohol services across Rutland with a number of different treatment pathways and support interventions. These include: Recovery worker support and peer mentors, substitute prescribing, community detox, harm reduction and needle exchange. Support is provided one to one and in groups and the service works closely with housing, employment and wellbeing services to ensure other needs are met. The service can advise and support friends and families of people with drug and alcohol problems and has a dedicated young peoples' service.

Leicestershire Action for Mental Health Project: Works across Leicester, Leicestershire, and Rutland. Provides independent mental health advocacy for people who are seeking to be, or who are already, involved with mental health services. There is also a specialised service for

carers of people with mental illnesses. http://www.lampadvocacy.co.uk/

The Carers Centre – Leicestershire & Rutland: Advocacy and support for carers across Leicestershire & Rutland http://claspthecarerscentre.org.uk/

Once, We Were Soldiers: Provides support for former serving members of the British Armed Forces including those with mental health needs. https://owwsoldiers.co.uk/

Living without Abuse: Domestic abuse charity providing support to men and women experiencing domestic abuse across Leicester, Leicestershire and Rutland https://www.lwa.org.uk/index.htm

Domestic Violence - There are a range of services available for those who experience domestic abuse and their perpetrators. Many are provided on an LLR basis by UAVA who offer support for any male or female over 13 years. This includes:

- A professional support line
- Confidential Helpline 8am to 8pm Monday to Saturday
- Independent Domestic Violence Advisors providing short term, intensive support and advocacy which focuses on risk and managing risks.
- Independent Sexual Violence service for those 13+ who has experience rape or sexual assault
- Outreach – providing emotional and practical support and counselling, and group work

In addition, Freedom programmes and recovery support including for children under 13 who have experienced or witnessed domestic violence are provided in Rutland and there is access to perpetrator programmes in LLR.

6. Unmet needs/Gaps

6.1. IAPT

There is a lack of qualified staff completing training programmes, particularly Psychological Wellbeing Practitioners, meaning the service carries staff vacancies', and as a result long waiting lists.

6.2. Community Mental Health Teams

Caseloads within Community Mental Health Teams are an issue and this increases the pressure on pathways and systems.

6.3. Acute beds

Whilst the number of available beds across Leicester, Leicestershire and Rutland compares closely with the national average, there is a capacity issue related to the length of stay of patients. As a result of these capacity issues there are a number of people that are placed out of area. This is an area of concern as the Government has set an ambition for local areas to eliminate inappropriate out-of-area placements by 2020/21.

6.4. Dual Diagnosis (substance misuse and mental health)

There are high numbers of substance misusers in treatment services who also have mental health problems, putting demand and expectation on the substance misuse treatment service.

A large number of adults who access mental health social work teams also have alcohol and/or drug problems in addition to their mental health problems.

6.5. Liaison Psychiatry

Current capacity pressures in liaison psychiatry services impacts adversely on other service provision.

6.6. Support for deaf/hearing impaired people

Communication barriers impact of deaf people being able to access the support they need. Service users have identified a number of issues with current service provision for people who ae deaf or who have hearing impairment. These include a gap in appropriate talking therapies for deaf people with mental health problems, and/or lack of resources and isolation for deaf people impacting on their mental health. There is a lack of social workers who are able to communicate using British Sign Language, staff in a range of services not trained in Deaf Awareness.

7. Recommendations

7.1. Wider Determinants of Mental Health, prevention of mental ill health

- Encourage GPs/primary care and the health and care services more generally to be aware of wider determinants that often contribute to poor wellbeing/mental health (e.g.

financial problems/debt, unemployment, and work and relationship problems), and use social prescribing approaches

- Consider targeted interventions to tackle other potential causes of poor mental health e.g. loneliness, social isolation

- Encourage and support our population to engage in activities known to protect mental health and wellbeing e.g. Five Ways to Wellbeing

7.2. **Services**

- CCGs/primary care to increase the numbers of people with common mental disorder who are detected and treated using IAPT services

- Capitalise on the growing understanding of the links between poor mental health and wellbeing and physical health, thereby Increase uptake of IAPT services.

- Develop a joint programme of work across primary and secondary care to tackle the poor health outcomes in people with serious mental illness

- Provide targeted support for patients with mental illness to address poor lifestyle factors including smoking, substance and alcohol abuse and inactivity

- Ensure that at least 60% of people with first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral (as recommended in The Five Year Forward View For Mental Health)

- Take action to understand (including better data) and to address rising levels of self-harm – especially among young females

- Ensure that groups at high risk of mental ill health have their needs properly understood and addressed (e.g. as part of procurement processes). This includes socio-economically deprived individuals and groups e.g. offenders, people with disabilities, BME, LGBT

- Specifically address the psychological support and intervention needs of deaf people and the needs of individuals whose first language is not English

- Mental Health recovery services should incorporate more involvement of people with lived experience in design and delivery of recovery services. Increase opportunities for peer support, and self-care

GLOSSARY OF TERMS

APMS	Adult Psychiatry Morbidity Survey
BME	Black and Minority Ethnic Groups
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CMD	Common Mental Disorders
ELR CCG	East Leicestershire and Rutland Clinical Commissioning Group
ESA	Employment Support Allowance
GAD	Generalised Anxiety Disorder
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
LGBT+	Lesbian, Gay, Bisexual, Transgender or Others
LLR	Leicester, Leicestershire and Rutland
LLR SAPG	Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group
LPT	Leicestershire Partnership NHS Trust
LSOA	Lower Super Output Area
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OCD	Obsessive Compulsive Disorder
PAVE	Pro-Active Vulnerability Engagement
PHE	Public Health England
PTSD	Post-Traumatic Stress Disorder
QOF	Quality Outcomes Framework
STP	Sustainability and Transformation Plan
UHL	University Hospitals Leicester

REFERENCES

[1] Public Health England. Common Mental Health Disorders (2018). At https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

[2] Public Health England. Learning Disability Profiles (2018). At https://fingertips.phe.org.uk/profile/learning-disabilities

[3] King, M., Semlyen, J., See Tai, S., Killaspy, H., Osborn, D., Popelyul, D., et al. (2008) Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people: a systematic review. At: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-8-70

[4] Department of Health, No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages (2011). At http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058

[5] Barker M, Richards C, Jones R, Bowes-Catton H, Plowman T, Yockney J, Morgan, M. (2012). The Bisexuality Report: Bisexual inclusion in LGBT equality and diversity. At https://bisexualresearch.files.wordpress.com/2011/08/the-bisexualityreport.pdf

[6] Stonewall. (2008) Prescription for Change: Lesbian and bisexual women's health check. At www.stonewall.org.uk/documents/prescription_for_change.pdf

[7] Nodin, N., Peel, E., Tyler, A., and Rivers, I. (2015) RaRE study, Risk and Resilience Explored. At http://www.uktrans.info/attachments/article/400/RARE_Research_Report_PACE_2015.pdf

[8] Ellis, S. J., Bailey, L., & McNeil, J. (2015). Tran's people's experiences of mental health and gender identity services: A UK study. Journal of Gay & Lesbian Mental Health, 19(1), 4-20 cited in British Psychological Society. Mental Health and LGBT People: Call for Evidence at www.bps.org.uk/system/files/consultationpapers/responses/BPS-response-Mental-Health-and-LGBT-People-Approved.pdf

[9] Office for National Statistics (2017). Sexual Identity, UK:2016. Experimental Official Statistics on sexual identity in the UK in 2016 by region, sex, age, marital status, ethnicity and National Statistics Socio-economic Classification. At https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016

[10] Kirkbride JB, Errazuriz A, Croudace TJ et al (2012). Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England.

[11] NICE. Antenatal and postnatal mental health: clinical management and service guidance. NICE guidelines (CG192). London: National Institute for Health and Care Excellence, 2014 (cited 2015 Jun 8). Available from: www.nice.org.uk/guidance/cg192

[12] NHS Health Education England, The Young Minds Trust (2018) "Addressing Adversity" Available at: https://youngminds.org.uk/media/2142/ym-addressing-adversity-book-web.pdf

[13] Holt-Lunstad, J., Birmingham, W., & Jones, B.Q. (2008). Is There Something Unique about Marriage? The Relative Impact of Marital Status, Relationship Quality, and Network Social Support on Ambulatory Blood Pressure and Mental Health. Annals of Behavioural Medicine, 35, 239–244.

[14] Chevalier A, Feinstein L (2006). Sheepskin or prozac: The causal effect of education on mental health. Discussion paper. London: Centre for Research on the Wider Benefits of Learning.

[15] World Health Organisation, Calouste Gulbekian Foundation. (2014) Social determinants of mental health.

[16] Kessler RC, Berglund P, Demler O et al (2005) Lifetime prevalence and the age of onset distributions of DSM-IV disorders in the national comorbidity survey replication. Archives of Psychiatry.

[17] Children's Society. (2008). The Good Childhood Inquiry: health research evidence. London: Children's Society.

[18] Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016). London: Faculty of Public Health and Mental Health Foundation.

[19] Public Health England. Public Health Outcomes Framework (2018). At https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

[20] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2016: England, Northern Ireland, Scotland and Wales October 2016. University of Manchester.

[21] Public Health England. Mental Health and Wellbeing JSNA. (2018) At https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna

[22] Carrà G, Johnson S. Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK. Social psychiatry and psychiatric epidemiology. 2009;44:429-47.

[23] McManus S, Bebbington P, Jenkins R, Brugha T. (2016). Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014. Leeds: NHS digital.

[24] Public Health England. Wider Determinants of Health (2018). At https://fingertips.phe.org.uk/profile/wider-determinants

[25] Joint Commissioning Panel for Mental Health. Guidance for Commissioning Public Mental Health Services. (2015) At https://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf

[26] HM Chief Inspector of Prisons for England and Wales Annual Report 2015-16 (2016).

[27] Home Office. Public Health England. (2016) Rebalancing Act. Revolving Doors Agency. At http://www.revolving-doors.org.uk/file/2049/download?token=4WZPsE8I

[28] Ministry of Justice (2017) MOJ Safety in Custody Statistics. Deaths in prison custody 1978 to 2016: Table 1.1

[29] Ministry of Justice (2017) MOJ Safety in Custody Statistics.Self-harm and assaults to December 2016: Table 3

[30] Public Health England. (2017) Health and Justice Annual Review 2016/17. At https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642924/PHE_Annual_Report_1617V2.pdf

[31] Ministry of Justice. Offender Management Statistics Quarterly (2018). At https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/676248/prison-population-data-tool-31-december-2017.xlsx

[32] Stuart H. (2003) Violence and mental illness: an overview. World Psychiatry. 2(2):121-4. At https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/

[33] Violent and non-violent crime against adults with severe mental illness H. Khalifeh, S. Johnson, L. M. Howard, R. Borschmann, D. Osborn, K. Dean, C. Hart, J. Hogg and P. Moran British Journal of Psychology https://www.rcpsych.ac.uk/pdf/BJP-2014-147843.pdf

[34] Mind for better mental health (2017) How to cope when supporting someone else factsheet. At https://www.mind.org.uk/information-support/helping-someone-else/carers-friends-family-coping-support/your-

mental-health/#.WvwE5aQvyM8

[35] AGE UK (2015) Loneliness at Local and Neighbourhood Level. At https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Age_UK_loneliness_risk_index_summary-(July2015).pdf?dtrk=true

[36] Official Statistics. Community Life Survey 2016/17 (2017). At https://www.gov.uk/government/statistics/community-life-survey-2016-17

[37] Public Health England. Crisis Care Profile (2018). At https://fingertips.phe.org.uk/profile-group/mental-health/profile/crisis-care

[38] NHS Digital. Psychological Therapies: Annual report on the use of IAPT services in England, further analyses on 2016-17 (2018) CSV download.

[39] Public Health England. Better Mental Health: JSNA Tooklit (2017). At https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/6-working-age-adults

[40] Public Health England. Suicide Prevention Profile. 2018. At https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

[41] National Institute for Health and Clinical Excellence (NICE),Self-harm: longer term management - Evidence Update April 2013 at: http://www.evidence.nhs.uk/topic/self-harm

[42] NHS Digital (2018) Mental Health Act Statistics, Annual Figures 2016/17. Data Tables: Table 1d.

[43] NHS Digital (2018) Mental Health Act Statistics, Annual Figures 2016/17. Data Tables: Table 5.

[44] Brown S, Kim M, Mitchell C et al (2010) Twenty-five year mortality of a community cohort with schizophrenia. BJPsych, 196, 116-121

[45] Public Health England. Severe Mental Illness Profile. 2018. At https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

[46] National Institute for Clinical Excellence. (2014) Antenatal and postnatal mental health: clinical management and service guidance. At www.nice.org.uk/guidance/cg192

[47] Public Health England. Mental Health in pregnancy, the postnatal period and babies and toddlers (2017) Report for Leicestershire local authority. At https://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health/data#page/13/gid/1938132960/pat/6/par/E12000004/ati/102/are/E06000017/iid/92351/age/179/sex/2

[48] Singh S (2014). Mental Health and Work: United Kingdom Paris: Organisation for Economic Co-operation and development. At: https://read.oecd-ilibrary.org/employment/mental-health-and-work-united-kingdom_9789264204997-en#page5

[49] Centre for Mental Health. (2010) The Economic and Social Costs of Mental Health Problems in 2009/10, London.

[50] Faculty of Public Health (2018) The Cost of Poor Mental Health. At https://www.fph.org.uk/policy-campaigns/special-interest-groups/special-interest-groups-list/public-mental-health-special-interest-group/better-mental-health-for-all/the-economic-case/the-costs-of-poor-mental-health/

[51] NHS England (2018) Mental Health Five Year Forward View Dashboard. At https://www.england.nhs.uk/publication/mental-health-five-year-forward-view-dashboard/

[52] Chang Chin-Kuo et al (2011) Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. At

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0019590

[53] Nordentoft Merete (2013) Excess Mortality, Causes of Death and Life Expectancy in 270,770 Patients with Recent Onset of Mental Disorders in Denmark, Finland and Sweden. At http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055176

[54] Faculty of Public Health (2018) Better mental health for all: The economic case. At: https://www.fph.org.uk/policy-campaigns/special-interest-groups/special-interest-groups-list/public-mental-health-special-interest-group/better-mental-health-for-all/the-economic-case/

[55] The Kings Fund (2016) Bringing together physical and mental health. A new frontier for integrated care. At https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf

[56] Department of Health (2014). Care Act statutory guidance. At: https://www.gov.uk/government/publications/care-act-statutory-guidance

[57] Leicester, Leicestershire and Rutland Health and Social Care (2017). Leciester, Leicestershire & Rutland health and social care. Sustainability and Transformation Plan (draft) At http://www.bettercareleicester.nhs.uk/Easysiteweb/getresource.axd?AssetID=47665

[58] NHS England (2018) Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Guidance for CCGs. At: https://www.england.nhs.uk/publication/improving-physical-healthcare-for-people-living-with-severe-mental-illness-smi-in-primary-care-guidance-for-ccgs/

[59] HM Government (2017) Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives. At https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf