Nottinghamshire County Council

Report to Health and Wellbeing Board

7th March 2012

Agenda Item: 5

REPORT OF DIRECTOR OF PUBLIC HEALTH

MENTAL HEALTH AND EMOTIONAL WELLBEING IN NOTTINGHAMSHIRE

Purpose of the Report

1. This report provides information about adult mental health and wellbeing, (excluding dementia which has been the focus of a previous report to the Board). It provides estimates of the prevalence of mental illness across Nottinghamshire, information on national and local policy drivers and a brief overview of the range of initiatives and services currently in place to improve population mental health. It also highlights where further action is needed to secure achievement of national objectives.

Information and Advice

What is Mental Health?

2. Mental health is a state of wellbeing in which an individual is able to realise his or her own potential, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is more than the absence of mental disorders or disabilities[1]. As such good mental health is central to the quality of life of the individual and the effective functioning of a community.

3. Multiple social, psychological and biological factors determine the level of mental health. These include persistent socio-economic pressures, poverty, and social exclusion, low levels of education, unhealthy lifestyles, physical ill health and genetic factors.

4. Mental illness is generally categorised into Common Mental Disorders (CMD), and Severe and enduring Mental Illness (SMI). CMD are far more prevalent than SMI, but are also far more likely to go undiagnosed and untreated. CMD includes the following diagnoses:

    - Depressive episode
    - Generalised anxiety disorder

[1]World Health Organisation. Mental Health Strengthening our response. www.who.org

- Mixed anxiety and depressive disorder
- Phobia
- Panic disorder
- Obsessive compulsive disorder.

5. Severe and enduring mental illness (SMI) refers to psychosis and includes disorders such as schizophrenia, bipolar disorder and manic depression.

Why Mental Health is a Priority

6. Mental ill health represents up to 23% of the total burden of ill health in the UK and is the largest single cause of disability[2]. In England at least one in four people will experience a mental health problem at some point in their life, and almost half of all adults will experience at least one episode of depression during their lifetime[3]. An 'average' GP list of 1,650 working age people will, at any one time, include:

    - 5 or 6 patients with a severe mental illness
    - 180 with common mental health problems
    - 44 with drug dependence
    - 84 dependent on alcohol[4].

Inequalities

7. Mental ill health is both a cause and a consequence of inequalities. Mental health problems often affect people early in life, impacting on their education and limiting life chances. People with mental health problems find it harder to obtain and stay in work[5], have lower incomes[6] and are more likely to live in areas of high social deprivation[7]. They are also more likely to have poor physical health with higher rates of smoking, alcohol and substance misuse, and lower levels of physical activity. Life expectancy of people with severe mental illness is, on average, 20 years lower than the general population[8,9]. While some of the decreased life expectancy may be attributed to lifestyle behaviours, the remainder is due to higher rates of suicide, the long term physical effects of anti

[2]World Health Organisation. The Global Burden of Disease: 2004 update. www.who.int/healthinfo/global_burden_disease

[3] Andrews G et al (2005). Lifetime risk of depression: restricted to a minority or waiting for most? British Journal of Psychiatry 187:495-496

[4] Mental Health Strategic Partnership (2011) No Health without mental health: A guide for General Practice

[5] Meltzer H et al (2010). Job insecurity, socio-economic circumstances and depression. Psychological Medicine 40 (8): 1401-1407

[6] McManus S et al (2009). Adult Psychiatric Morbidity in England 2007: Results of a household survey. NHS Information Centre for Health and Social Care.

[7] Cooper R et al (2008). DR2 – the effect of the physical environment on mental wellbeing. Mental Capital and Wellbeing Project. London: Government Office for Science, Foresight.

[8] Brown S et al (2010). Twenty five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry 196: 116-121.

[9] Parks J et al (2006). Morbidity and mortality in People with serious mental illness, 13th Technical report. Alexandria, Virginia: National Association of State Mental Health Program Directors.

psychotic medication and disparities in accessing health care[10]. Addressing the physical health needs of people with mental illness is an important aspect of reducing health inequalities.

8. This Board has previously received a report concerning substance misuse, and it is important to recognise the established link between mental illness, drug and alcohol use and social disadvantage. This is explored later in this report.

9. The current economic downturn in the UK is likely to have a detrimental impact on mental wellbeing, exposing more people to known risk factors for mental health problems such as unemployment, disruptions in income, uncertain and stressful work environments and debt[11,12]. Harm to psychological wellbeing is not only caused by actual financial hardship, but also by the fear of financial strain and job loss. As more people find themselves in financial difficulty there is likely to be an associated increase in demand for mental health services in both primary and secondary care. At the same time, employers may be pressurised into reducing their own spending on occupational health services, further increasing demand for public health and social care services.

10. There are three aspects to reducing mental health inequality:

- Tackling the inequalities that lead to poor mental health
- Tackling the inequalities that results from poor mental health
- Tackling the inequalities in service provision – access, experience and outcomes.

The cost of mental ill health

11. The financial cost of mental ill health in England is estimated to be £105 billion, of which, around £30 billion is work-related[13]. The costs of mental illness are currently greater than the costs of crime and are projected to double over the next 20 years, although a significant proportion of this increase relates to dementia service provision. Mental health problems account for more NHS expenditure than any other health programme[14]; they also add to the costs of education and criminal justice systems and homelessness services. In addition to the significant costs to the economy, are the incalculable costs to the individual, their family and community.

[10] Hert, Correll et al (2011) Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care", *World Psychiatry vol 10 pp 52-77*
[11] Dorling D (2009). Unemployment and health BMJ 338, b829
[12] Aznar C A (2009). Life in Debt: The profile of CAB clients in 2008. Citizens Advice Bureau.
[13]Sainsbury Centre for Mental Health (2010). The Economic and Social Costs of Mental Health Problems in 2009/10.. www.centreformentalhealt.org.uk/pdfs/Economic_and_social_cost_2010.pdf
[14]McCrone et al (2008). Paying the price.The cost of mental health care in England to 2026. Kings Fund

National and Local Drivers

National Mental Health Strategy

12. In 2011, the Coalition Government published No Health Without Mental Health[15], a cross government mental health outcomes strategy. The aims of the strategy are to achieve "parity of esteem between mental and physical health services" in England and for mental health to be "everyone's business". This includes government departments, employers, education, local authorities, communities and individuals. The strategy places particular emphasis on access to psychological therapies. This is a shift in emphasis from previous national policy where the focus of investment had been on services for SMI. There has also been a shift in emphasis in respect to treatment ethos with a much greater focus on providing support and empowerment to people with mental illness in an attempt to normalise their life experience through maintaining employment wherever possible and providing stable housing. Evidence exists to support the provision of care in the community rather than institutions, with hospitalisation being seen as a last resort.

13. The national strategy is built around six objectives.

    a. *More people will have good mental health*

    Fewer people will develop mental health problems and more people will have good mental health. The key areas for action are ensuring a good start in life and reducing the social and other determinants of mental ill health.

    b. *More people with mental health problems will recover*

    More people who develop mental health problems will have a good quality of life, with improved chances for education, employment and stability of housing. Key areas for action include identification of mental health problems and early intervention, equity of access to appropriate services, offer of choice of high quality services and whole family support.

    c. *More people with mental health problems will have good physical health*

    Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health. This objective aims to address two distinct issues – people with mental health problems are at greater risk of physical ill health, and people with long term physical health problems are at greater risk of mental illness. Key areas for action will be improved monitoring of the physical health of clients accessing mental health services, and heightened awareness and identification of mental distress in patients with long term physical illness.

[15] HM Government/DH (2011) No health Without Mental Health: A Cross government mental health outcomes strategy for people of all ages. DH London.

d. *More people will have a positive experience of care and support*

Care and support should offer access to timely, evidence-based interventions that give people the greatest choice and control. Promoting individual control is an important aspect of recovery from mental illness and should be a core principle of mental health services. Key areas for action are designing services around the needs of the individual, enabling transition between services when appropriate, and involving users and carers in care planning.

e. Fewer people will suffer avoidable harm

Services will be of the highest quality and at least as safe as any public service. This objective encompasses the triple aims of safeguarding clients accessing services, preventing clients from self-harming (including suicide), and safeguarding the public from people with mental illness. Key actions will be to review local plans once the new Suicide Prevention Strategy is published early in 2012, and ensure robust mechanisms are in place to manage risk and learn lessons from serious incidents.

f. *Fewer people will experience stigma and discrimination*

Public understanding of mental health will improve. Stigma and discrimination contributes significantly to the worse life chances experienced by people with mental illness. It can also lead to individuals' not seeking treatment and becoming isolated, thereby worsening their conditions. Tackling stigma is a central theme of the national strategy and it is recognised that this requires a sustained social movement.

National Suicide Prevention Strategy

14. The current National Suicide Prevention Strategy was published in 2002 and a revised strategy is expected to be published early in 2012. The 2002 strategy set a target of reducing the death rate from suicide by 20%, from a 1997 baseline, by 2010. A joint Nottinghamshire County and Nottingham City Suicide Prevention Action Plan was developed in response to the national strategy.

NHS Operating Framework 2012/13

15. Published in December 2011, this reiterates the national strategy, putting particular emphasis on:

- "access to psychological therapies as part of the commitment to full rollout by 2014/15 so that services remain on track to meet at least 15 per cent of disorder prevalence, with a recovery rate of at least 50 per cent in fully established services.

- the physical healthcare of those with mental illness to reduce their excess mortality;

- offender health, working in partnership with the National Offender Management Service".

The Bradley Report

16. This independent review was commissioned by the Secretary of State for Justice to examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services and the barriers to such diversion. The review made recommendations to government including the organisation of effective liaison and diversion arrangements and the services needed to support them. Diversion refers to a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence[16].

Public Health Outcomes Frameworks

17. The recently published Public Health Outcomes Framework includes mental health-related outcome measures in three of the four domains. The framework includes seven mental health specific outcomes. However, it is also important to acknowledge that improvements in mental health care and promoting mental wellbeing will also contribute to the achievement of the more generic, high level outcomes. Some of the indicators are still being refined at national level, and local level data is not yet available e.g. excess under 75 mortality in adults with serious mental illness.

Domain	Indicator
Domain 1. Improving the wider determinant of health	People with mental illness and or disability in settled accommodation.
	People in Prison who have mental illness or a significant mental illness.
	Employment for those with a long term health condition including those with a learning difficulty/disability or mental illness.
Domain 2. Health improvement	Hospital admissions as a result of self-harm.
	Self-reported wellbeing.
Domain 4 Healthcare public health and preventing premature mortality	Excess under 75 mortality in adults with serious mental illness.
	Suicide.

[16] The Bradley Report 2009. DH, London.

Local Drivers

18. Through the Joint Strategic Needs Assessment (JSNA), mental health has been identified as a priority in the Health and Wellbeing Strategy. As previously highlighted, mental health is socially patterned and closely linked to deprivation. The JSNA highlighted significant variation across Nottinghamshire in terms of the prevalence of mental illness in our communities. Addressing mental illness and promoting mental wellbeing will be a key step to reducing overall health inequalities.

19. A recent equity audit of the Improving Access to Psychological Therapies service for NHS Nottinghamshire County highlighted variation in access to the service, with particularly lower than expected uptake in older people. It also identified variation in rates of access from different CCGs which are not fully explained by variation in illness prevalence. Work to address this is already underway.

20. Weighted for need, both NHS Nottinghamshire County and NHS Bassetlaw commissioners have a lower spend per head of population on mental health services than either the regional or England average. Further detail is available in **Appendix B**.

Risk Factors for Mental Illness

21. Previous sections of this report have briefly described many of the causes of mental illness, but it is important to recognise that some demographic groups are at greater risk of poor mental health due to specific risk factors. As a result these groups may also need specifically targeted services.

Older People

22. The most common mental health problem in older people is depression (rather than dementia). Proportionately this affects more older people than any other demographic group. This is likely to be because older people face more of the events and situations that may trigger depression.

    - **Retirement** - Work is well known to have a positive influence on mental wellbeing. It provides not only an income but also a structure, sense of purpose, status and social network. Retirement can be a stressful event leading to feelings of low self-esteem and emptiness. Many people may find it difficult to adjust after many years of work, and relationships can be affected as couples spend much more time together.

    - **Bereavement** - Older people are more likely to experience the loss of someone close such as a partner, family member or friends.

    - **Physical activity** - Physical activity has positive benefits for both physical and mental health and is particularly beneficial for certain conditions such as depression. But physical ability changes as people age and many older people find it more difficult to be physically active.

- **Diet and nutrition** - The link between nutrition and mental health is complex but eating well and regular eating patterns are important to maintain health. Many older people may face challenges to eating regular healthy meals such as decreased appetite, lack of transport to shops, and living alone perhaps after the death of a partner who had been responsible for preparing meals.

- **Social isolation** - Regular contact with relatives and friends has been shown to be beneficial to the mental health of older people. Poverty and mobility problems may impact on the ability to maintain an active social life, and the death of friends or absence of family members living nearby may increase social isolation of older people.

- **Physical ill health** - Long term physical ill health and disability can have a profound effect on mental health and wellbeing. Older people are more likely to have long term physical health problems.

- ***Caring responsibilities*** *- Many older people have caring responsibilities either for a partner, an adult relative or grandchildren. Caring for someone with a physical or mental health problem can be stressful and impact on the mental wellbeing of the care giver.*

23. Older People often have different care and treatment needs from younger people with mental health problems with needs that cross the boundaries of health, social, local authority and voluntary services. Services need to be structured in such a way that they can respond to a complex mix of social, psychological, physical and biological factors.

24. Older people with more SMI have particular difficulty in gaining access to age appropriate services. There is national evidence that older people's mental health services have fewer specialist staff per case than general adult mental health services.

25. Implementation of the Equality Act in October 2010 has highlighted the need to address service inequalities which could be deemed to constitute direct or indirect age discrimination.

26. Mental illness in older people may be undiagnosed, as older people are more reluctant to seek help, or misdiagnosed as symptoms in older people may differ from those in younger age groups. In addition symptoms such as agitation and anxiety may be mistaken for Parkinson's disease or Alzheimer's disease. Symptoms of depression such as lack of concentration, forgetfulness and loss of thinking ability may be misdiagnosed as dementia. Although 20-40% of older people in the community show signs of depression meriting treatment, only 4-8% will consult a GP.

Substance Misuse

27. A clear association exists between mental illness and drug and alcohol dependence, and the relationship is complex. A primary psychiatric illness may

lead to substance misuse, and use of substances may make the mental health problem worse or alter its course. At the same time, intoxication and/or substance dependence may lead to psychological symptoms or illness[17].

28. What is clear is that those experiencing mental ill-health have a higher risk of substance misuse. The majority of mental illness starts before adulthood[18,19]. Other behavioural problems, including substance misuse also start more often during this period. For young people, emotional and behavioural disorders are associated with an increased risk of experimentation, misuse and dependence[20].

29. People who misuse drugs and alcohol are at greater risk of both CMD and SMI. The term dual diagnosis is normally only used when a person has severe mental health problems and severe substance misuse problems that meet the criteria for specialist services[22], but many people with less severe substance misuse problems will also experience mental illness.

Homelessness

30. People who are homeless or living in insecure accommodation have very much higher rates of mental illness than the general population. Precise figures for the prevalence of mental health problems in this population are difficult to capture through the usual channels, as they are frequently not in touch with mental health services. The last comprehensive survey in the UK [21] included the following key findings:

    - Psychosis in 8% of hostel residents (compared with 0.4% general population)
    - Neurotic disorders in 38% hostel residents (compared with 16% general population)
    - Alcohol dependence in 47% rough sleepers/day centre users
    - Drug use in 46% of those in night shelters
    - Drug dependence in 22% of those in night shelters.

31. Personality disorder (PD) is very common among those with drug and alcohol misuse, and therefore high levels of PD would be expected in homeless populations. The average age of homeless people has decreased in the last decade. This would tend to result in yet higher prevalence of PD (commoner in young people) and higher rates of substance misuse especially injecting drug use.

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[17]Hawkings C, Gilburt H (2004). Dual Diagnosis Toolkit: A practical guide for professionals and practitioners. Turning Point & Rethink.

[18]Kessler RC, Berglund P, Demler O et al (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. Archives of General Psychiatry, 62, 593-602

[19]Kim-Cohen J et al (2003) Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort. Archives of General Psychiatry, 60, 709-717

[20]Green H, McGinnity A, Meltzer H et al (2005).Mental Health of Children and Young People in Great Britain 2004. Office for National Statistics

[21]Gill B, Meltzer M. and Hinds K (1996). The Prevalence of Psychiatric Morbidity among Homeless Adults OPCS Surveys of Psychiatric Morbidity in Great Britain, Bulletin No. 3. London: OPCS,

32. Mental health problems can both cause and be a consequence of homelessness. The signs of mental illness preceded their first loss of accommodation in 92% of homeless people studied by North et al[22]. Once homeless, stigmatisation, isolation, the disruption of supportive relationships, substance use, physical illness and difficulty in obtaining medical care all combine to reduce the individual's likelihood of addressing their mental health problem successfully.

Involvement with Criminal Justice System

33. People with mental health problems are overrepresented in all parts of the criminal justice system. 90% of prisoners have a mental health problem and over 70% have two or more mental disorders. Yet less than 1% of offenders in the community are referred for mental health treatment. When the mental health problems of offenders or defendants are not recognised or dealt with appropriately their problems often get worse, leading to increased levels of distress and disruption. Also, when mental health problems remain undiagnosed, the risks of re-offending are greatly increased[23].

Military Service

34. Service in HM Forces is generally associated with good mental and physical health. However, recent cases have drawn attention to Post Traumatic Stress Disorder (PTSD) and, more generally, to service-related mental disorder including mild traumatic brain injury (mTBI)[24]. The linked issue of alcohol abuse is significantly associated with service in the Armed Forces and there is evidence that it is more common among combat veterans[25]. Mental illness is a root cause of both homelessness and involvement in the criminal justice system. It is probable that veterans are either over-represented or more likely to have mental health problems in the two groups[26,27].

35. The Coalition Government has established a Military Covenant with the armed forces to ensure no military personnel will be disadvantaged because of their service. An important aspect of this is ensuring there is a seamless transition from military health services to NHS and Social Care for those service men and women leaving military service.

Worklessness

36. The majority of people with mental illness are working age adults, but mental illness can have a severe impact on an individual's ability to obtain and maintain

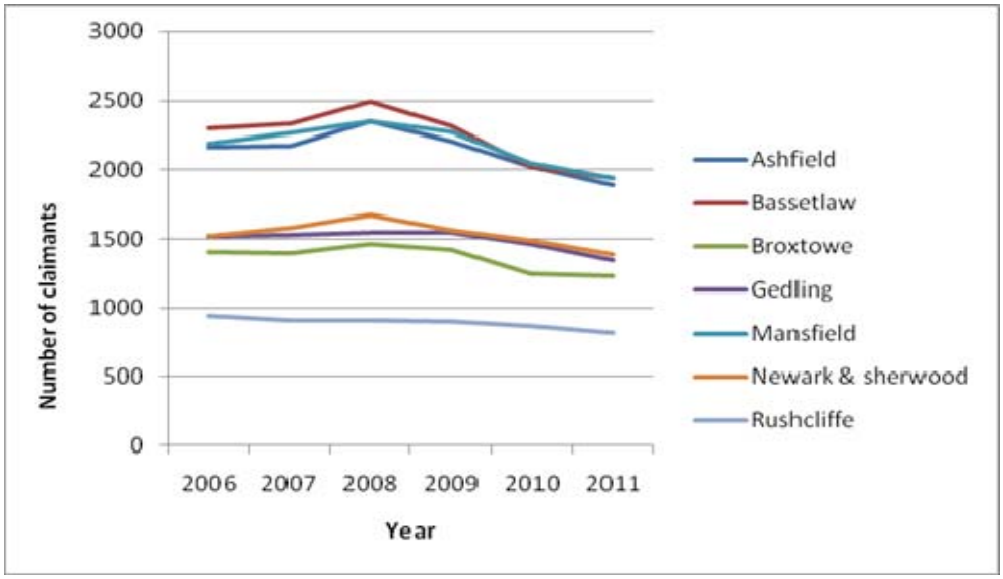
[22]North C. et al (1998) "Correlates of early onset and chronicity of homelessness in a large urban population."- Journal of Nervous and Mental Disease: 186, pp. 393–400.
[23] Bryant L. (2010) A Common Sense Approach to Working with Defendants and Offenders with Mental Health Problems. Together for Mental Wellbeing, London.
[24]Mild traumatic brain injury project team final report.DMSD/16/1/03. MOD, 25 March 2008.
[25]Fear NT et al (2010). Mental health of the UK Armed Forces: what are the consequences of deployment to Iraq and Afghanistan? A cohort study. Lancet, 13 May.
[26]National Association of Probation Officers briefing paper. September 2009.
[27]The experience of homeless ex-service personnel in London. York University June 2008.

employment. Incapacity benefit (IBD), Severe Disability Allowance (SDA) and Employment Support Allowance (ESA) may all be claimed on the basis of "mental or behavioural disorders". Data is available from the Department for Work and Pensions concerning the number of people who claim benefits and this provides an up-to-date source of information on Nottinghamshire residents of working age that are unable to work due to mental health problems.

37. As at May 2011, 33,770 people in Nottinghamshire were claiming IBD, SDA or ESA. This equates to nearly 7% of the working age population[28]. However, there is significant variation across the county with Mansfield showing the highest rate at 10.3% and Rushcliffe the lowest at 3.4%. Over 38% of IBD, SDA and ESA claims across Nottinghamshire relate to mental or behavioural disorders.

38. Data in respect of ESA claimants does not provide the medical reason for the claim prior to 2010. However, such detail is available for IBD/SDA claims and Figure1 shows the downward trend in IBD/SDA claims due to mental or behavioural disorders by district for the period 2006 to 2011. This reflects an overall reduction in claims for these benefits for all medical causes. However, the number of claims due to mental or behavioural disorder as a proportion of total IBD/SDA claims is increasing from a low of 36% in 2008 to 44% in 2011.

Figure 1 IBD/SDA claims by Nottinghamshire residents due to mental or behavioural disorders 2006 to 2011



Source: NOMIS Official Labour Market Statistics

Caring Responsibilities

39. Many carers have little time for themselves, to eat healthily, take regular physical exercise and maintain a social life. Caring can be emotionally draining, stressful and affect sleep. As a consequence carers are at greater risk of mental illness. The General Household Survey 2000 found that of those caring for more than 20

[28] Source: NOMIS Official Labour Market Statistics available at http://www.nomisweb.co.uk/reports/lmp/la/1967128603/report.aspx#tabwab

hours per week and living with the person they cared for, 14% reported feeling depressed. Of those who cared for more than 50 hours per week this figure rose to 34%.

40. Nottinghamshire has a higher proportion of carers than the England average, with the highest numbers in the Ashfield area. The 2011 census identified 83,000 carers, of whom, approximately 26,000 provided 20 hours or more of care a week.

Understanding Needs Across Nottinghamshire

41. Unfortunately our information systems tend to focus on measurements of ill health or in this case mental illness. An indicator is being developed that will go some way towards addressing this, the indicator is 'self-reported wellbeing' and is part of the Public Health outcomes framework which will go some way to address this.

42. The Survey of Psychiatric Morbidity among Adults Living in Private Households[29] is generally regarded as providing the best available data about the rates of mental health problems in adults in England. The surveys have been carried out on three occasions, in 1993, 2000 and 2007, and include large samples of the population. The survey uses assessment tools to detect the prevalence of a range of mental illnesses including common mental health disorders, psychoses, and suicide and self-harm.

Common Mental Disorders (CMD)

43. Unfortunately, the psychiatric morbidity survey sample sizes are not large enough to enable direct reporting at a county or local authority level. However, analysis has been undertaken to apply the prevalence rates of CMD from the 2000 survey for England to the Nottinghamshire population to give an estimate of the number of people with CMD within each local authority area. These estimates are shown in table 1.

44. The findings of the 2007 survey were not significantly different to the 2000 survey so we can be assured that estimates based on the 2000 survey remain appropriate. The main exception to this is the calculation of prevalence among people aged 75+, where 2007 data had to be used as this age group were excluded from the 2000 survey. Note that the analysis should be treated as an estimate only. It is based on national rates which have been adjusted to take into account a range of local demographic characteristics at the level of the lower tier local authority. This data has been modelled further to derive estimates of the number of people expected to have such a diagnosis in each Clinical Commissioning Group (please refer to the JSNA).

[29]McManus S et al 2009. Adult Psychiatric Morbidity in England 2007: Results of a household survey, The Information Centre

Table 1 Estimated prevalence of CMD in Adults by Local Authority based on 2000 Psychiatric Morbidity Survey

Local authority	Prevalence of any CMD (rate/1000 pop)	Estimated number of cases
Nottinghamshire County	135.8	86,550
Ashfield	150.9	14,290
Bassetlaw	121.3	11,250
Broxtowe	143.2	13,460
Gedling	147.3	13,620
Mansfield	155.1	12,710
Newark & Sherwood	117.6	10,850
Rushcliffe	115.6	10,360

Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment

45. The rates vary considerably, with Rushcliffe having the lowest estimated prevalence and Mansfield and Ashfield having the highest estimated prevalence. This reflects the variation in levels of deprivation between the areas and demonstrates the social patterning of mental illness. In addition, prevalence of CMD varies by age and sex. Across all age groups prevalence is higher amongst females than males, and the highest prevalence is found among females aged 45-54 years.

46. The number of older people with depression in Nottinghamshire is expected to increase by 30-40% by 2025 as the population ages. The increase in severe depression is expected to be 42%.

Severe and Enduring Mental Health Problems

47. The 2007 Survey of Psychiatric Morbidity Among Adults found the prevalence rate for probable psychotic disorder in the year prior to interview (2006) was 0.4%. This is broadly in line with evidence from other studies of the epidemiology of SMI in Great Britain. In men and women the highest prevalence was observed among those aged 35 to 44 years.

48. Survey data in respect of the prevalence of psychotic illness has not been modelled in the same way as for CMD. As a result any estimation of the local prevalence can be based only on a crude application of the England rate to the Nottinghamshire population. However, this takes no account of factors prevailing in particular populations that affect prevalence and, would assume that each local authority population has the same prevalence as the overall England prevalence. This is unlikely to be the case as demographic factors that are associated with psychotic disorder are unlikely to be equally distributed across local authority populations and, as a result, there are likely to be variations in prevalence between local authorities. Because of this, SMI prevalence data for each local authority area has not been presented.

49. To give an indication of the difference in scale of the prevalence of SMI compared to CMD, using the 0.4% prevalence rate it is estimated that approximately 3,100 people in Nottinghamshire County are suffering from SMI, compared to over 86,500 people with CMD.

Self Harm

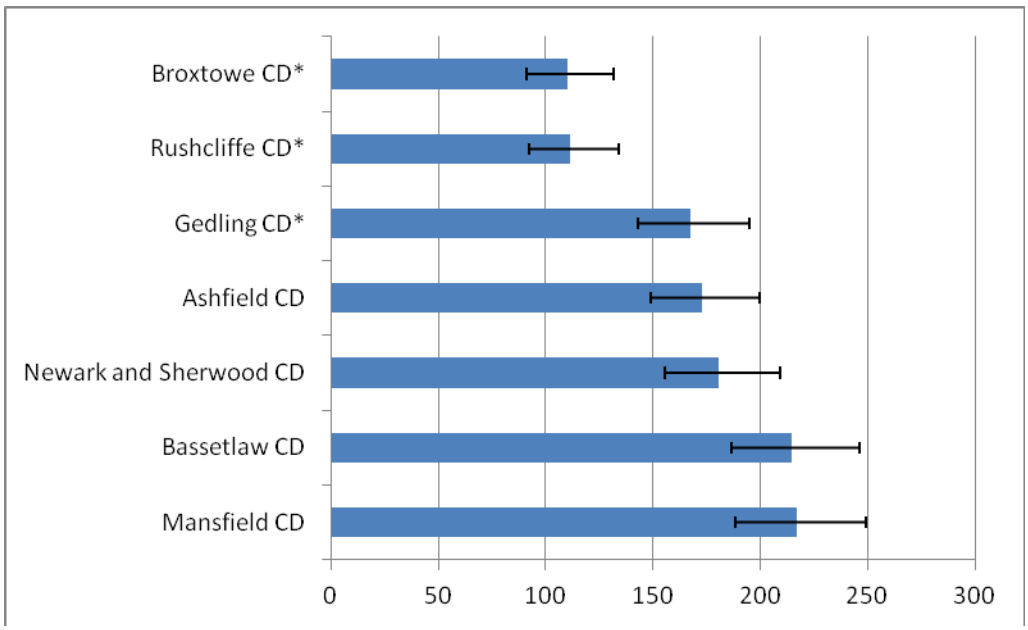
50. The term self-harm covers a wide range of behaviours, including habitual self-cutting and poisoning. Self-harm is of particular interest because of its power in predicting who is most likely to go on to commit suicide[30]. By its very nature, self-harm is a secretive behaviour and so collection of population prevalence data is difficult and is likely to under estimate the scale of the problem.

51. Self-harm is one of the commonest reasons for A&E attendance in England, but detailed information on the number and pattern of such attendances is very sparse. Data collated nationally from A&E (NHS Information Centre) record approximately 100,000 attendances for self-harm annually. However, it has been estimated that the actual number could be almost double this with the shortfall being due to case recognition, data completeness and recording[31].

52. A recent report scoping the usability of A&E attendance data in the East Midlands[32] concluded that A&E data is potentially a rich source of information but data quality must improve before robust analyses can be undertaken to inform local work. Overall in the East Midlands in 2008/9 over half of A&E HES attendances did not include a diagnosis code. The data presented in Figure 2 below relates to hospital admissions for self-harm, and this is one of the mental health specific measures in the Public Health Outcomes Framework. It is important to recognise that only a small proportion of people who self-harm ever attend or are admitted to hospital,[33] and using hospital data alone will give a distorted picture of the epidemiology and management of this problem.

[30]Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm. Systematic review.*Br J Psychiatry* 2002; **181**: 193–199.
[31]Hawton K, Fagg J, Simkin S, Bale E, Bond A. Trends in deliberate self-harm in Oxford, 1985–1995. Implications for clinical services and the prevention of suicide.*Br J Psychiatry* 1997; **171**: 556–560
[32] Alcohol related A&E attendances: A scoping study. EMPHO, 2010. Available at http://www.empho.org.uk/viewResource.aspx?id=11910
[33]Kapur N, House A, Creed F, Feldman E, Friedman T, Guthrie E. Management of deliberate self poisoning in adults in four teaching hospitals: descriptive study. *Br Med J* 1998; **316**: 831–832.

Figure 2: District level Emergency Hospital Admissions for Self Harm, directly age standardised rates per 100,000. 2009/10



Source: Local Authority Health profiles produced by Association of Public Health Observatories
*significantly better than the national average

Suicide

53. In England one person dies every two hours as a result of suicide[34]. For men under 35, suicide is the most common cause of death. Several factors are known to increase the risk of suicide. These include:

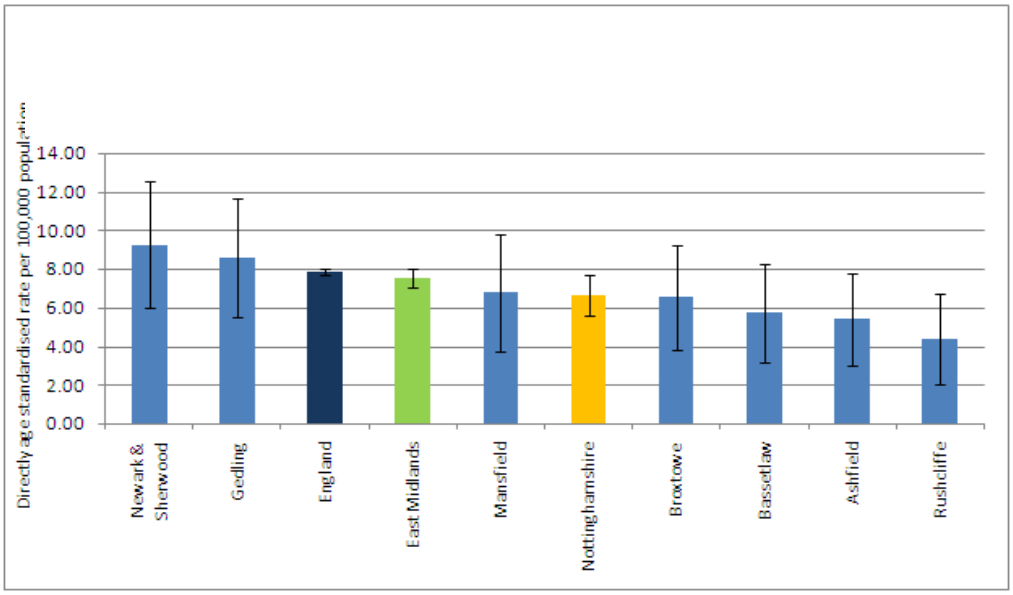
- Gender – men are three times more likely than women to take their own lives
- Age - people aged 40-49 have the highest suicide rate
- Mental illness
- Psychically disabling or painful illnesses
- Alcohol and drug misuse
- Prison
- Experiencing a stressful life event e.g. job loss, debt, bereavement and family breakdown[5].

54. Figure 3 shows the directly age standardised mortality rates from suicide and injury undetermined for the period 2007–2009 for each of the localities in Nottinghamshire, together with the rates for the East Midlands and England. The highest rate was in Newark & Sherwood but wide confidence intervals[35] mean

[34]HM Government 2011.Consultation on preventing suicide in England.A Cross-government outcomes strategy to save lives.
[35] *Confidence intervals provide the range of values in which we can be 95% sure the true value lies. A wide range indicates a greater degree of uncertainty about the estimate.*

that all but one of the local authorities where not significantly different from the England average. Only Rushcliffe shows any significant difference with a lower rate than both the East Midlands and England.

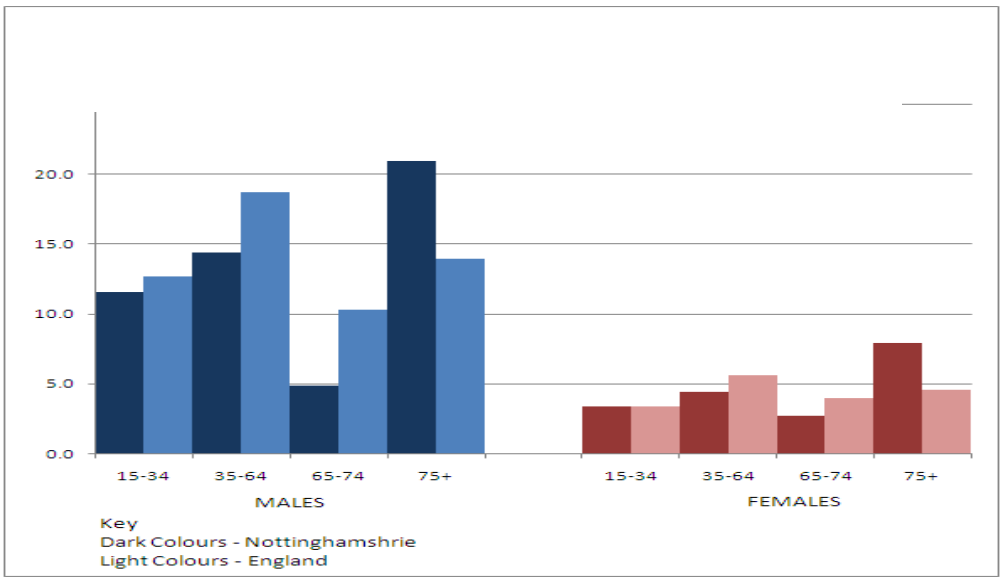
Figure 3 Directly Age Standardised mortality rate from suicide and injury undetermined in Nottinghamshire, 2007-2009 (pooled)



Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment

55. Figure 4 shows the mortality rates from suicide and injury of undetermined intent in Nottinghamshire and England for the period 2007-2009 broken down by gender and age group. Of particular note is the difference in the pattern of suicides by age group between Nottinghamshire and England. Nottinghamshire has a higher rate of suicides in those aged 75+ compared to the England average. It is important to remember the absolute numbers of deaths by suicide for older age groups are lower than for younger age groups, but the smaller overall population 75+ results in the lower number of suicides giving a higher rate. This also means that a small reduction in the number of suicides in those aged 75+ will have a greater effect on the rate than the same reduction in numbers of suicides in younger age groups.

Figure 4 Age and sex specific death rates per 100,000 people from suicide and injury undetermined in England and Nottinghamshire for 2007-2009 (pooled)



Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment

Current Position

56. There is already a significant amount of work underway to take forward this agenda. Some of this happens through core services such as those provided by GPs within their practices, some services are not commissioned, but rather are delivered through third sector organisations e.g. Jigsaw's Befriending service. To provide some insight into the range of services in place more detail is available in **Appendix A**. This appendix has three sections; general adult mental health, older people's mental health and high risk/vulnerable groups, (this mirrors the structure of the JSNA). Where possible the services have been aligned to the six national objectives to indicate where progress is already being made towards achievement. Please note that this is not intended to be exhaustive list. Further more detailed analysis of current provision will form part of the development of the Nottinghamshire mental health strategy.

Further Action Required

57. The local mental health strategy, currently under development, will identify a range of key actions needed to make further progress towards achieving the six national objectives. At the time of writing this report emerging findings include:

- The existence of age criteria for access to some adult mental health services. Under the Equalities Act 2010 any potential direct or indirect discrimination on the grounds of age must be addressed as a priority.

- Lack of coordination of services for young people making the transition from children's to adult mental health services, with some individuals not being eligible for support from adult services that they received through children's services.

- Inappropriate placement of adults in long term “rehabilitation” services. Adult mental health services must embed a recovery model of care into all services to promote independence and choice.

Statutory and Policy Implications

58. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

It is recommended that the Health and Wellbeing Board:

1) Endorse the intention to develop a local Mental Health Strategy and associated plan of action to support the achievements of the six national objectives for mental health and emotional wellbeing

2) Ensure that the commissioning plans of the Clinical Commissioning Groups and local authorities take account of the Health and Wellbeing needs described in this report.

CHRIS KENNY
Director of Public Health

For any enquiries about this report please contact:
Barbara Brady
Public Health Consultant

Constitutional Comments (06/02/2012)

59. The Health and Wellbeing Board may approve the recommendations in the report.

Financial Comments (RWK 07/02/2012)

60. None

Background Papers

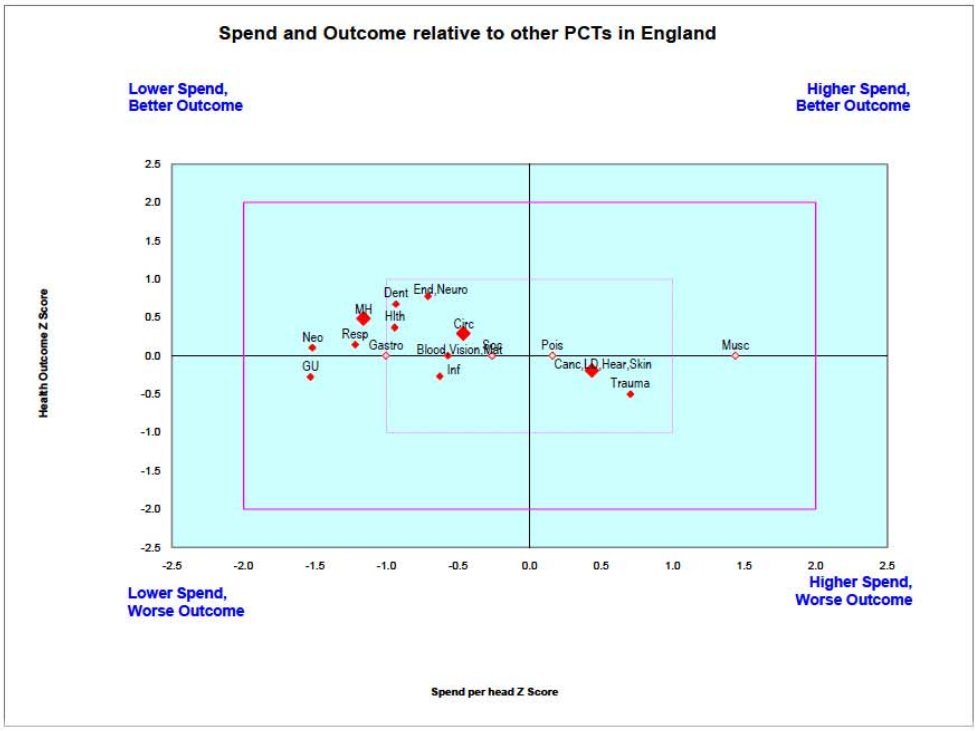
None.

Electoral Division(s) and Member(s) Affected

All. HWB31

Appendix A

Nottinghamshire County PCT 2009/10



◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

Interpreting the chart:

Each dot represents a programme budget category. The three largest spending programmes nationally (Mental Health, Circulatory Diseases and Cancer) are represented by larger dots.

The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. This means that for some programmes no outcome data is available.

The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.

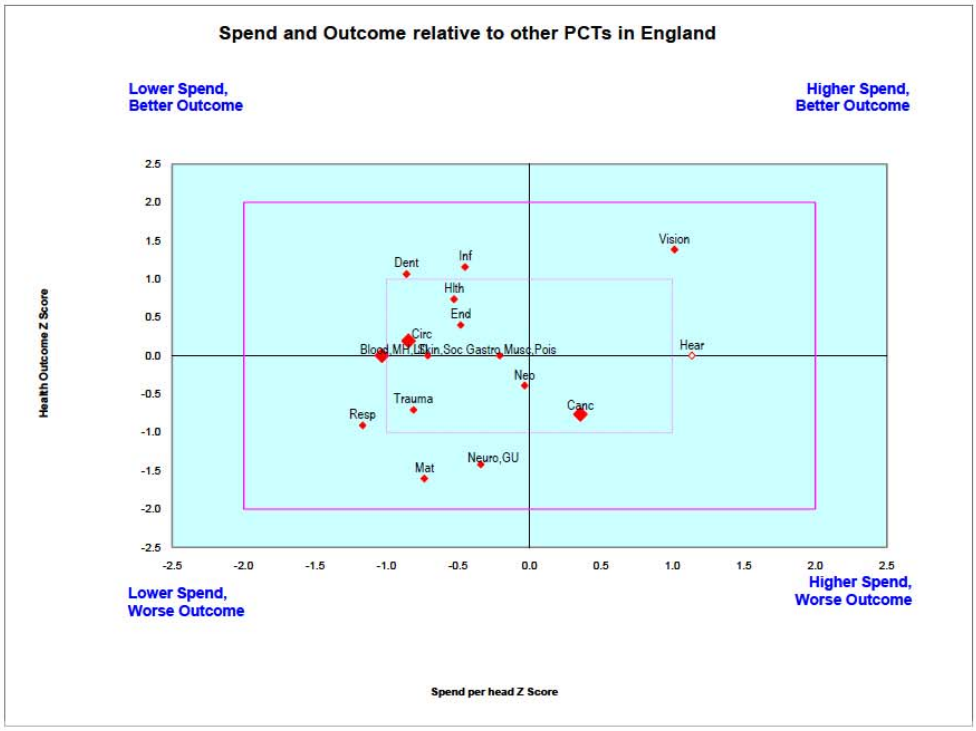
A programme lying outside the solid pink +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome.

Programmes lying outside the dotted pink +/- 1 z score box may also warrant further exploration.

Z Score:

A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further.

Bassetlaw PCT 2009/10



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Appendix B

General Adult MH services

National Objective	Services, providers or strategies that contribute to the objective
More people will have good mental health	1. Lets talk wellbeing – This is the IAPT service and has a general aim of promoting mental wellbeing. 2. In Bassetlaw a Workplace Health Award Scheme (Wellbeing@Work) has been developed where there are six themed areas. One of the areas is mental health and wellbeing. This aims to promote positive mental health and wellbeing and equip organisations to be able to support staff with mental health problems. 3. Across the rest of Nottinghamshire a Fit for Work scheme is funded by the Department for Work and Pensions until March 2013. 4. A new Information, Advice and Advocacy service will be in place from April 2012 to promote emotional wellbeing 5. New mental health support service provided via adult social care MH teams to provide a preventive service to people who may not be eligible for social care services.
More people with mental health problems will recover	1. Lets talk wellbeing – IAPT 2. Books on prescription scheme – across the whole county by GP referral or IAPT service guided referral 3. Fit for work initiatives – target MH & musculoskeletal conditions, supporting those affected to stay in work 4. Rehabilitation service review undertaken in 2011 identified individuals who were not currently appropriately placed. As a result clients are being reviewed on a case by case basis with a view to moving them into more appropriate accommodation/services.
More people with mental health problems will have good physical health.	1. QOF GP health checks annually for those with an SMI 2. Work on going to establish LES to facilitate management of cluster 13 patients in primary care rather than MH Trust. 3. 4 out of 5 CCGs (not Mansfield & Ashfield) looking to develop more effective pathway for patients with long term physical conditions to include psychological wellbeing as part of care plan, and train primary care team in low level IAPT techniques. 4. NMHT has senior manager with specific remit for physical health of clients accessing MH services. 5. MH Trust now manage many community services (following TCS) so have opportunity to develop closer links and improve physical health services to MH clients
More people will have a positive experience of care and support.	1. NMHT has two user involvement centres and service user and carer feedback forms and forums are promoted across all services within Nottinghamshire 2. IAPT data returns must include user and carer feedback 3. New jointly funded information, advice and advocacy service will be in place from April 2012 to provide guided signposting, and support independence and choice. 4. Implementation of self directed services in Adult Social Care ensures the involvement of service users and carers and promotes personalisation.
Fewer people will suffer avoidable harm	1. Local processes for reviewing serious untoward incidents (SUI) and risk management are robust and work well. 2. Multi agency suicide prevention group established with local action plan in place
Fewer people will experience stigma and discrimination.	1. NMHT coordinate excellent, regular anti stigma campaigns 2. Lets talk wellbeing have anti stigma work embedded into their ethos 3. PCT been active in supporting MH Awareness Week and World MH Day 4. PCT MH leads have attended GP PLT events to promote MH services such as Books on Prescription 5. Notts CC undertake survey of Hate Crime including crimes against those with mental illness. 6. Adult social care services continue to challenge stigma by promoting social inclusion through supported employment opportunities.

Initiatives and services targeted at older adults

National Objective	Services, providers or strategies that contribute to the objective
More people will have good mental health	1. *Safeguarding the Convoy (Campaign to End Loneliness) Age UK 2011* is a research paper describing & why people become lonely. This is being used to inform and develop **o**ur approach locally. 2. Link Age plus scheme is jointly commissioned with social care to support the development of social networks for older people. 3. Information & advice e.g. Infoscript is a service to provide older people with information re what services are available 4. Advocacy services will be jointly provided by health and social care
More people with mental health problems will recover	1. There are a range of mainstream older people's health & social care services which aim to ensure people recover to the best of their ability.
More people with mental health problems will have good physical health.	1. Mental health intermediate care is currently provided in 3 CCGs with the intention to extend coverage to all CCGs. 2. Acute care liaison is currently available, but only in SFHT
More people will have a positive experience of care and support.	1. Acute care liaison (SFHT only) 2. The advocacy service being jointly commissioned by health and social care will provide a robust advocacy service for older people.
Fewer people will suffer avoidable harm	1. Notts CC operate a robust mechanism for safeguarding adults whereby all incidents are reported and processes are in place to investigate and learn from any incidents 2. Independent Mental Capacity Advocate/Deprivation Of Liberty Safeguards will form part of the jointly commissioned advocacy service
Fewer people will experience stigma and discrimination.	1. The Equality Act 2010 requires that all services do not discriminate on the grounds of age.

Initiatives and services targeted at high risk/vulnerable groups

National Objective	Services, providers or strategies that contribute to the objective
More people will have good mental health	Substance misusers: 1. Nottinghamshire Alcohol Strategy 2010-15 2. All substance misuse providers consider wider mental health issues on initial assessment. Alcohol services use the Alcohol outcome tool http://www.outcomesstar.org.uk/alcohol-star/ which looks at emotional health (this is also part of the alcohol PbR pilot) In addition to this the PbR pilot also uses HoNoS http://www.rcpsych.ac.uk/training/honos/whatishonos.aspx
	Homeless:
	Veterans: 1. East Midlands Veterans Groups established to focus on the health needs of military personnel being discharged from the forces. Each old PCT area will have a Veterans Champion to support veterans in accessing appropriate services 2. Nottinghamshire Partnership group formed to improve health care offered to veterans. Agreed triage service (operated by 3rd sector military focussed organisations) for assessment and support around a range of health and social issues.
	Offenders: 1. Protecting and promoting mental health and wellbeing are associated with probation and prison offender management programmes which includes; • Improved educational and employment attainment • Reducing risk factors – such as substance misuse • Strategies to increase resilience i.e. supporting offenders in developing skills to deal with life problems.
More people with mental health problems will recover	Substance misusers: 1. In addition to the above and the delivery of psycho social interventions in treatment services (CBT, motivational interviewing etc) 2. Dual Diagnosis services are commissioned for clients with complex mental health and substance misuse needs. Such services provide psychosocial support as well as pharmacological support. 3. Treatment packages are tailored to address the needs of the individual and areas such as managing anxiety and depression are covered
	Homeless: 1. Hostel Liaison Group provides assessment, brief interventions and referral to mainstream services for homeless people with mental health problems 2. Beacon Project provides service to homeless people with past or current substance misuse problem. Signpost and refer to health and social care support services. 3. LES established with 1 practice in Mansfield to provide primary care services to homeless people
	Veterans: 1. EM Veterans group working to ensure integrated pathway for MH clients to make transition from military health services to NHS services. Trying to establish joint assessment process.
	Offenders: 1. The focus on commissioned prison mental health pathways supports those with serve and enduring MH problems.

National Objective	Services, providers or strategies that contribute to the objective
More people with mental health problems will have good physical health.	Substance misusers: 1. All treatment services assess physical health needs and liaise with GP's where appropriate. 2. High volume service users identified at Emergency Department (ED) often have a complex web of mental and physical conditions alongside their substance (mainly alcohol use) a case management approach is putting care plans in place which are used by EMAS and ED to manage the physical/medical conditions
	Homeless: 1. Beacon Project, LES and Hostel Liaison group all aim to ensure homeless people have access to appropriate health services to address their physical health needs.
	Veterans: 1. Veterans Champion to be appointed from Regional funding to ensure integration and coordination of veterans health and social care
	Offenders: 1. Most of the focus on health improvement has been reducing harm associated with substance misuse
More people will have a positive experience of care and support.	Substance misusers: 1. Treatment providers have service user panels for feedback, in addition use the patient opinion website to leave comments.
	Homeless:
	Veterans: 1. Veterans Champion should help ensure services are appropriate to the specific needs veterans.
	Offenders:
Fewer people will suffer avoidable harm	Substance misusers:
	Homeless: 1. Hostel liaison group offers support in finding suitable accommodation so that homeless people can be in a place of safety and reduce the risk of assault.
	Veterans:
	Offenders: 1. Suicide prevention strategies are high profile and adhered to within prison establishments and police stations
Fewer people will experience stigma and discrimination.	Substance misusers: 1. Feedback from clients is that it is often periods in their life when it all gets too much – death of partners, loss of jobs, marriage breakdown, problems with children etc where they recognise the effects on their mental health –depression and anxiety, seek help in primary care, but are alo self medicating with alcohol. 2. For women the stigma is a major problem – fear of losing children etc if they admit their drinking is out of control.
	Homeless:
	Veterans:
	Offenders: 1. Some reluctance for prisoners to come forward when MH is an issue because of the risk of stigmatisation.