LEICESTERSHIRE JOINT STRATEGIC NEEDS ASSESSMENT

MENTAL HEALTH OF ADULTS CHAPTER

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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 Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, CCGs 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, CCGs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with CCG and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, involving representation from NHS England, CCGs, Leicestershire Partnership Trust, University Hospitals of Leicester, District Councils and the voluntary sector, a JSNA Reference Group has been established. This Reference Group supports the JSNA work across the Health and Wellbeing Board. To examine the detail of the chapters, Task and Finish groups have been established to bring together local professionals, where they can share their expert knowledge on the work area being examined.

The outputs of the JSNA will include:

1. Subject-specific chapters of an assessment of current and future health and social care needs
2. An online infographic summary of each chapter available on the internet
3. An online data dashboard that is updated on a quarterly basis to allow users to self-

serve high level data requests

This JSNA chapter has reviewed the population health needs of the people of Leicestershire in relation to Mental Health in Adults. This has involved looking at the determinants of Mental Health, the health needs of the population in Leicestershire, the impact of Mental Health, the policy and guidance supporting Mental Health, 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.

Please note, the majority of indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. The term significance is used throughout the report and refers to statistical significance. This examines if the result presented is different to the national result, due to something other than chance. Most often, this is calculated using 95% confidence intervals.

EXECUTIVE SUMMARY

Almost one in four people in the UK experience at least one mental health problem each year, with one in six experiencing a common mental health problem, such as anxiety or depression, in any given week. Nationally, Improving Access to Psychological Therapies (IAPT data shows that depression is the most commonly recorded common mental health disorder (CMD), accounting for 28.5% of referrals entering treatment. While the prevalence and incidence of depression through the Quality Outcomes Framework (QOF) for both CCGs in Leicestershire is significantly higher than England, IAPT data suggests the most commonly recorded CMD locally is mixed anxiety and depression for both CCGs, accounting for approximately one third of each caseload (WLCCG: 32.5%; ELR CCG: 34.1%). The Adult Psychiatric Morbidity Survey (APMS) 2014 also found mixed anxiety and depression to be the most commonly reported CMD. Further work may be needed to understand whether this is truly reflective of the prevalence in the population, or whether these results are reflective of proactive identification and case management of patients, or differing recording practices within the IAPT service.

The latest data for Leicestershire shows that the percentage of people with severe mental illness on GP Practice registers is significantly lower than England, with an increasing trend over time in line with the national trend. Acute mental health admissions for Leicestershire are also significantly lower than England average. However, acute mental health bed days are significantly higher than 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. Furthermore, only 37.0% of Leicestershire's adults who were in contact with secondary mental health services and on a Care Programme Approach (CPA) lived in stable and appropriate accommodation significantly lower than England's 54.0%.

Further work is needed to understand the prevalence of severe mental health conditions, with more reliable data collection and recording. Further work is also needed to understand which specific severe mental illnesses are most prevalent within the county.

Add note: it is recognised that many with CMDs are not in treatment, hence difficult to ascertain a definitive number for the prevalence of CMDs (or self-harm). SMI's are in service so more accurate.

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1. Who is at risk?

Almost one in four adults in the UK experience at least one mental health problem each year, with one in six experiencing a common mental health problem, such as anxiety or depression, in any given week.[1] [2] The proportion of overall 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. [3] This is the largest burden of illness, compared to 16% each for cancer and heart disease.[4] This figure is thought to be a significant underestimate as it excludes several mental disorders.[5]

Mental health problems arise through a complex web of causation. It is recognised that the factors in 1.1 below may be both associated causes and associated effects of mental health problems, and it is not always easy to determine the cause and effect pathway due to this. However, evidence suggests the prevention and mitigation of risks, where possible, are essential in reducing the proportion of disease burden.

Mental wellbeing is considered a part of mental health. Anything that can negatively impact an individual's quality of life, such as the social and environmental factors mentioned, could be considered a risk factor for mental wellbeing. Poor mental wellbeing is also a recognised risk factor for common mental health problems such as anxiety and depression. This is due to the impact that feelings of self-efficacy, control and resilience, which impact life satisfaction, can have on positive attitudes and wellbeing. It is important to note that identification of the risk factors below does not mean a mental health condition will definitively develop. However, evidence suggests these risk factors increase the likelihood of developing mental health problems, and hence prevalence can be higher in these segments of the population.

1.1. Protected characteristics and individual factors

Genetics and biological factors, such as family history and hereditary genes can increase the risk of poor mental health.[6] Other risk factors include those classified under protected characteristics within the Equality Act 2010. Age is one example of this where for different points of the life course, mental health problems and poor mental wellbeing may be more or less likely to occur.[7] Those who identify as Lesbian, Gay, Bisexual, Transgender or others that do not feel they fit into any traditional categories of gender or sexuality (LGBT+), and certain ethnic groups such as those of black African backgrounds, have higher rates of mental illness than the general population.[24] [28] Gender can also be an influencing factor where, for example, females are more likely to present symptoms of anxiety and depression, whereas suicide is more prevalent in males.[8]

1.1.1. *Physical health and disability*

The risk factors for physical and mental health are recognised as co-dependent and overlapping. Due to the complex web of causality, it is recognised that poor mental health and wellbeing can worsen physical health, and poor physical health can worsen mental health and wellbeing.[9] The Kings Fund estimates that 30% of people in England with a long-term physical health problem also have a mental health problem, and 46% of people with a mental health problem also have a long term physical health problem.[10] This encompasses a wide range of illnesses including heart disease, diabetes, respiratory disease, cancer and infections.[11] Those with better wellbeing are known to have lower rates of illness, recover quicker and stay well for longer, both physically and mentally. This is also proven through cohort studies which demonstrate a survival advantage in those with mental wellbeing.[12]

The Adult Psychiatric Morbidity Survey (APMS) 2014 found the prevalence of mental disorders to be higher in those with poor physical health. Higher rates of chronic physical health conditions were associated with low mental wellbeing and even subthreshold levels of symptoms for common mental health problems.[2] Suffering from physical and mental health problems can delay recovery from both conditions.[13]

The 2011 Census suggests that people with a long term physical health problem or disability are two to three times more likely to develop mental health problems, particularly anxiety and depression. For Leicestershire, 16.2% of the population were found to have a long-term health problem or disability that limited their day-to-day activities. This is significantly lower than the England average of 17.6%. However, variation was apparent across districts, with Harborough having the lowest prevalence at 14.6% and North West Leicestershire the highest at 18.1%; this is the only district to have prevalence significantly higher than national with all others being significantly lower.[14]

Adults with a learning disability are estimated to experience double the risk of depression and a three-fold increase in the risk of schizophrenia. [14] [15] The QOF indicates that in 2016/17, 0.4% of Leicestershire's population were registered with a Learning Disability with a GP, although only 54.9% of eligible adults with a learning disability were having a GP health check.[16] This is similar to the national rate of 48.9%.

1.1.2. *Medically Unexplained Symptoms (MUS)*

Medically unexplained symptoms (MUS) refer to people in physical pain or discomfort, where a medical professional is unable to give a distinctive diagnosis or explanation for that pain.[17] It is estimated that MUS account for up to 45% of GP consultations while a study

based in secondary care indicated that about 50% of patients had no clear diagnosis at 3 months.[18] This can lead to patients feeling stressed or anxious, exacerbated further by less emotional support in coping with MUS by doctors, who may focus on physical symptoms.[19] It is estimated that up to 70% of patients with MUS are living with depression and/or anxiety related conditions.[20] While it is difficult to ascertain how many people in Leicestershire are living with MUS, data from the IAPT services shows that in 2017/18, approximately 625 Leicestershire residents with MUS were referred to an IAPT service. This is likely to represent a tiny proportion of number of people with MUS.

1.1.3. *Gender reassignment and sexual orientation*

Research indicates the increased likelihood of certain mental health problems occurring in the LGBT+ population. For example, LGBT+ people are 1.5 times more likely to develop depression and anxiety compared to the rest of the population.[23] They are also more likely to self-harm.[21]

When comparing all the common sexual identity groups, bisexual people were found to have increased risks of depression, anxiety, self-harm and attempting suicide.[22] 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. [23] For females, suicidal thoughts and self-harm were also more prevalent in the lesbian and bisexual women populations compared to the general population.[24] 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.[25]

A transgender mental health study showed that 88% of transgender people had experienced depression and 84% had thought of ending their life. Transgender mental health is complex, as the International Classification of Diseases (ICD10) classifies gender identity disorder, which encompasses transsexualism and dual-role transvestism, as a mental disorder.[26]

Despite research showing the link between mental illness and the LGBT+ population, it is difficult to estimate what percentage of the population is affected. 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 (ONS) produced experimental statistics on sexual identity in the UK by region, and estimates LGB's to 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.[27]

1.1.4. *Race*

The 2011 Census shows 8.6% of the population in Leicestershire are from black and minority ethnic (BME) backgrounds. 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.[28] Black populations have the highest rates of posttraumatic 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.[2] Those from minority ethnic backgrounds are also less likely to access mental health services; hence these may underestimate the true prevalence in the population, with pockets of the population remaining undiagnosed.

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 further affect the foetus, baby, family and the mother's physical health.[29] 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. [30] 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 and wellbeing. A relatively small study in 2008 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.[31] Recent studies from Ireland and the USA showed that negative social interactions and relationships, especially with partners/spouses; increase the risk of depression, anxiety and suicidal ideation, while positive interactions reduce the risk of these issues. [32] [33]

The 2011 Census showed that 11% of Leicestershire's adult's marital status was separated or divorced, significantly lower than the England average of 11.6%. This varied by district with Hinckley and Bosworth having the highest proportion of separations or divorce at 12% followed by North West Leicestershire at 11.9%, both significantly higher than England.

Melton was similar to England at 11.8% and all other districts had a proportion significantly lower than England with the lowest being Oadby and Wigston at 9.1%.[14]

1.2. Education, learning and development

Low levels of education can impede 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 health problems during adulthood can lead to poorer outcomes in educational achievement, but lower educational achievement can lead to poorer mental health.[34] [35]

The 2011 Census showed that over a third (35.5%) of Leicestershire's population aged 16 and above had no qualifications or a low level of education, significantly lower than the England average of 35.8%. This varied by district, with Blaby, North West Leicestershire and Hinckley and Bosworth having a significantly higher proportion of adults with no qualifications or a low level of education compared to England (36.8%, 39.2% and 38.7% respectively). Charnwood and Harborough had a significantly lower proportion of adults with low education or no qualifications (32.6% and 31.3% respectively).[14]

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.[36] However, only a minority of those with mental health problems (except psychosis) receive treatment in childhood, meaning mental health problems in childhood are more 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. [37]

More information
For further information on Children's Mental Health, please visit the Children and Young People's Mental Health JSNA Chapter:
http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

1.4. Social Media

The past decade has seen an increase in online social networking through social media. This has altered ways people communicate and interact. Some studies suggest that the prolonged use of social networking sites can lead to addiction, or a culture of comparison, in turn lowering user's self-esteem and triggering symptoms of depression. Concerns have been raised around spending excess time online, sharing too much information, cyber

bullying, the influence of social media on body image, and sourcing of harmful content or advice including websites that promote self-harm. Other studies have highlighted the positive, protective factors of social media suggesting the feelings of inclusion in a community, especially for marginalised groups, increases self-esteem and reduces feelings of isolation.[38]

The evidence for social media use and mental health conditions is emerging, and hence has not yet been fully investigated. With little long-term research, and no research at a Leicestershire level, it is difficult to reliably conclude the impact that social media has on mental health for different subgroups of the population, at both a national and local level. The correlational nature of social media further makes conclusions difficult to achieve; i.e. reliably determining whether social media usage leads to lower self-esteem, or whether those with lower self-esteem use social media more often.[38] It is difficult to accurately weigh up the benefits against harms in an overall sense, especially in a rapidly evolving digital age-the research is slow to catch up.

1.5. Lifestyle

Mental health problems are associated with a higher prevalence of risk taking behaviours and increased dependency on the use of substances. This includes smoking, drinking and drug use and a lack of excercise.[9 39 40]

Smokers are significantly more likely to have a mental health problems compared to non-smokers.[39] The Annual Population survey (APS) estimated that 13.5% of adults smoked in Leicestershire in 2016, significantly lower than England 15.5%. While this is not a significant decline from the previous year, it is significantly lower than when the survey was first introduced in 2012 when the smoking prevalence in adults was 19.3%.[45] GP data further shows that in 2014/15, approximately a third (33.8%) of Leicestershire's adults with a severe mental illness were registered smokers.[41]

Data from the Health Survey for England from 2011-2014, estimated that a fifth (21%) of Leicestershire's population had engaged in binge drinking. This was significantly worse than England (16.5%) and also second worst performing against all statistically similar (CIPFA) nearest neighbours.[45] Data from the QOF shows that over three quarters of those diagnosed with serious mental illness in 2016/17 had a record of alcohol consumption in the preceding 12 months. For East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) and West Leicestershire Clinical Commissioning Group (WL CCG), this was 75.7% and 80% respectively, accounting for 1,132 and 1,708 respectively.[41]

Direct indicators of dual diagnosis (mental ill health and substance misuse) are largely

unavailable. However, research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment.[42] Having a history of alcohol or drug use has been recorded in 54% of all suicides in people experiencing mental health problems of whom 11% are in touch with drug treatment services at the time of death.[43] In 2014/15, Leicestershire's estimated prevalence of opiate and crack/cocaine use amongst 15-64 year olds was 6.3 per 1,000 population. This is similar to the England rate of 8.6 per 1,000 population.[44]

Data from the Active Lives Survey in 2015/16 suggests that over a fifth (21.7%) of Leicestershire'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 (CMO) guidelines recommending above 150 moderate intensity equivalent minutes of physical activity per week. This is similar to the England average.[45]

1.6. Employment and economic factors

Unemployed individuals, benefits claimants and those living in households with lowest incomes are known to be at increased risk of common mental health problems, such as depression.[2] [35] The 'Dying from Inequality' Report further highlights that socioeconomic deprivation, defined through unemployment, economic recession, low-skilled occupations and low education, is a risk factor for suicide.[46]

The 2014 APMS showed the age-standardised CMD rate in employed people aged 16-64 was half that of their non-employed counterparts. In Leicestershire in 2016, 3.4% of the working age population were unemployed, significantly lower than national 4.8%.[47] In August 2016, 0.12% of the working age population were classed as long term unemployed in Leicestershire, significantly lower than the England average of 0.37%.[14]

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 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.[2] Further analysis revealed that ESA claimants also had a higher prevalence of personality disorder, suicidal thoughts and suicidal attempts.

In 2017, the percentage of Leicestershire's working age population claiming ESA, incapacity benefit or severe disablement allowance was 4.1%, significantly better (lower) than England's average of 5.7%.[47]

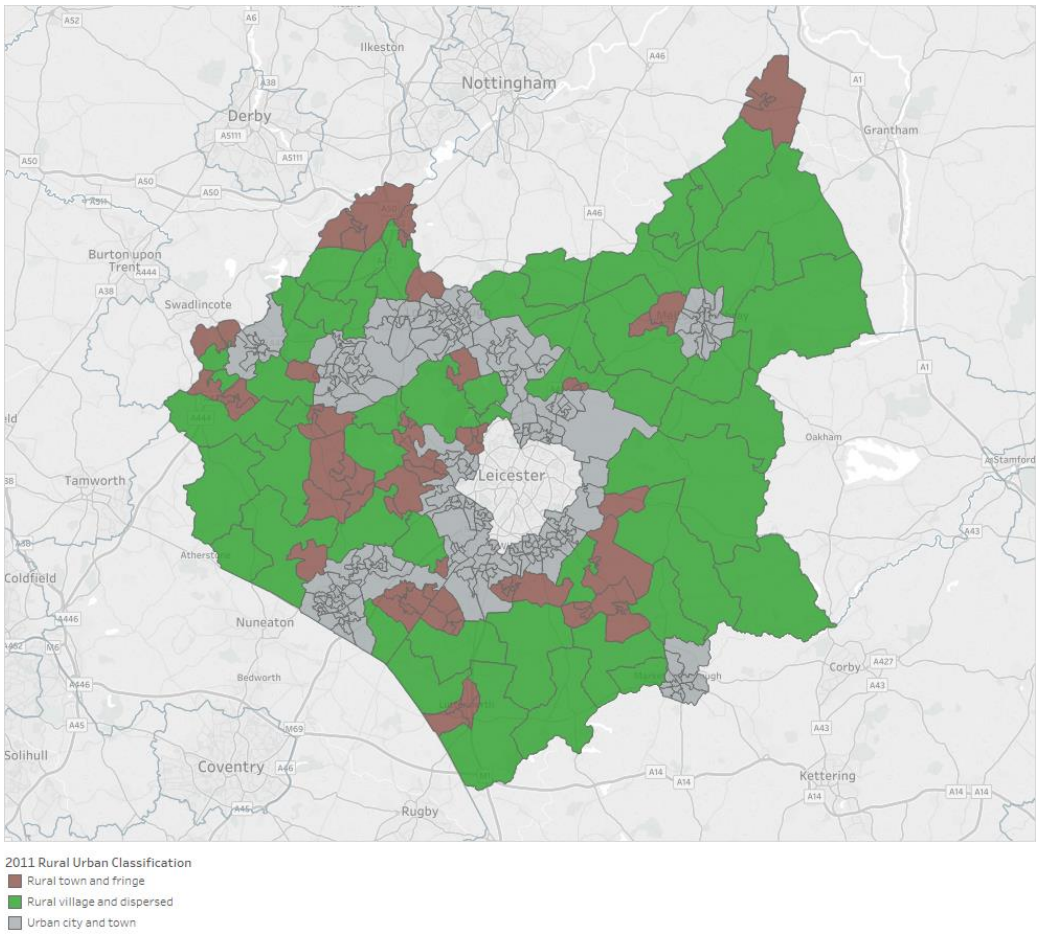
Employment in turn has an impact on household income. Those living in households with incomes in the lowest 20% are at a higher risk of all mental disorders than those with incomes in the highest 20%.[1] In Leicestershire, in 2016, 1.9% of the population were living in the 20% most deprived areas in England.

1.7. Rurality

While statistics indicate that common mental health problems occur with a lower frequency in rural areas, this is attributed to income rather than rurality itself. Those on low incomes in rural areas tend to have poorer mental health than those on higher incomes.[48] Research also shows that those who are socially deprived and living in urban areas also more likely to self-harm.[49]

Figure 1 displays the Rural Urban Classification for Leicestershire at lower super output area (LSOA) level. LSOAs were designed to improve the reporting of small area statistics and are built up from groups of output areas (OA). LSOAs have a minimum population of 1,000 people and a maximum population of 3,000. They contain a minimum of 400 households and a maximum of 1,200 households. Where possible, LSOA boundaries follow natural boundaries such as roads and rivers. Leicestershire is predominantly rural by area, with the majority of Melton and Harborough districts classed as rural. However, the population is concentrated within urban areas. Overall, 69.6% of the population of Leicestershire live in areas classed as Urban City and Town, while 17.7% live in Rural Town and Fringe and the remaining 12.7% live in areas classed as Rural Village and Dispersed.

Figure 1: Urban rural classification by LSOA, Leicestershire



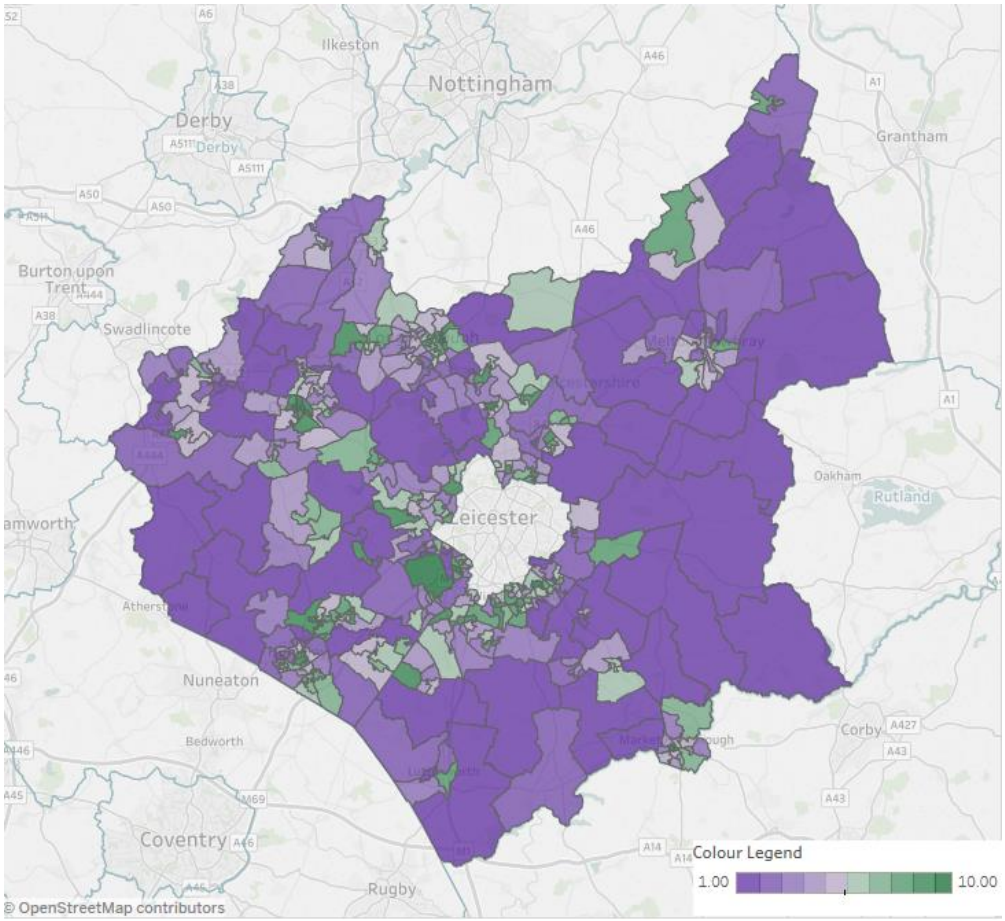
Source: 2011 Rural Classification, ONS, 2013.

More information
For further information rural urban classification in Leicestershire, please visit:
https://tableau.leics.gov.uk/#/workbooks/1678/views

In rural areas, imposed isolation can lead to a greater sense of alienation and loneliness. Lack of public transport and specialised mental health care services in rural areas, coupled with a culture of self-reliance, means residents are also less likely to seek help if they do develop mental health problems.[50] The map below shows data for Leicestershire from the Indices of Deprivation. (ID2015). The Indices are made up of eight domains, one of which is barriers to housing and services. The Barriers to Housing and Services Domain measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: 'geographical barriers', which relate to the physical proximity of local services, and 'wider barriers' which includes issues relating to access to housing such as affordability and homelessness. While Leicestershire is not a relatively deprived area when considering the indices of deprivation, its rural makeup means that 43 of its 396 LSOAs fall into the 20%

most deprived areas of the country when considering barriers to housing and services. When considering its geographical barriers sub-domain, this increases to 95 LSOAs as shown in Figure 2.

Figure 2: Geographical barriers sub-domain from the Indices of Deprivation by national decile for Leicestershire LSOA's



Source: Communities and Local Government, 2015.

More information
For further information area classification in Leicestershire, please visit:
https://tableau.leics.gov.uk/#/workbooks/2083/views

1.8. Loneliness

Social isolation and loneliness are harmful to physical and mental health and increase the risk of morbidity and mortality. While 'loneliness' does not necessarily define a specific segment of the population, it is important to acknowledge the risk it plays in poor mental wellbeing. Despite loneliness having a social aspect, it must be distinguished from social isolation. 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.[51]

The Community Life Survey shows that 5.4% of people in England reported feelings of loneliness often or always in 2016/17. This was not statistically different from 2015/16 or over the three year period commencing 2013/14. Variations were apparent by age group, with 10% of 16-24 year olds being the group with the highest reported loneliness levels, 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.[7] 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.

More information
For further information and maps on the relative risk of loneliness for Leicestershire districts and wards please visit:

https://www.ageuk.org.uk/our-impact/policy-research/loneliness-research-and-resources/loneliness-maps/#about

1.9. Living Arrangements

It is important to note that not all people living alone would be considered to be socially isolated, or considered lonely. However, the 2014 APMS showed 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 11.4% of Leicestershire's population were living alone, significantly lower than the England average of 12.8%.[44]

When considering the older population, the Census showed that 5.21% of households in Leicestershire were occupied by a single person aged 65 and over. This was similar to the national average of 5.24%.

1.10. Other sub-groups

Other sub-groups of the population can be missed in overarching statistics, such as travellers, and the homeless. These sub-groups, who have not been mentioned in key statistics above, can be more exposed and vulnerable to the unfavourable social, economic, and environmental circumstances encompassed in the above risk factors. They are therefore considered to be at a higher risk of developing mental health problems than the general population.

1.10.1. *Prisoners and offenders in the community*

Prisoners experience mental health issues at rates in excess of those in the general population, as shown below. In England and Wales, 54% of women and 34% of men in prison say they are affected by emotional wellbeing or mental health issues.[52] 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.[53]

It is important to note that this does not mean that people with mental health problems are offenders; rather evidence shows that most crimes are committed by people who do not have 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.[54]

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.[55] [56] In 2016, more than a third of all prison deaths in England and Wales were self-inflicted.[57] Released prisoners further have a significantly higher risk of suicide compared to the general population.[53] In England in 2016/17, 9.2% of people in prison were on a care programme approach (CPA) plan, hence diagnosed with a severe mental illness, an increase from 8.8% in 2015/16.[45]

There are two prisons within Leicester and Leicestershire. As of March 2017, the Gartree prison in Market Harborough contained 707 males aged 21 and over. Meanwhile Leicester prison contained 322 males aged 21 and over.

1.10.2. *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.[58] Further research shows those exposed to female genital mutilation (FGM) or those who have been trafficked or raped have particularly higher rates of PTSD than the general population.[59] [60]

Data from Leicestershire police shows that from April 2017 to March 2018, there were 15.3 crimes and incidents of violence against the person per 1,000 population. This accounted for 10,459 acts reported to the police. There were 4,248 domestic violence against the person crimes and incidents, equating to 6.2 per 1,000 population. In the same time period, there were 1,052 recorded sexual offences at a rate of 1.5 per 1,000 population. It is important to remember these figures are based only on those that are reported to the police; the true

prevalence of these crimes may be higher.

1.10.3. *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.[61] [62]

In 2016, the rate of migrant GP registrations in Leicestershire was 5.8 per 1000 population, significantly lower than the England average of 12.9 per 1000 population. All districts displayed significantly lower rates of migrant registrations than England, although varied from 2.7 per 1,000 population in Melton, to 10.9 per 1,000 population in Charnwood. The Leicestershire rate has shown a slightly increasing trend since 2012 where the rate was 4.5 per 1000 population- This is in line with nationally increasing trends.

1.10.4. *Disrupted social ties*

Disrupted social ties can impact the mental health of many subgroups, and can include those who are in life transitions, such as students. It also includes those who are restricted from having as much social contact as they would like, such as carers.

Social capital represents the networks, relationships, connections and collective attitudes felt by people in a society. High rates of social capital are associated with positive well-being, while the loneliness that comes from a lack of social contact is associated with poor mental wellbeing.[63] Research has shown that the stress and worry, lack of time for one's self, isolation, money worries, lack of sleep, and feelings of frustration, and, guilt and low self-esteem can impact on carers' mental health and wellbeing. This can lead to depression, anxiety and obsessive compulsive disorder (OCD).[64]

Results from the Personal Social Services Carers Survey show that in Leicestershire in 2016/17, 31.4% 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. This was similar to the England average of 35.5%.[45]

1.10.5. *Adult social care users*

This is another group of people who may not have as much social contact as they would like. The Adult Social Care Users survey estimated that less than half of adult social care users felt they had as much social contact as they would like; this equated to 46.2% in 2016/17, similar to the England average of 45.4%.[45]

1.10.6. ***Students***

There is a relative lack of high quality evidence in the mental health of students in the UK. Students in higher education represent a unique group in which to describe the epidemiology of mental illness. They broadly fall into the age group of 17–25 years. This age span encompasses the transition from adolescence to adulthood. Around three-quarters of adults with a mental illness first experience symptoms before the age of 25.

It is recognised that many of the transition points in life can be particularly challenging. For some students an unfamiliar higher education environment can be very stressful, particularly for those who already have an underlying illness. Going to university often entails: separation from family and existing friends; move to a new area or country; experience of a range of different cultures; communicating in a language in which they are not fully fluent; meeting unfamiliar modes of learning, teaching and assessment, and unfamiliar professional requirements; managing changed financial circumstances, including living on greatly reduced incomes or taking out loans for the first time; managing the transition from home to university life; making the transition from home to university local health providers and support services.

It is also important to note that some level of stress does not necessarily have to have a negative impact and can be stimulating. Engaging in higher education can also make a positive contribution to mental wellbeing in that it: provides a structured and purposeful environment; provides opportunities for academic and personal achievement leading to a fuller sense of identity and increased self-esteem; offers the opportunity to learn to manage multiple demands and build confidence; can reduce isolation and provide opportunities for new friendships; provides opportunities for exercise, creativity and community involvement and contribution.

Nationally, student service managers, counsellors and mental health advisors report increasing numbers of clients and an increase in the severity of the problems that trouble them.[65] One study carried out an internet-based survey of mental distress in students in four UK higher education institutions:students were assessed using the Clinical Outcomes in Routine Evaluation 10-item measure (CORE-10). This was done as part of a study of alcohol use in students. The researchers found that 29.0% of students described clinical levels of psychological distress. In 8.0%, this was moderate to severe or severe.[66] Meanwhile a Yougov poll of over 1,000 students in 2016 suggested that more than a quarter of students (27%) report having a mental health problem of one type or another. [67]

There are three universities around Leicestershire: University of Leicester, De Montfort and Loughborough University. However, it is not possible to determine how many Leicestershire

individuals are in higher education, whether at these universities or others further out.

1.10.7. *Military population*

It is recognised that those serving in the military are exposed to conditions which may cause physical or mental distress, including but not limited to Post Traumatic Stress Disorder (PTSD). Two British Army barracks are located in Rutland, Kendrew Barracks in Cottesmore and St George's Barracks in North Luffenham. Entitled civilian personnel include service personnel family dependents and Ministry of Defence (MOD) employed civilian personnel who are entitled to care at MOD primary care facilities. Active military personnel have their primary care (GP services) provided by the MOD rather than the NHS. When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS.

1.10.8. *Homeless*

Homelessness and poor quality housing result in a 3 fold and 4 fold increased risk of mental health problems.[68] [69] The Joint Commissioning Panel for Mental Health estimates that 27% of homeless people have probable psychosis.[70]

In 2015/16, the rate of statutory homelessness in Leicestershire is 1.3 per 1000 population, significantly lower than the England average of 2.5 per 1000 population. Two districts, Melton and Oadby and Wigston had similar rates of homelessness as England at 3.1 per 1000 population and 2.1 per 1000 population respectively. All other districts had rates significantly lower than national, with the lowest being in Blaby at 0.3 per 1000 population.[14] In 2016/17 37.0% of Leicestershire's adults who were receiving secondary mental health services on the Care Programme Approach lived in stable and appropriate accommodation, significantly lower than England's 54.0%.[45]

2. Level of need in Leicestershire

2.1. Mental wellbeing

Mental wellbeing is more than the absence of mental illness, and cannot be defined through medical or psychiatric conditions or disorders. Discussion has ranged, in recent years, over the extent to which mental wellbeing is represented by psychological attributes such as confidence, agency, optimism, good relationships with others – collectively called psychological wellbeing – and by affective or emotional states such as happiness and life satisfaction.[9] As mental wellbeing cannot be easily 'diagnosed', data relies on self-reported responses from surveys or questionnaires.

Data from the Annual Population Survey 2016/17 estimates that 8.2% of Leicestershire's population report a low happiness score. This is similar to the England average of 8.5%. While Leicestershire's value has shown an increase since 2015/16 when 6.5% reported a low happiness score, the lowest since the survey began in 2011/12, the increase is not statistically significant.

Almost one fifth (19.9%) of Leicestershire's residents reported a high anxiety score, identical to the England average. While this was an increase from 2015/16 value of 16.8% (the lowest since the survey began in 2011/12), the increase is not statistically significant. While the percentage reporting low 'satisfaction' and low 'worthwhile' is not available annually for Leicestershire, values are nationally estimated at 4.5% and 3.6% respectively. As this is a household survey, all caveats with this methodology should be considered when interpreting data, and it is important to note that traveller and homeless populations who may be at risk of lower mental wellbeing are not included in this analysis.[71]

Combined data from the survey from 2012-2015 gives further insight to personal wellbeing at different ages. Analysis shows that ratings of life satisfaction and happiness were lowest, and anxiety highest, on average, for those aged 45-59, keeping in line with previous research which presents the relationship between age and well-being in a U-shaped curve for those aged under 75.[72] This is of particular relevance to Leicestershire considering that over one fifth of the population (21.6%) of the population are currently aged 45-59. Analysis also shows the well-being ratings for all scores show a notable decline for those aged 75 or above, with the lowest average 'worthwhile' ratings being amongst the over 90 age group, again important to note considering Leicestershire's growing aging population.

More information
For further information on Leicestershire's population, please visit:
https://public.tableau.com/profile/r.i.team.leicestershire.county.council#!/vizhome/2017DistrictPopulationEstimatesDashboard/2016-17PopulationEstimates

Data from the GP Patient Survey in 2015/16 estimated that 4.8% of Leicestershire's GP registered population considered themselves to have a long term mental health problem, similar to the national value of 5.2%. In 2016/17, the national value rose to 5.7%, with the Leicestershire CCGs showing varying responses. ELR CCG reported significantly lower long-term mental health problems at 4.9%, for the first time in four years when compared to England. WL CCG's estimate remained similar to England with 5.5% reporting long term mental health problems.[44] This accounts for 207 people and 275 people respectively. Please note, there was no given definition for long term mental health problems in the survey, therefore responses are based on subjective responses. The survey is based on a sample, therefore will not account for all those who consider themselves to have a long-term mental health problem.

2.2. Common mental health conditions

2.2.1. *Overall common mental health conditions*

Common mental health conditions, also known as common mental disorders or neurotic disorders, encompass different types of depression and anxiety, including generalised anxiety disorder, phobias, 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. Many of these conditions are known to overlap; for example someone who is experiencing anxiety and depression may also have OCD symptoms. It is further recognised that not all CMD's are diagnosed. For this reason, data relies on estimates, with the understanding that those in service and receiving treatment do not account for all those with CMD's.

2.2.1.1. Common mental health conditions by age

In 2014/15, it was estimated that 11.6% of WL CCG's registered population and 12.2% of ELR CCG's registered population, aged 16-74 had a common mental health disorder. This accounts to approximately 32,300 people and 28,300 people affected respectively. It is likely that only a smaller proportion is actually diagnosed.

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%). Symptoms were most prevalent in the working

age population, who were twice as likely to have symptoms compared to those aged over 65.

The Improving Access to Psychological Therapies (IAPT) service provides psychological assessment and treatment for mild to moderate common mental health problems. Patients can self-refer or be referred by their GP. Table 1 shows that in 2016/17, the highest proportion of referrals for ELR CCG were for the 18-35 age group (47.9%), while for WLCCG and nationally, the highest proportion were for the 36-64 age group (43.3% and 49.1% respectively). The lowest proportion of referrals received by the IAPT service in 2016/17 were for the 16-17 age group for both ELR CCG (3.0%) and WL CCG (2.7%). This is in line with the national average, although locally, the proportion of referrals for 16-17s is more than double the national average for both CCGs.

When considering the adult population, the 65 and over age group have the lowest proportion of referrals, both locally and nationally (ELR CCG: 8.3%, WL CCG: 6.1%, England: 7.2%). This is in broadly line with APMS prevalence estimates for CMD's which show the working age population were twice as likely to have CMD symptoms compared to those aged over 65.

Table 1: Referrals received by IAPT by age, 2016/17

	16 to 17		18 to 35		36 to 64		65 and over	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
ELR CCG	185	3.0	2615	42.9	2795	45.8	505	8.3
WL CCG	205	2.7	3640	47.9	3285	43.3	465	6.1
England	6,083	1.1	241,589	42.6	278,574	49.1	40,673	7.2

Source: NHS Digital, Psychological Therapies, Annual Report on the use of IAPT services[73]
*Under 16's are not included in percentage calculations

2.2.1.2. Common mental health conditions by age-sex group

The APMS found all anxiety disorders to be 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%). A second although less pronounced peak for females was evident between the ages of 45-54. This is of particular relevance to Leicestershire, where the majority of the population are currently middle aged.

Table 2 shows when the estimated prevalence of 22.7% is applied to Leicestershire's females aged 45-54; almost 12,000 women are estimated to be affected by common mental health conditions.

Table 2: Common mental health disorders estimated prevalence in Leicestershire females

Age	APMS Prevalence %	Leics females population	Leics applied estimate counts
16-24	26.0	35,971	9,352
25-34	19.1	39,944	7,629
35-44	20.6	41,961	8,644
45-54	22.7	51,985	11,801
55-64	19.1	42,330	8,085
65-74	12.9	39,229	5,061
75+	10.0	34,354	3,435
All	19.1	285,774	54,583

Source: APMS 2014, ONS Mid-2016 Estimates

For males, CMD symptoms peaked in the 25-34 age group nationally, with 15.3% reporting symptoms of a level likely to benefit from acknowledgement and possible intervention. Symptoms remained stable for men during their working age and then tailed off after the age of 65-74. As with females, when these national estimates are applied locally, as in Table 3, the age group with the largest number of males estimated to be affected is 45-54, with a count of 6,681. Therefore the largest absolute numbers affected in Leicestershire for both males and females is estimated to be the 45-54 age group. Other than the 65-74 and 75+ females, all other female age groups estimated counts are higher than the 45-54 age group in males.

Table 3: Common mental health disorders estimated prevalence in Leicestershire males

Age	APMS Prevalence	Leics males pop	Leics applied estimate counts
16-24	9.1	42,292	3,849
25-34	15.3	37,570	5,748
35-44	15.1	40,240	6,076
45-54	13.2	50,610	6,681
55-64	14.9	42,383	6,315
65-74	7.3	37,459	2,735
75+	5.3	25,505	1,352
All	12.2	276,059	33,679

Source: APMS 2014, ONS Mid-2016 Estimates

These figures are based on those who had a CIS-R score of 12 or more, meaning they indicate symptoms of anxiety or depression of a level likely to benefit from acknowledgement and possible intervention. These figures are considered underestimates as they only consider people living in private housing. Therefore, vulnerable populations

such as the homeless, those living in sheltered housing, in prison or in hospital, are excluded.

2.2.1.3. IAPT: Common mental health conditions by outcome measure

IAPT reports on three outcome measures; reliable improvement, reliable recovery, and moved to recovery. These are presented in Table 4. Generally, while the 65 and over age group are estimated to have a lower prevalence of CMD's compared to other age groups, those that are diagnosed and seek recovery through IAPT are more likely to show improvement or recovery compared to younger age bands. Please note, there have been no statistical tests applied to these figures.

A referral has shown reliable improvement if their scores on one or both assessment measures reliably decrease whilst the other shows no reliable increase. National figures show that the 65 and over age groups has the highest proportion (67.9%) showing reliable improvement when compared to other age groups finishing treatment. A similar pattern is evident for WL CCG with 67.0% of those aged 65 and over showing reliable improvement. For ELR CCG, the 36 to 64 age group had the highest proportion showing reliable improvement (67.0%), closely followed by the 65 and over age group (66.0%).Both locally and nationally, the 16-17 year old age group showed the lowest reliable improvement when compared to other age groups (ELR CCG:55%, WL CCG: 59%, England: 56.6%)

A referral has moved to recovery if they are classified as a clinical case when they enter treatment but no longer classified as a clinical case when they have completed a course of treatment. Recovery is measured in terms of the anxiety and depression scores. For a referral to be considered recovered, the patient needs to score below the clinical threshold on both scores at the end of treatment, to ensure that recovery is measured by looking at the welfare of the individual rather than one specific symptom. Aside from individuals aged under 16 years, at a national and local level, as age increases so does the proportion of IAPT patients moving to recovery. In both CCGs, 62.0% of IAPT patients aged 65 and over moved to recovery, the highest proportion out of all age groups.

A referral has shown reliable recovery if they have both reliably improved and also recovered. This means that their scores on one or both measures reliably increases whilst the other shows no reliable increase, and also that they have moved from being a clinical case at the start of treatment to not a clinical case at the end of treatment. Aside from individuals aged under 16 years, at a national and local level, as age increases so does the proportion of IAPT patients showing reliable recovery, with the highest proportion of reliable recovery occurring in the 65 and over age group. (ELR CCG: 59%, WL CCG: 57%,

England: 59.9%)

For further information on these outcome measures, please visit Appendix 3 of the Annual Report: https://files.digital.nhs.uk/publication/s/n/psyc-ther-ann-rep-2016-17_add.pdf

Table 4: Referrals finishing a course of treatment by outcome measure and age, 2016/17

		Referrals finishing a course of treatment in year	Reliably Improved		Moved to Recovery		Reliably recovered	
	Age group		Number	%	Number	%	Number	%
ELR CCG	Under 16	*	*	*	*	*	*	*
	16 to 17	45	25	55	15	38	15	38
	18 to 35	1010	660	65	470	49	445	46
	36 to 64	1340	890	67	705	58	665	55
	65 and over	230	150	66	120	62	115	59
WL CCG	Under 16	*	*	*	*	*	*	*
	16 to 17	75	45	59	25	34	25	34
	18 to 35	1400	830	59	535	40	510	39
	36 to 64	1745	1085	62	805	50	765	48
	65 and over	270	180	67	150	62	140	57
England	Under 16	187	123	65.8	113	62.8	97	53.9
	16 to 17	6,083	3,441	56.6	2,380	42	2,201	38.8
	18 to 35	241,589	154,656	64	105,053	46.3	99,925	44
	36 to 64	278,574	183,420	65.8	129,274	50.3	123,415	48
	65 and over	40,673	27,614	67.9	22,068	63.5	20,822	59.9

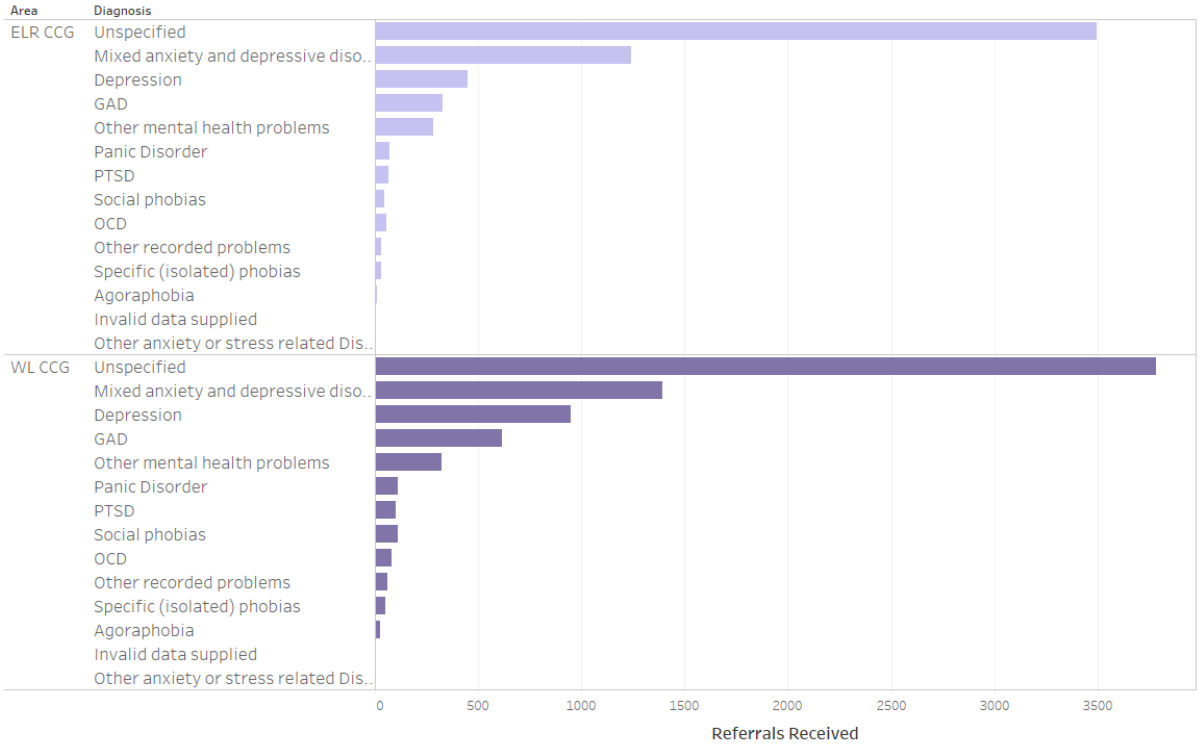
*counts under 5 have been suppressed

Source: NHS Digital, Psychological Therapies, Annual Report on the use of IAPT services[74]

2.2.2. *IAPT: Common mental health conditions by diagnosis*

In 2016/17, there were 7,590 IAPT referrals for WL CCG (where the CCG is the recorded commissioner) and 6,100 IAPT referrals were for ELR CCG. In the same time period, 4,240 referrals entered treatment for WL CCG, while 3,355 entered treatment for ELR CCG. Figure 3 shows upon receipt of referral, the most common identified diagnosis was 'unspecified' making up 49.8% (3,785) of WL CCG referrals, and 57.3% (3,495) of ELR CCG referrals. Upon entering treatment, 11.2% (475) of diagnosis for WLCCG were classed as 'unspecified', while 28.9% (970) of diagnosis for ELR CCG were classed as 'unspecified'.[75] For this reason, the below IAPT diagnosis data is based only upon those entering treatment.

Figure 3: Referrals received by problem descriptor, IAPT 2016/17



Source: NHS Digital, Psychological Therapies: Annual report on the use of IAPT services

In order to enter treatment, a referred patient must have a first attended treatment appointment in the year. The referral received date is not necessarily in the year. It is important to note that while the below data is based on problem descriptor, more commonly known as diagnosis, this information has not been reliably recorded over the years. The figures presented below (2.2.3 to 2.2.8) will not equal the total mentioned above as they do not account for all the 'other mental health problems' and 'other recorded problems' categories. The figures presented below are likely to be underestimates due to this. Further, this only represents those who entered treatment, and does not account for mental health conditions in the population that have not been diagnosed.

2.2.3. *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 and therefore straddle common and serious mental illness. [76]

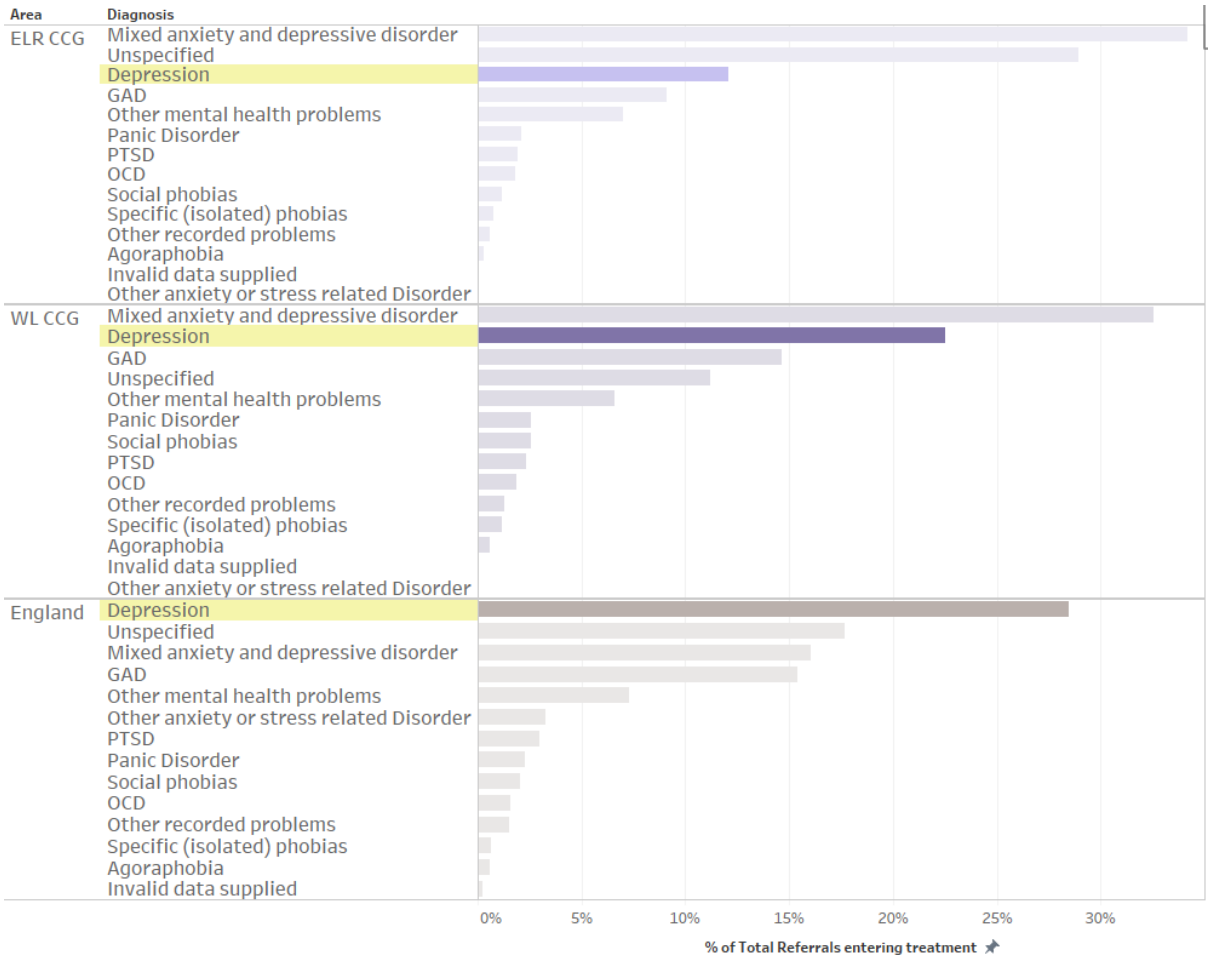
Prevalence is the proportion of a population with a disease or a particular condition at a

specific point in time. The Quality Outcomes Framework (QOF) 2017 shows the recorded prevalence for depression in the GP registered population aged 18 or over, is 10.3% for ELR CCG's population and 10.7% for WL CCG's population. These are both significantly higher than the England average of 9.1%, as they have been since data was first compared in 2011/12. Both CCGs recorded depression prevalence have shown significant increases year on year since 2012/13, in line with the national picture. When comparing to similar CCGs, ELR CCG has the second highest prevalence, while WL CCG has the 4th highest (ranked out of 11).[14] However, the data is based on recorded diagnosis, so while this may be a true reflection of rising prevalence, the increase could also be attributed to better diagnosis and recording. As figures are based on the GP registered population, those less likely to be registered with a GP (i.e. homeless, ethnic minorities, migrants, travellers) will be underreported, and this could be an underestimate.

Incidence looks at the rate of new, or newly diagnosed, cases of a particular disease, illness or health problem. The QOF found the recorded incidence of depression in the 18+ registered population to be 1.7% for ELR and 1.6% for WL CCG, both significantly higher than the England average of 1.5% in 2016/17. For WL CCG, there were statistically significant increases year on year from 2012/13 to 2015/16. This increasing trend continued through to 2016/17 although the latest year's data do not indicate a statistically significant increase. For all five years, WL rate has remained higher than the national rate, although this gap has decreased overtime. For ELR, there have been statistically significant increases from 2014/15 through to 2016/17. For all three years, the ELR CCG rate has remained above the national average with the gap widening from 1.2% to 1.5% over the last 3 years. This QOF recorded incidence is considerably less than what has been estimated in epidemiological studies, which have ranged from 2.5% to 8.8%. [14]

The IAPT service data in Figure 4 shows that in 2016/17, 22.5% of the referrals entering treatment for WL CCG were diagnosed with depression, accounting for 955 people. This was the second most common recorded diagnosis for WLCCG. For ELR CCG, 12.1% of referrals entering treatment were diagnosed with depression, accounting for 405 people. This was the third most common recorded diagnosis for ELR CCG. Nationally, this was the most common diagnosis, with depression accounting for 28.5% of referrals entering treatment.[75]

Figure 4: Referrals entering treatment for depression, IAPT 2016/17



Source: NHS Digital, Psychological Therapies: Annual report on the use of IAPT services

Survey data can help to build the local prevalence picture as it can help to highlight gaps between diagnosed and undiagnosed prevalence. The Adult Psychiatry Morbidity Survey (APMS) 2014 found depression to be the third most commonly identified CMD in England, with 3.3 in every 100 people experiencing symptoms in any given week. Depression was estimated to be more prevalent in females than males at 3.7% compared to 2.9% respectively, although this was not statistically significant. For females, the age group with the highest prevalence were 35-44 year olds with 5.5% estimated to have experienced a depressive episode in the past week, whilst for males the highest prevalence proportions existed in the 45-54 and 55-64 age groups with 4.2% estimated to have experienced depressive episode in the past week. Depression was more common in the working age population in 2014 than in previous years, increasing from 2.2% in 1993 to 2.6% in 2007 to 3.8% in 2014.

2.2.4. *Generalised anxiety disorder (GAD)*

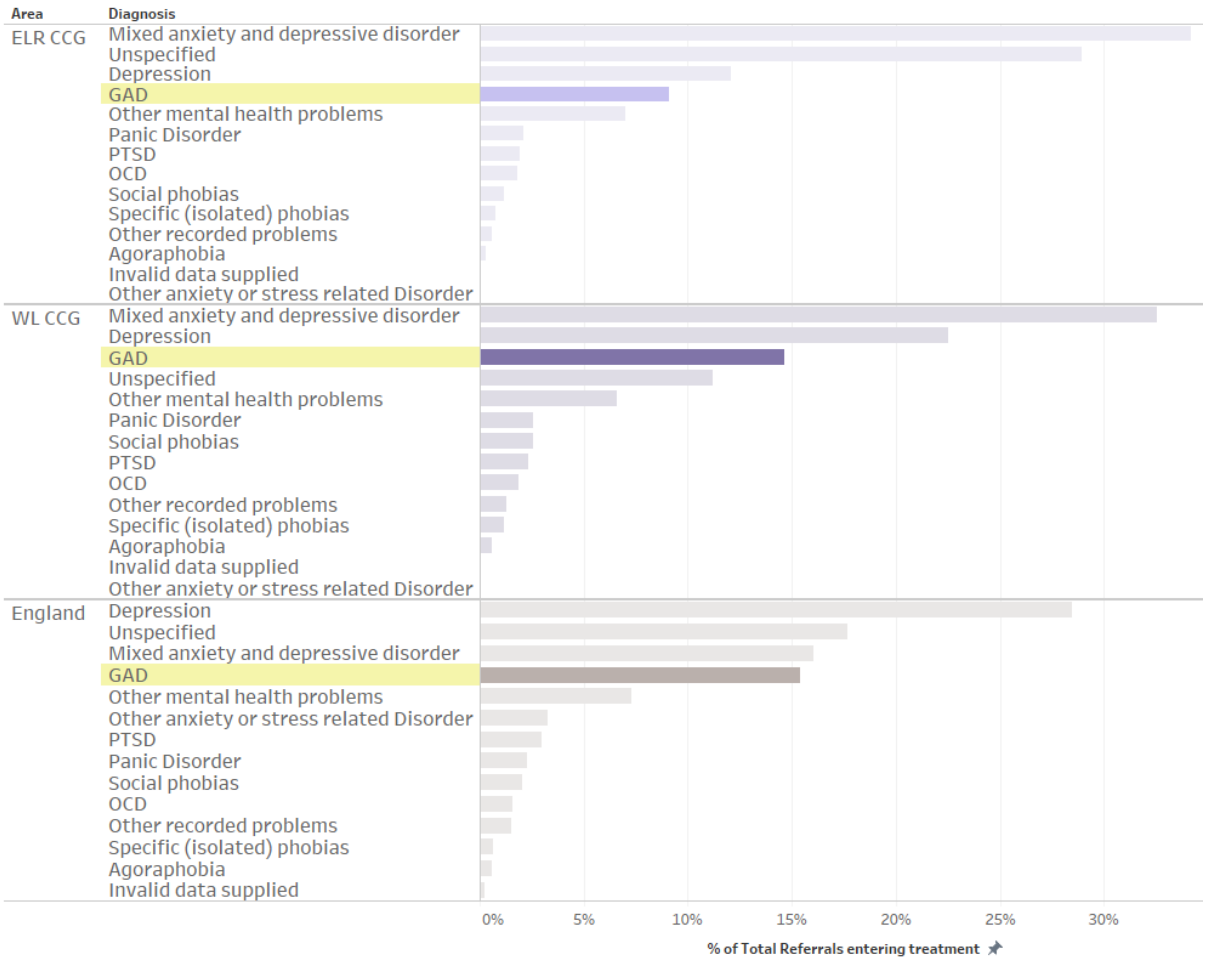
GAD is an anxiety disorder characterised by excessive worry, with individuals experiencing difficulty in controlling that worry. Symptoms include restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep.[76]

The 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). However, GAD was more common in the population aged 16-64 in 2014 than in previous years, increasing from 4.4% in 1993, to 4.7% in 2007 to 6.6% in 2014.

In 2012, Public Health England estimated that GAD was prevalent in 3.5% of Leicestershire'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.[14]

The IAPT service data in Figure 5 shows that in 2016/17, 14.6% of the referrals entering treatment for WL CCG were diagnosed with GAD, accounting for 620 people. This was the third most common recorded diagnosis for WLCCG. For ELR CCG, 9.1% of referrals entering treatment were diagnosed with GAD, accounting for 305 people. This was the fourth most common recorded diagnosis for ELR CCG.[75] Nationally, this was the fourth most common diagnosis, with GAD accounting for 15.4% of referrals entering treatment.

Figure 5: Referrals entering treatment for GAD, IAPT 2016/17



Source: NHS Digital, Psychological Therapies: Annual report on the use of IAPT services

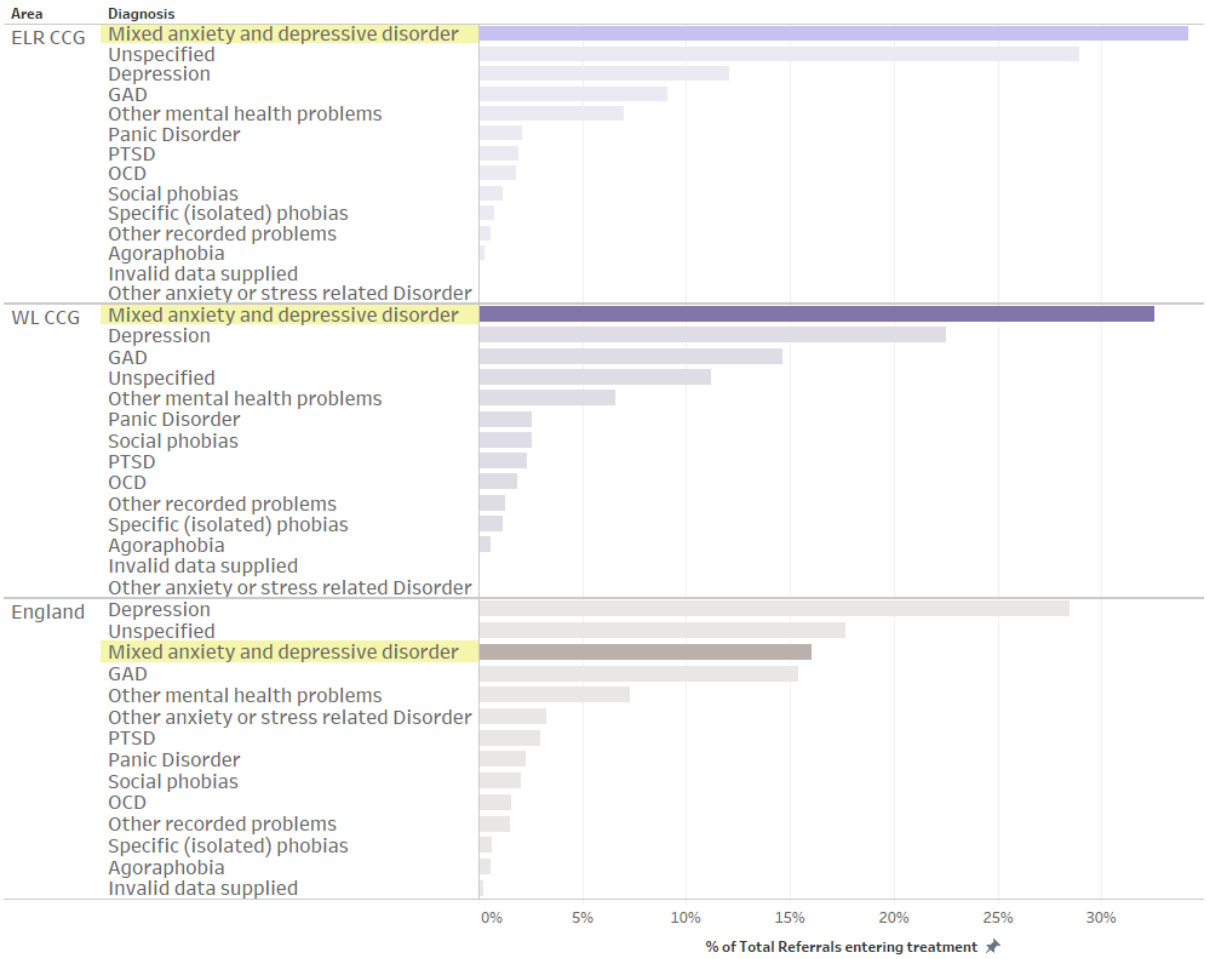
2.2.5. *Mixed anxiety and depression*

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 in Figure 6 shows that in 2016/17, 32.5% of the referrals entering treatment for WL CCG were diagnosed with mixed anxiety and depression, accounting for 1,380 people. This was the most common recorded diagnosis for WLCCG. For ELR CCG, 34.1% of referrals entering treatment were diagnosed with mixed anxiety and depression, accounting for 1,145 people. This was the most common recorded diagnosis for ELR CCG.

Nationally, this was the third most common diagnosis, accounting for 16.1% of referrals entering treatment, approximately half that of local figures.[75] It is difficult to ascertain whether this is reflective of the true IAPT caseloads, or whether it is due to differences in recording.

Figure 6: Referrals entering treatment for Mixed Anxiety and Depression, IAPT 2016/17



The General Practice Patient Survey (GPPS) is an annual survey which asks patients about their experience at their GP practice, along with questions on their health. One of the questions asks whether they feel anxious or depressed. It is important to note that patients may interpret this differently, as some may define this as mixed anxiety and depression, while others may answer based on their separate experiences of anxiety or depression. Hence, responses are not necessarily based solely on GP diagnosis, but may also include subjective personal assessments. The 2016/17 GPPS found that 13.8% of the 18+ population in WL CCG felt anxious or depressed. This is similar to England's 13.7%. In ELR CCG, a significantly lower proportion of people (11.0%) reported feeling anxious or stressed compared to the England average.[44] These figures are considered to be underestimated as

they are based on the GP registered population, and will therefore exclude vulnerable groups who are not registered with a GP. Trends for both CCGs have remained generally stable over the past 5 years.

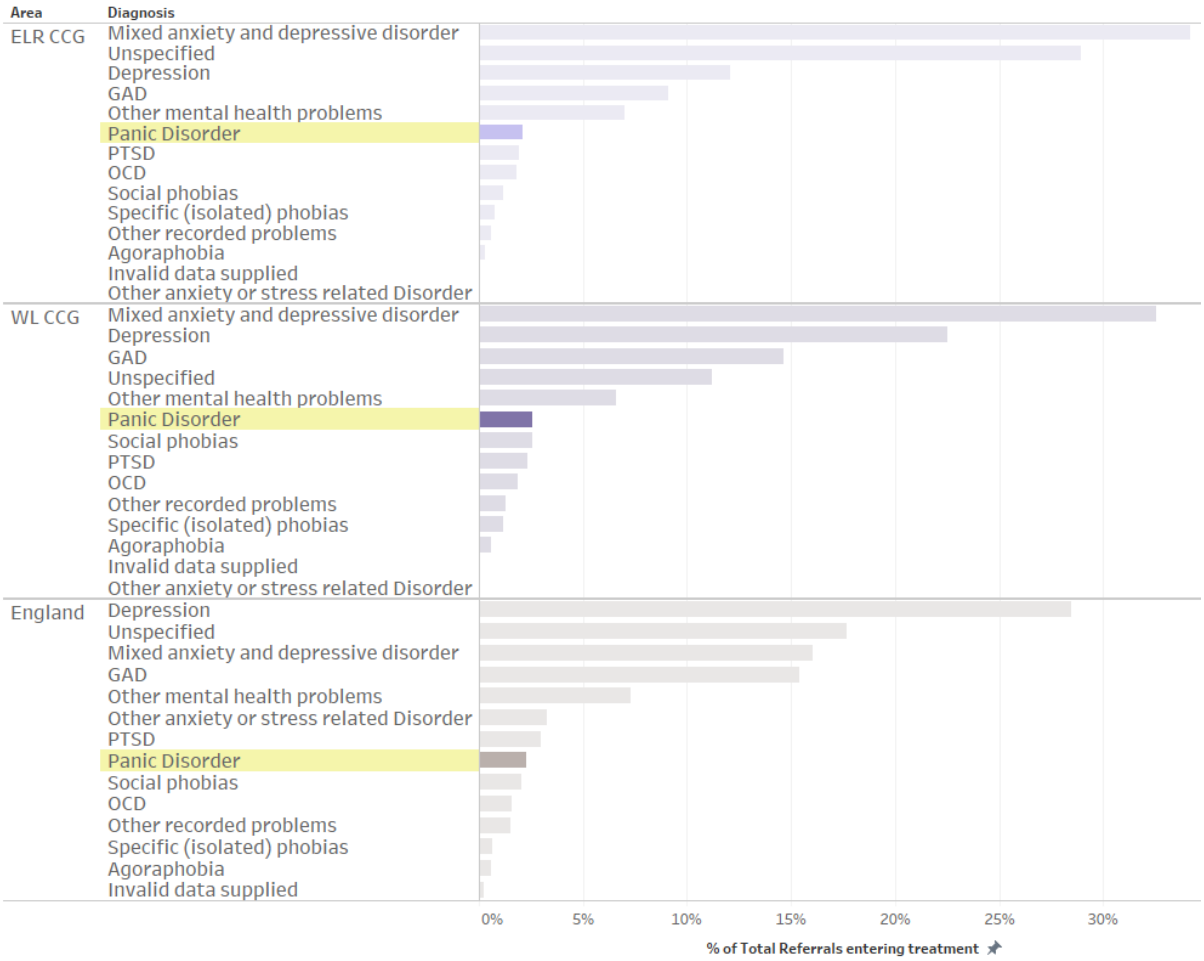
2.2.6. *Panic disorder*

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.[76]

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% reported having panic attacks. 30.2% reported this had been diagnosed by a professional, meaning almost 70% of panic attacks were not diagnosed.

The IAPT service data in Figure 7 shows that in 2016/17, 2.6% of the referrals entering treatment for WL CCG were diagnosed with panic disorder, accounting for 110 people. For ELR CCG, 2.1% of referrals entering treatment were diagnosed with panic disorder, accounting for 70 people. Nationally, this was the 7th most common diagnosis, with accounting for 2.3% of referrals entering treatment.[75]

Figure 7: Referrals entering treatment for panic disorder, IAPT 2016/17



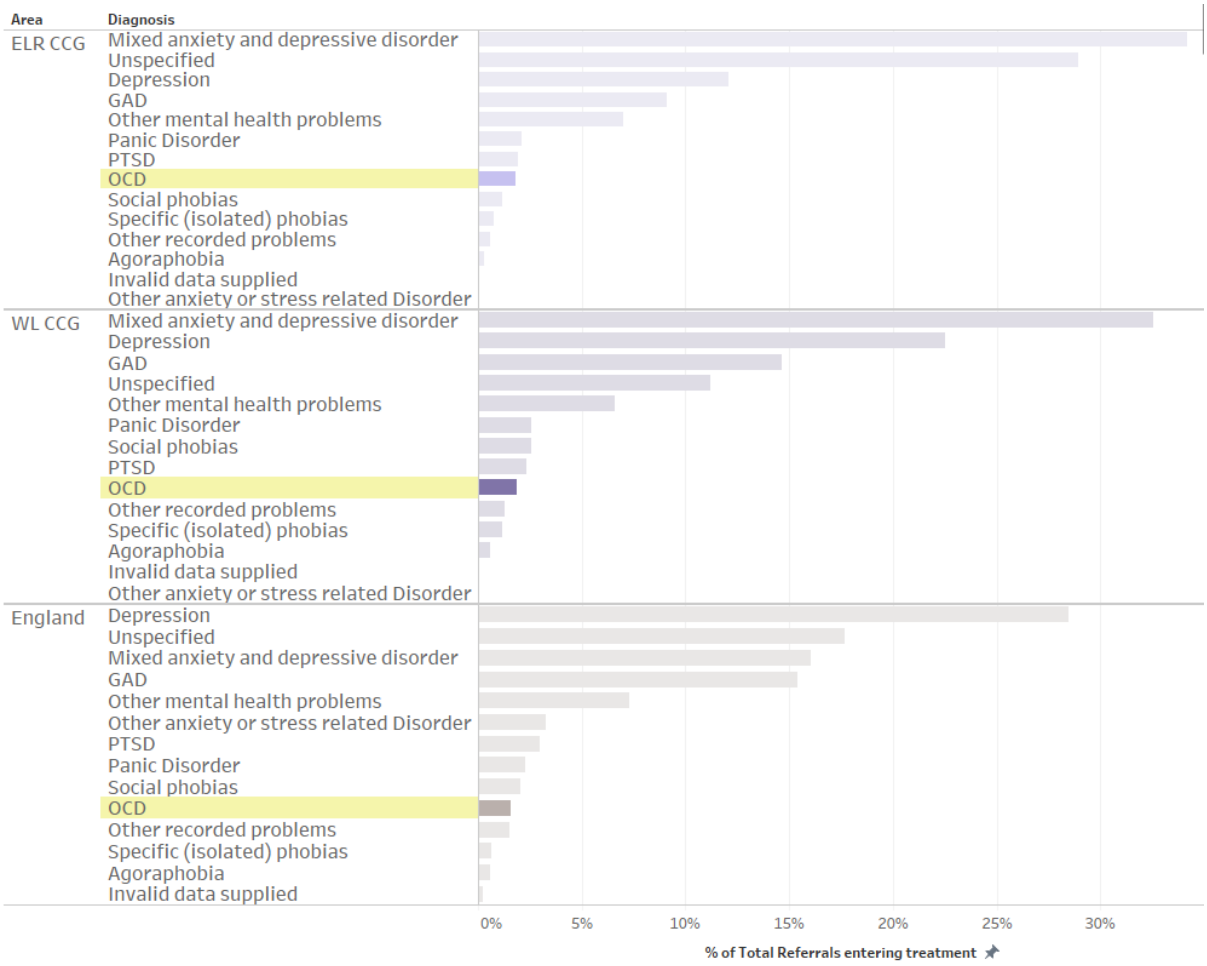
2.2.7. *Obsessive compulsive disorder (OCD)*

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 in Figure 8 shows that in 2016/17, 1.9% of the referrals entering treatment for WL CCG were diagnosed with OCD, accounting for 80 people. For ELR CCG, 1.8% of referrals entering treatment were diagnosed with OCD, accounting for 60 people. Nationally, OCD accounted for 1.6% of referrals entering treatment.[75]

Figure 8: Referrals entering treatment for OCD, IAPT 2016/17

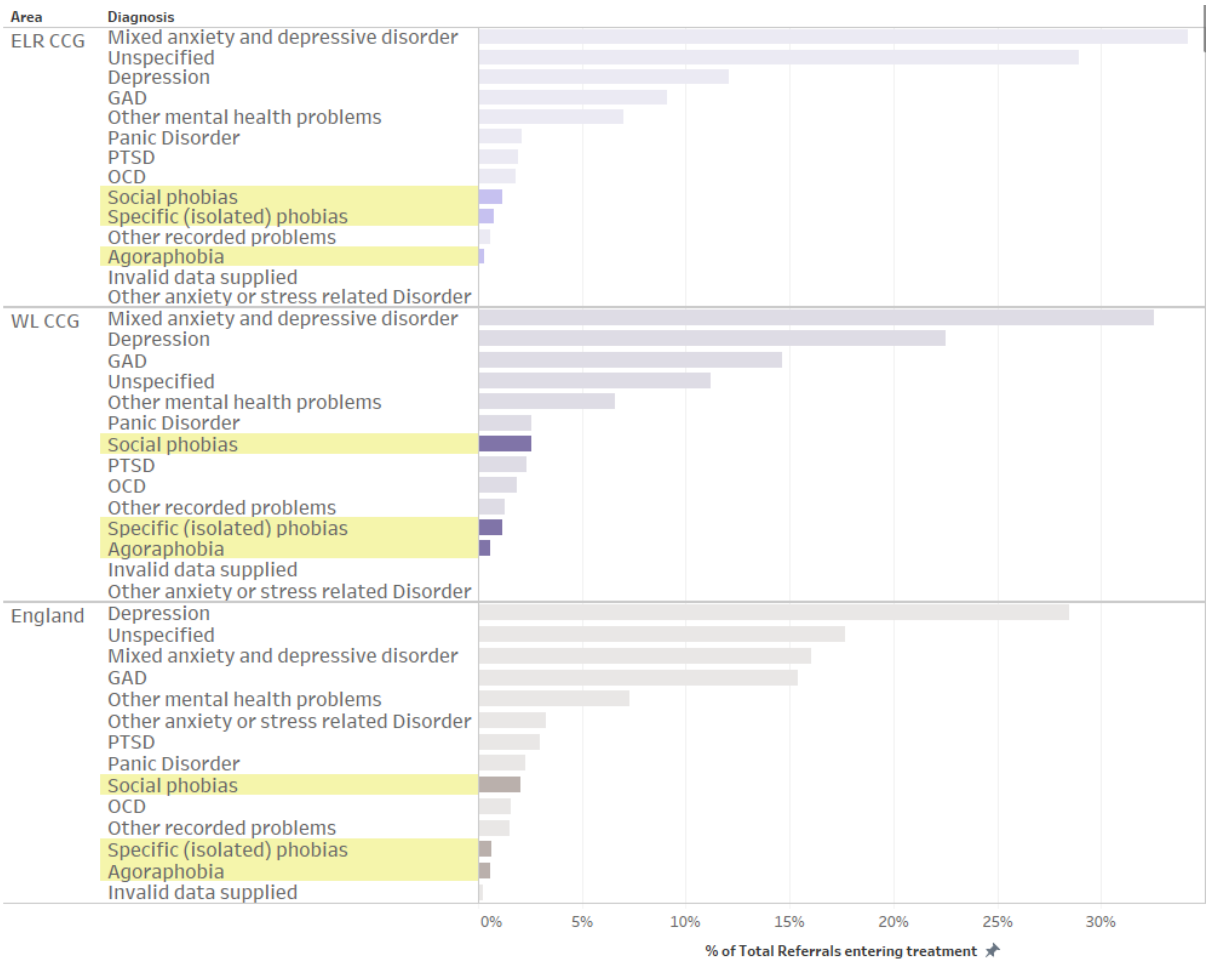


2.2.8. ***Phobias***

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.

Figure 9 shows that in 2016/17, 4.4% of the referrals entering treatment for WL CCG were diagnosed with phobias, accounting for 185 people. For ELR CCG, 2.2% of referrals entering treatment were diagnosed with phobias, accounting for 75 people.[75]

Figure 9: Referrals entering treatment for social phobias, specific (isolated) phobias, and agoraphobia, IAPT 2016/17



2.2.9. *Post-traumatic stress disorder (PTSD)*

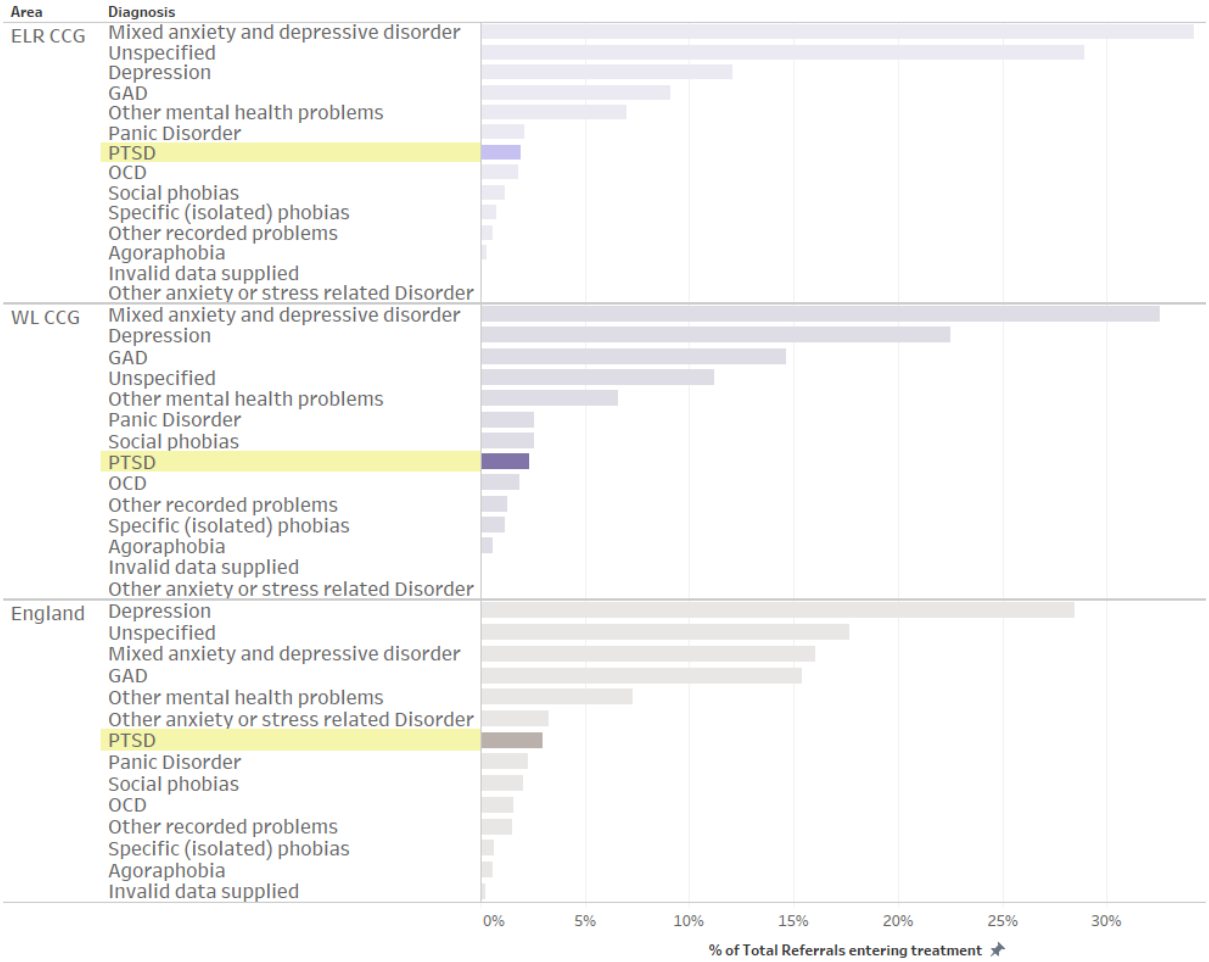
PTSD can be developed following distressing events; it is most commonly associated with military personnel, however is also prevalent in those who have experienced physical, sexual or emotional abuse, disasters or severe accidents. Symptoms often included intrusive, repeating memories that cause a feeling of reliving the trauma. PTSD is often comorbid with other mental health conditions such as depression.[76]

The APMS 2014 found 4.4% of England's population to have experienced symptoms of PTSD in the past month, with similar rates for men and women. Overall, 3.3% of people believed that they have had PTSD, with 1.9% having been diagnosed by a professional. Of those screening positive for PTSD, 12.8% had been diagnosed by a health professional.

The IAPT service data in Figure 10 shows that in 2016/17, 2.4% of the referrals entering treatment for WL CCG were diagnosed with PTSD, accounting for 100 people. For ELR CCG, 1.9% of referrals entering treatment were diagnosed with PTSD, accounting for 65 people.

Nationally, PTSD accounted for 3.0% of referrals entering treatment.[75]

Figure 10: Referrals entering treatment for PTSD, IAPT 2016/17



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. Following an episode of self-harm, there is a significant and persistent risk of suicide. Those who present to Accident & Emergency (A&E) with self-harm have a one in six chance of repeat attendance at A&E within the year. One study of people presenting at A&E showed a subsequent suicide rate of 0.7% in the first year - 66 times the suicide rate in the general population. After 15 years of follow up, 4.8% of males and 1.8% of females had died by suicide.[77] Other estimates suggest that once a person has self-harmed, with or without suicidal intent, the likelihood that they will die from suicide increases 50-100 times compared to those who have never self-harmed. More than 50% of those who have died from suicide have previously self-harmed.[80] The NICE guidelines

on self-harm note that people who have survived a medically serious suicide attempt are more likely to have poorer outcomes in terms of life expectancy.[78]

In Leicestershire, the directly standardised rate of emergency hospital admissions for intentional self-harm for all ages in 2016/17 is 161.8 per 100,000 population, representing 1,104 stays in the year. Females are significantly more likely to self-harm with a directly standardised rate of 214.3 per 100,000 population, compared to males 112.9 per 100,000 population. Overall, Leicestershire performs significantly better than the England average of 185.3 per 100,000 population, although the trend for Leicestershire has been rising since 2013/14.

The 2016/17 value shows a statistically significant increase on the previous year, representing the steepest rise since 2010/11, hence closing the gap with the national average. The two Leicestershire districts with the highest number of residents with emergency admissions for self-harm are Blaby and North West Leicestershire with 191.4 and 186.8 stays per 100,000 population respectively. These are the only two districts that have a rate similar to national, with all others performing significantly better (lower).

When considering crude rates by age bands, Leicestershire data for 20-24 year olds shows that the crude rate of hospital admissions as a result of self-harm has fluctuated since data was first collected in 2011/12; however, the overall local trend has shown an increase, while nationally the trend has been declining. The Leicestershire rate for 2016/17 was 369.5 per 100,000 population in Leicestershire, compared to 393.2 per 100,000 population nationally. Locally, this accounts for 165 people, and represents the first time since 2011/12 that Leicestershire has performed similar to national, with all previous time periods being lower than the national average.

While the increase could be related to a true reflection of increased self-harm in the population, it could also be attributed improved data collection and underlying cause recording, or to increase in hospitals being accessed, and patients admitted, for self-harm. It is also important to note that while 99% of inpatient admissions for self-harm are emergency admissions, these are not representative of the true prevalence of self-harm. Rather hospital admissions are a proxy of the prevalence, and this indicator is based on only those self-harm events that are severe enough to warrant hospital admission. Further, these figures are based on all ages, including the younger population.

More information
For further information on self-harm in those aged under 24, please visit the Children and Young People's Mental Health JSNA Chapter:
http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

2.3.2. ***Suicide***

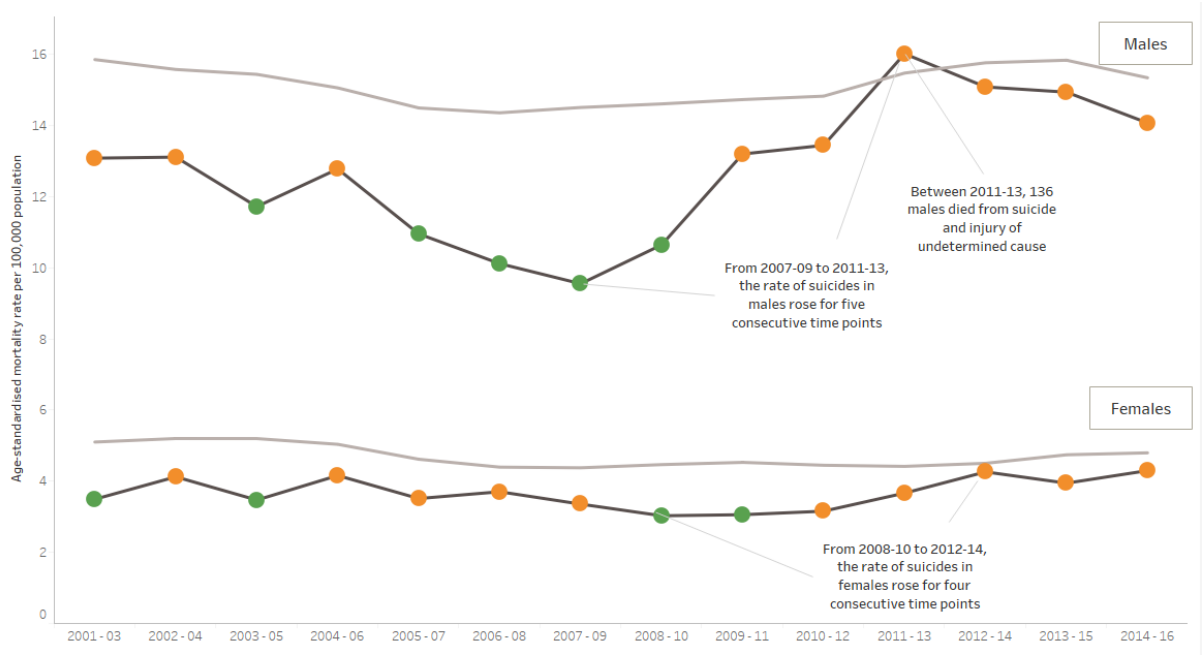
Suicides and 'injury undetermined' are seen as an indicator of underlying rates of mental ill-health. There are approximately 60 deaths from suicide per year in the county. This makes it a significant cause of death, particularly amongst younger people. Suicide remains the biggest killer of men under 50 and the leading cause of death in people aged 15–24.[79]

Males are three times more likely than females to die as a result of suicide. Men aged 35-54 years are at highest risk. The factors associated with men are depression (especially untreated or undiagnosed); alcohol and drug use; unemployment; relationship problems; social isolation and low self-esteem.

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 three year periods. It is important to note this data is based on those who completed suicides and do not account for all suicide attempts. The age standardised mortality rate from suicide in Leicestershire in 2014-16 was 8.9 per 100,000 population, similar to England which has a rate of 9.9 per 100,000 population. For Leicestershire, this equals 161 deaths over three years, 122 of which are attributed to males, and 39 of which were females. (14.1 per 100,000 population compared to 4.3 per 100,000 population respectively as shown in Figure 11).[80]

From 2007-09 to 2011-13, the rate of suicides rose for five consecutive time periods in males. Between 2011-13, 136 males died from suicide. Since 2011-13, the rate of suicides in Leicestershire decreased marginally, from 169 deaths in 2011-13 to 164 deaths in 2013-15 and 161 in 2014 to 2016. While numbers are declining, the decrease is not statistically significant.

Figure 11: Suicides in Leicestershire



Source: Public Health Outcomes Framework, Public Health England

Out of all districts, Charnwood has the lowest rate of suicides, at 6.9 per 100,000 population. This is the only district to perform significantly better than England in 2014-16. All other districts perform similar to England, with Oadby and Wigston having the highest directly standardised rate at 13.9 per 100,000 population.

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% of 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.[8]

Specific groups at increased risk of suicide include looked after children, care leavers, offenders; survivors of abuse or violence, including sexual abuse; veterans; people living with long-term physical health conditions; lesbian, gay, bisexual and transgender people; and people from black and minority ethnic groups and asylum seekers.

Suicides are not inevitable and are often the end point of a complex history of risk factors and distressing events. The prevention of suicide has to address this complexity through concerted action and collaboration amongst services, communities, individuals and across society as a whole.

2.4. Severe and enduring mental illness

Severe and enduring mental illness refers mainly to the long term experience of schizophrenia and psychosis but also to other chronic functional disorders.[81] It is recognised that those with severe and enduring mental illness are likely to be diagnosed and in treatment. The percentage of people with severe mental illness on GP Practice registers was 0.77% in Leicestershire in 2016/17, significantly lower than England's 0.92%. This follows a gradually increasing trend, in line with national trends since 2013/14. Leicestershire ranks fifth lowest out of all CIPFA nearest neighbours.[44]

The percentage of people with severe mental illness on GP Practice registers in 2016/17 is 0.71% for ELR CCG and 0.77% for WLCCG. These are both significantly lower than the England average of 0.92%, as they have been since data was first compared in 2012/13. Both CCGs recorded SMI have been gradually increasing over time, in line with the national picture. When comparing to similar CCGs, ELR has the 4th lowest prevalence, while WLCCG has the 5th lowest (ranked out of 11).

As the data is based on recorded prevalence, it is difficult to ascertain whether this is a true reflection of increased prevalence or better recording. Further, the population groups who are less likely to be registered with a GP (i.e. homeless, ethnic minorities, migrants, travellers) will be underreported in these figures, hence this could be an underestimate of the true prevalence in the population.

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.[82] This suggests that although fewer people are going into hospital compared to the England average, those that do go in stay there for longer than average.

In 2016/17, in the Leicestershire, Leicester and Rutland 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 nationally.[83] 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.[84] There may be some data quality issues with these figures.

Up to half of people who have serious mental illness are seen only in a primary care setting i.e. not under secondary care. NICE guidelines recommend that good professional practice

in meeting the needs of these patients includes ensuring people with severe mental illness such as schizophrenia, bipolar affective disorder and other psychoses have a comprehensive care plan documented in record. Data from the Quality Outcomes Framework (QOF) shows that in 2016/17 62.7% of people with SMI had a comprehensive care plan in the WL CCG area. This is significantly lower than England average of 79.0%, and also the lowest since data was first collated in 2012/13. ELR CCG also displayed their lowest proportion since data was first collected with only half of the population with severe mental illness, (50.6%) having a comprehensive care plan.[44] There is little data available to determine the prevalence of severe mental illnesses such as schizophrenia, psychosis and bi-polar.

2.4.1. *Physical health needs of people with SMI*

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 mortality rate in adults with a serious mental illness aged under 75 in Leicestershire was 362.9% (expressed as a percentage). Here, the mental health population for observed deaths is defined as anyone who has been in contact with secondary mental health services in that financial year, or the two previous years, who is still alive at the beginning of the 2014/15 year. Expected deaths are based on the number of deaths that would be expected in the population with serious mental illness, if the death rates were exactly the same as in the general national population. Therefore, the Leicestershire percentage is showing that deaths in the population with severe mental illness are over three times higher than that of the general population. This pattern is reflected both nationally and regionally. The data does not take other illnesses or physical illnesses into account, which are shown to have a higher prevalence in those with mental health conditions.[9]

2.5. Adult Social Care users (18-64 years) with mental health support needs

Analysis of data extracts from the Council's case management system indicates that there were 1,148 adult service users with mental health support needs recorded in the previous 12 months. For those aged 18 to 64 years, termed working age adults (WAA), who are assessed as eligible for a package of care, the majority are in receipt of a Direct Payment (376 out of 545) enabling them to manage their care in the community.

An analysis of case throughput over the previous 12 months indicates 246 planned cases and 195 urgent cases came to the attention of the teams responsible for working age adults with mental health support needs.

Some people who have been kept in hospital under the Mental Health Act can get free help and support after they leave hospital. The law that gives this right is section 117 of the

Mental Health Act, and it is often referred to as 'section 117 aftercare'. A proportion of those adult service users known to the Council will be eligible for section 117 aftercare, entitling them to ongoing health and social care support for their assessed needs, funded by the NHS and the local authority. Data analysis indicates that 140 service users eligible for section 117 aftercare became known to the Council in the previous 12 months. Eligibility for section 117 aftercare may continue for a number of years with the result that the cumulative standing total of adults eligible for aftercare known to the Council, as at April 2018, was 1,209.

A qualitative analysis of discharge destinations from mental health rehabilitation services, as provided by LPT for the period August 2015 to February 2018, sought to identify numbers of individuals who could 'step down' from rehabilitation and residential care into more independent housing provision, with support where required. The findings suggested that 12-15 patients per annum could 'step down' into supported housing schemes with on-site/intensive support, and a further 28-30 patients could 'step down' into accommodation with floating support services.

Analysis of accommodation status for working age adults with mental health support needs known to the Council indicates that over 80% (429 out of 520) are resident in the community, with a further 13.8% (72 individuals) placed in residential or nursing homes.

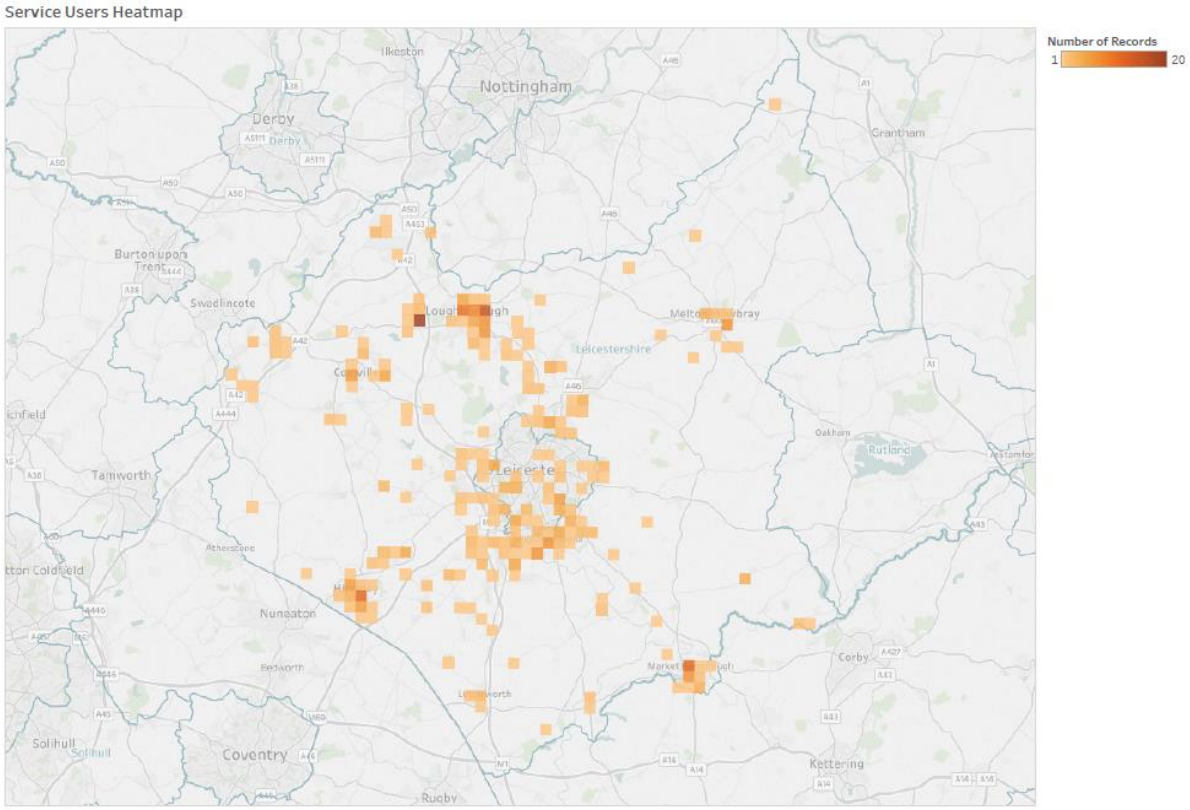
Table 5: Adult Social Care Service Users (18-64) with Mental Health Support Needs[85]

Local Authority	Community	Extra Care	Nursing Care	Residential Care	Supported Living	**Totals**
Blaby	56	1	0	2	3	62
Charnwood	119	0	5	17	3	144
Harborough	58	0	1	5	0	64
Hinckley & Bosworth	58	0	0	2	5	65
Melton	21	0	0	1	1	23
North West Leicestershire	44	0	1	0	0	45
Oadby & Wigston	39	0	0	2	1	42
Leicester	17	0	2	27	4	50
Out of County	17	0	1	6	1	25
Totals	429	1	10	62	18	520

A further cohort of service users with high level needs is the focus of the Leicestershire Transforming Care Partnership (TCP), which aims to deliver on the national TCP programme

to close inpatient facilities for people with a learning disability, and/or Autism with mental health needs who display behaviours that challenge. For Leicestershire, as of end of December 2016 there were 25 individuals identified for whom community based accommodation with support was required.

Figure 12: Service Users Heatmap[85]



2.6. 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 (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. 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.[86] 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.[87] 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.[86]

In Leicestershire, 6,344 women gave birth in 2015/16.[88] Table 6 shows that in 2015/16, the most prevalent mental health disorder affecting postpartum women in Leicestershire was adjustment disorders and distress, affecting between 15.1% - 30.0% of mothers in Leicestershire. This equates to between 955 and 1905 mothers in the county. Mild-moderate depressive illness and anxiety was the second most prevalent condition affecting between 10.0% - 15.1% of mothers in Leicestershire. It is estimated that severe depressive illness affected 3.1% of postpartum women (195) in Leicestershire.

Table 6: Estimated number and percentage of mental health conditions of postpartum women in Leicestershire in 2015/16[88]

	Count*	Percentage (%)*
Estimated number of women with adjustment disorders and distress (upper estimate)	1905	30.0
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)	955	15.1
Estimated number of women with adjustment disorders and distress (lower estimate)	955	15.1
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)	635	10.0
Estimated number of women with severe depressive illness	195	3.1
Estimated number of women with postpartum psychosis	195	3.1
Estimated number of women with chronic SMI	15	0.2
Estimated number of women with PTSD	15	0.2

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.[89] It is estimated there are 195 women in Leicestershire (3.1%) who suffered from PTSD in the perinatal period in 2015/16.[90]

2.7. Co-existing mental illness and substance misuse

A significant proportion of people in England with mental health problems have co-occurring problems with drug or alcohol misuse. Likewise poor mental health is

commonplace in people who are dependent on or have problems with drugs and alcohol. Dual diagnosis hence refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage). Studies have estimated prevalence rates of 20-37% in secondary mental health services and 6-15% in substance misuse settings nationally.[91]

The relationship is complex and varies from individual to individual. 'The Dual Diagnosis Good Practice Guide[92]' from the Department of Health describes four possible relationships:

• A primary psychiatric illness precipitates or leads to substance misuse

• Use of substances makes the mental health problem worse or alters its course

• Intoxication and/or substance dependence leads to psychological symptoms

• Substance misuse and/or withdrawal leads to psychiatric symptoms or illnesses

Methodological challenges including differing definitions of dual diagnosis, varying timescales for assessing comorbidity, difficulties with diagnosis including diagnostic overshadowing, and the lack of a good theoretical model of the association between severe mental illness and substance misuse, mean that it is still unclear how many people in the UK have a severe mental illness and comorbid substance misuse problem.[93]

2.7.1. *Illicit Drugs*

In Leicestershire and Rutland, 15.2% of those entering substance misuse treatment services were also receiving mental health support services for a reason other than their substance misuse in 2016/17. This is significantly lower than England's average of 24.3%. While this measure is indicative of levels of co-existing mental health problems in the drug treatment population, it should not be regarded as a comprehensive measure of dual diagnosis as it only captures whether individuals are receiving mental health treatment at a given point in time based on those entering treatment, rather than at any point in time.

Table 7 shows Leicestershire admissions for drug related mental health and behavioural disorders are significantly lower than the England average at 71 per 100,000 population. Although showing an increasing trend, in line with England, these figures are the lowest amongst statistical neighbours.[94]

Table 7: NHS hospital finished admission episodes with a primary or secondary diagnosis of drug related mental health and behavioural disorder

	2015/16		2014/15		2013/14	
	Admissions		Admissions		Admissions	
	All (n)	Per 100,000	All (n)	Per 100,000	All (n)	Per 100,000
England	81,904	148	74,801	136	68,597	125
Leicestershire	455	71	396	62	336	53
Warwickshire	500	95	431	81	481	91
Gloucestershire	847	147	719	125	521	91
Staffordshire	845	106	728	91	546	68
North Yorkshire	646	126	535	103	520	96
Worcestershire	508	97	453	87	436	84

Source: NHS Digital, Hospital Episode Statistics

2.7.2. *Alcohol*

In 2016/17, the percentage of individuals in concurrent contact with mental health services and substance misuse services for alcohol misuse in Leicestershire and Rutland was 21.5%, similar to the England average of 22.7%. While this measure is indicative of levels of co-existing mental health problems in the alcohol treatment population, it should not be regarded as a comprehensive measure of dual diagnosis as it only captures whether individuals are receiving mental health treatment at a given point in time based on those entering treatment.

In 2016/17, the directly standardised admission rate to hospital for mental and behavioural disorders due to alcohol was 58.7 per 100,000 population for Leicestershire, significantly lower than the national rate of 72.3. This equals 393 patients, a slight but not significant decrease from the 421 admitted in 2015/16. Admission rates are significantly better than national for males (81.4 per 100,000 population compared to 102.1 per 100,000 population respectively), and similar to national rates for females. (36.5 per100,000 population compared to 43.3 per 100,000 population respectively). Two districts, North West Leicestershire and Hinckley and Bosworth had significantly lower than national admission rates at 55.0 and 55.8 per 100,000 respectively, while all other districts admission rates were similar to national. These figures are based on admissions to hospital where the primary diagnosis is alcohol-attributable mental and behavioural disorders due to use of alcohol code.[95]

When the definition is extended to include both primary and secondary diagnosis, Leicestershire's admission rate increases to 238 per 100,000 population, significantly better than England's 367 per 100,000 population. Admissions are higher in males at 342 per 100,000 population, compared to females at 139 per 100,000 population, but these both

remain lower than national admission rates. All districts perform significantly better than national for males, although for females Oadby and Wigston and Hinckley and Bosworth perform similar to England, with figures being 158 per 100,000, 186 per 100,000 and 208 per 100,000 respectively.[95]

2.8. Data Summary

2.8.1. *Mental Wellbeing*

Leicestershire's anxiety and low happiness scores are similar to England, whereas the risk factors for poor mental health and wellbeing are generally less prevalent in Leicestershire than the England average. National survey data shows these issues are generally more prevalent in the middle-aged population, rather than the elderly population (who are more likely to report low worthwhile scores). This is particularly relevant for Leicestershire, where over a fifth (21.6%) of the population is aged 45-59.

2.8.2. *Common Mental Health Conditions*

Almost one in four adults in the UK experience at least one mental health problem each year, with one in six experiencing a common mental health problem, such as anxiety or depression, in any given week.[96 97]

Nationally, CMDs are estimated to be most prevalent in the 16-24 age group. Locally applied APMS estimates indicate that females within the 45-54 years age band present the highest proportion of common mental health conditions when compared to other age-sex groups for Leicestershire. This is due to a higher proportion of our population being middle aged.

IAPT referrals data shows that the highest proportion of referrals into the service for ELR CCG were for the 18-35 age group (47.9%), while for WLCCG and nationally, the highest proportion were for the 36 to 64 age group (43.3% and 49.1% respectively). The lowest proportion of referrals received by the IAPT service in 2016/17 were for the 16-17 age group for both ELR CCG (3.0%) and WL CCG (2.7%). This is in line with the national average, although locally, the proportion of referrals for 16-17s is more than double the national average for both CCGs.

When considering the adult population, the 65 and over age group have the lowest proportion of referrals, both locally and nationally (ELR CCG: 8.3%, WL CCG: 6.1%, England: 7.2%). This is in broadly line with APMS prevalence estimates for CMDs which show the working age population were twice as likely to have CMD symptoms compared to those aged over 65. It is recognised that there are there are particular barriers to older people being referred to the IAPT service. E.g. patients themselves don't present or GPs unsure if

IAPT is helpful in older people or symptoms get ascribed to ageing or physical problems.

When considering the three IAPT outcome measures with an age split, the lowest proportion of reliable improvement was in the 16-17 age group for both CCG's, and nationally. Nationally, and in WL CCG, the 65 and over age groups had the highest proportion reliably improving, while for ELR CCG, the 36 to 64 age group had the highest proportion showing reliable improvement (67.0%), closely followed by the 65 and over age group (66.0%). Aside from individuals aged under 16 years, at a national and local level, as age increases so does the proportion of IAPT patients moving to recovery and showing reliably recovery, with both measures showing the highest proportions in the 65 and over age group.

Over one tenth of each CCG's registered population had a diagnosis of depression according to the Quality Outcomes Framework, both proportions being significantly higher than the England average. The incidence of depression for both CCGs is also significantly higher than England. Further work may be required to understand if this is due to proactive identification and case management of patients or a true reflection of higher depression levels locally. National survey data suggests depression is the third most prevalent CMD.

Meanwhile, IAPT data shows that depression is the most commonly recorded CMD nationally, accounting for 28.5% of referrals entering treatment. For WL CCG, it was the second most commonly diagnosed CMD, while for ELR it was the third most commonly diagnosed CMD, accounting for 22.5% and 12.1% of referrals entering treatment respectively.

Mixed anxiety and depression is the most prevalent common mental health condition nationally through APMS. IAPT data also shows this is the most common diagnosis for both CCG's accounting for approximately one third of each caseload (WLCCG- 32.5%; ELR CCG- 34.1%). However, nationally this is the third most common diagnosis, accounting for 16.1% of referrals entering treatment. While GAD is the second most commonly identified CMD nationally, CCG based data for WL and ELR puts it as the third and fourth most commonly identified disorder respectively. Further work may be needed to understand whether this is truly reflective of the prevalence in the population, or whether these results reflect elements of differing recording practices locally.

2.8.3. ***Self-harm and Suicide***

The latest data for hospital admissions for self-harm shows Leicestershire performs significantly better than the national rate, although trend analysis shows the gap between Leicestershire and England has been closing. Between 2015/16 to 2016/17, the rate of

admissions for intentional self-harm in Leicestershire increased significantly. However it must be noted that the data may be somewhat misleading and the large rise may reflect improved data collection. If the increase witnessed in Leicestershire is a true increase and a reflection of demand from the local population, admissions to hospitals may be the tip of the iceberg in relation to the burden of self-harm in the population as many cases of self-harm don't lead to hospital admission. It is therefore difficult to determine whether this increase reflects an increase in prevalence of self-harming.

In Leicestershire, 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 the rate of suicides in females. While the trend is declining, there has not been a statistically significant decrease in recent years.

2.8.4. ***SMI***

The latest data for Leicestershire shows that the percentage of people with severe mental illness on GP Practice registers is significantly lower than England, with an increasing trend over time in line with the national trend. Acute mental health admissions for Leicestershire are also significantly lower than England average. However, acute mental health bed days are significantly higher than 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. Furthermore, only 37.0% of Leicestershire's adults who were in contact with secondary mental health services lived in stable and appropriate accommodation significantly lower than England's 54.0%.

Further work may be needed to understand the prevalence of severe mental health conditions, with more reliable data collection and recording. Further work is also needed to understand which severe mental illnesses are most prevalent within the county.

2.8.5. ***Overall***

Data suggests the most commonly identified mental health condition in Leicestershire is mixed anxiety and depression. It is difficult to reliably conclude whether this is truly reflective of the prevalence in the population, or whether this is a component of proactive identification, or differing coding practices within the IAPT service. It is recognised that many of these mental health problems are likely to be co-existing whereas here we have discussed the majority of diagnosis independently. The population affected by multiple mental health conditions are likely to be of similar demographics and should be targeted for prevention based programmes.

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, with different mental health conditions and factors resulting in varying estimates. For example, the Organisation for Economic Co-operation and Development (OECD) estimate the productivity losses, benefits payments and cost to the NHS associated with mental health problems cost the English economy £70 billion a year.[98] Meanwhile the Centre for Mental Health estimated costs at £105 billion each year, when impacts on work, crime and violence have been considered.[99]

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".[9] 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.[100] Due to this, these are considered underestimates.

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 and 15.5% for WLCCG.[101 102]

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.[103 104] 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.

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
https://www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/

3.1. Employment and sickness absence

People with mental health problems have lower rates of employment than the general population. Data from the Labour Force Survey estimates that 58% of people with mental illness or learning disability were employed in Leicestershire in 2016 Q4, compared to 43.3% nationally. While the trend has gradually increased since 2009, it is not possible to ascertain whether increases are statistically significant.[44] At the same time, the percentage gap in employment rate of those with mental health disorders or learning disabilities and the overall population has been decreasing, although at a slower rate. The 2014 Q4 data showed an 18.3% gap between the employment rate of those with mental health or LD disorders and the overall population.[14]

The 'percentage point gap' is way of understanding how many people with mental illness who are in employment compared to the general population. This is the percentage of the total population employed minus the percentage of working age adults who are receiving secondary mental health services on the Care Programme Approach. The percentage point gap in Leicestershire is 74.4 percentage points, significantly worse than the England average of 67.4 (i.e. proportionately fewer people with mental illness who are employed). This is higher for men compared to women, at 76.7 percentage points compared to 71.3 percentage points respectively.[45]

Employment Support Allowance (ESA) is a welfare payment that can be claimed by those having difficulty finding work because of a long term medical condition or disability. In 2016, there were 19.0 ESA claimants for mental and behavioural conditions per 1,000 Leicestershire residents who are of working age. This is significantly lower than the England average of 27.5 people per 1,000 populations, and has shown an overall increasing trend since 2012, in line with national trends. This varies by district, with the lowest being 14.2 claimants per 1,000 population in Harborough, and the highest being 20.8 per 1,000 population in North West Leicestershire. All Leicestershire districts are significantly lower than England.[44]

For those in employment, mental health problems can impact on productivity. NICE guidelines state that improved mental health and wellbeing is associated with increased productivity at work, as well as reduced absenteeism.[105] The Department of Health estimates that 70 million days are lost from work each year due to poor mental health, with mental health being a leading cause of sickness absence.[106] While some individuals may not feel well enough to work, others may not be able to remain in current work settings, particularly if they have an untreated mental health problem. Research identifies a clear risk of untreated mental health problems causing a downward shift on social-economic status.[107]

3.2. Return on investment

"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.[100 108]

Mental health interventions have been shown to give returns on investment in the short, medium and long term (in the first year, 2-5 years and 6+ years respectively).[109] Benefits are calculated based on the mental health problems they prevent, and do not include the added value from increasing mental wellbeing.

More information
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

3.3. Integrating mental and physical health

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. The first two issues alone cost the NHS in England more than £11 billion annually.[110]

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 [21]

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)[9]

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[102]

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[111]

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. Leicestershire Joint Health and Wellbeing Strategy 2017-2022[112]

The strategy outlines the local Health and Wellbeing Board's approach to reducing health

inequalities and improving health and wellbeing outcomes for the population of Leicestershire.

The strategy has five outcomes;

i) The people of Leicestershire are enabled to take control of their own health and wellbeing

ii) The gap between health outcomes for different people and places has reduced

iii) Children and young people in Leicestershire are safe and living in families where they can achieve their full potential and have good health and wellbeing

iv) People plan ahead to stay healthy and age well and older people feel they have a good quality of life

v) People give equal priority to their mental health and wellbeing and can access the right support throughout their life course

4.7. LLR Sustainability + Transformation Plan 2017 (STP) Mental Health Workstream[113]

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.

4.8. Promoting independence, supporting communities - Leicestershire County Council Adult Social Care Strategy 2016-2020 [114]

The strategy references work with partners to promote, maintain and enhance an individual's independence, supporting people to gain/regain skills to live independently. The aim is to provide 'just enough' support to assist the individual to develop their strengths and abilities without becoming overly dependent on Council support.

4.9. Promoting independence, supporting communities Mental Health Strategy for Working Age Adults – Leicestershire County Council

Describes how the Adult Social Care Strategy will be put into action for people of working age that are experiencing mental health problems.

4.10. Improving Physical Healthcare for People living with SMI in Primary Care: Guidance for CCG's (2018) NHS England[115]

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.

4.11. Prevention Concordat for Better Mental Health (2017) PHE[116]

The Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The concordat promotes evidence based planning and commissioning to increase the impact on reducing health inequalities. The sustainability and cost effectiveness of this approach is enhanced by the inclusion of action that impacts on the wider determinants of mental health and wellbeing.

The Concordat is intended to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across: local authorities, the NHS, public, private and voluntary, community and social enterprise (VCSE) sector organisations, educational settings and employers.

It represents a public mental health informed approach to prevention, as outlined in the NHS Five Year forward view and promotes relevant NICE guidance and existing evidence based interventions and delivery approaches, such as 'making every contact count'.

The Prevention Concordat for Better Mental Health seeks to prevent mental health problems and promote good health through local and national action including addressing the wider determinants of mental health and focusing on prevention. It recognises the need to build capacity and capability of the workforce to prevent mental health problems and promote good mental health. A Prevention Concordat has been adopted for the East Midlands and local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers, employers and the voluntary and community sector within Leicestershire have signed up to this approach.

4.12. Preventing Suicide in England: third progress report HM Government (2017)[117]

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, this plan includes the STOP Suicide Prevention Campaign, which is being developed through the District Local Authorities. The campaign includes the development of a Suicide Prevention website.

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 Leicestershire. 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 and Health Scrutiny Committees.

4.13. 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)

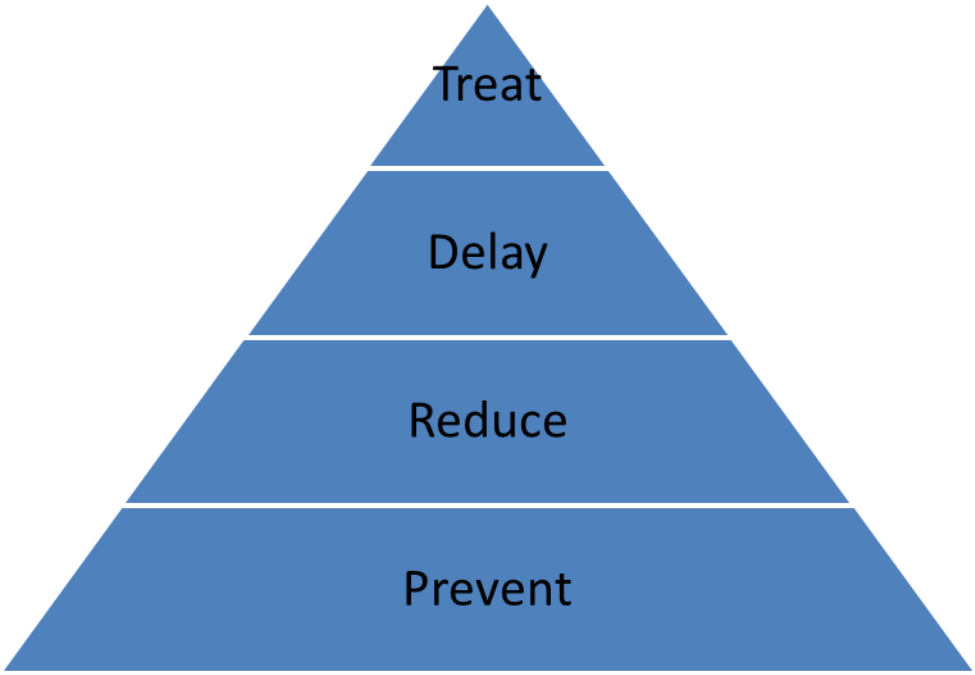
Thriving at Work; the Stevenson/Farmer review of mental health and employers. DWP/DoH+SC (2017)

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 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 across the county is a layered approach with a continued emphasis on people being supported towards greater independence. It is summarised in the pyramid below.



5.2. Voluntary and Community Sector Services

Despite a difficult funding climate with less voluntary & community based services being commissioned Leicestershire continues to be home to a number of innovative front line services providing support for adults experiencing or at a high risk of experiencing poor mental health. Examples include:

Norton Housing Support: Provides accommodation to adults with mental health needs and / or learning disabilities in Leicester and Leicestershire through shared home setting. http://nortonhousingandsupport.org.uk/

Leicestershire Action for Mental Health Project (LAMP): Works across Leicester, Leicestershire, and Rutland. Provides independent mental health advocacy (IMHA) 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 Singing Café: Music therapy for adults with mental health challenges. http://www.singingcafe.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

This is not an exhaustive list. There are many more local organisations and groups providing services and support for people with mental health problems. More information can be found at www.valonline.org.uk

5.3. IAPT – Let's Talk Wellbeing

Improving Access to Psychological Therapies (IAPT) is a national programme commissioned and delivered at a local level. The service provides psychological assessment and treatment for mild to moderate common mental health problems. The service is evidence-based and follows NICE Guidance.

The IAPT service is commissioned by the two CCGs (East Leicestershire and Rutland CCG, and West Leicestershire CCG) and provided by Nottinghamshire Healthcare NHS Trust. The service is known as Let's Talk Wellbeing. The service is available to anyone over the age of 16 who is registered with a GP in Leicestershire or Rutland, and accepts referrals from GP's or people can self-refer.

IAPT services provide a stepped-care model. Step 1 – 'watchful waiting' ; Step 2 – up to 6 sessions with a trained/qualified Psychological Wellbeing Practitioner (PWP); Step 3 – usually 8-12 sessions with a BACP accredited Cognitive Behavioural Therapist (CBT). For more severe and/or enduring mental health concerns referral is made to Community Mental Health Teams (CMHT)/LPT.

The challenge for the service is a national target to increase access from 15% to 25% of the target population (based on local prevalence data) by 2021.

The local IAPT service also provides Mental Health Facilitators, who work alongside GP practices to improve access to health checks and annual mental health assessments for people with severe mental illness.

5.4. Leicestershire Partnership Trust

The 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.

5.4.1. *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

5.4.2. ***LPT Community Mental Health Services***

Community mental health services include;

Community Mental Health Teams (CMHT) – there are five teams across Leicestershire. Referrals to CMHT are made 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. Services are delivered from CMHT hubs across the county.

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. Provides a service across LLR. Referral is primarily through a GP.

Assertive Outreach – the multidisciplinary team provide individual packages of care to people with severe persistent mental illness across Leicester and Leicestershire, usually delivered in a person's own home. Specialist Psychological therapies – the service provides a range of psychological therapies including Cognitive Behavioural Psychotherapy (CBT) and Dynamic Psychotherapy. Referral is through GP or mental health worker.

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 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. Courses are delivered from a number of different sites across the county. 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 sessions in a range of venues across the county.

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

Hospital housing enabler service at the Bradgate Unit – Health and Social Care Integration at Leicestershire County Council have been analysing the impact of housing problems and the specific types of housing issues that affect mental health patients through the referrals into our hospital housing enabler service at the Bradgate Unit. This service provides dedicated housing expertise of 2.5 wte for adult mental health service patients; offering support in the hospital and in the community. The housing team work as part of the discharge team to ensure the most suitable options are in place and that discharge plans are as effective as possible from a housing and community support perspective.

The issues faced often include homelessness, which is a complex set of factors for mental health service users. This is not just about those of no fixed abode, or those with no recourse to public funds, but those with difficulties in accessing and sustaining tenancies, those who are now unable to return to their previous home address, and the evident need

for ongoing support with housing (and related benefits/welfare matters) as part of recovery and reablement when back in the community. It is therefore important that the accommodation strategies and housing support services reflect the specific needs of MH service users, as without suitable housing options, they will continue to place great demands on acute inpatient care, and on local authorities in terms of emergency or temporary housing. This situation can lead to repeated hospital admissions or a revolving use of hostel or bed and breakfast accommodation for example, which in turn impacts negatively on their overall mental health, mental wellbeing and recovery in the community. Since April 2016, the service has seen 95 patients who were recorded as having no fixed address. This equates to almost a third of all patients seen within the Bradgate Unit from April 2016 until May 2018 (315).

5.5. 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 intensive ely 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.

5.6. Local Authority Mental Health Services

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

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

Community Mental Health Teams – there are six locality teams across the county, Blaby/Oadby & Wigston, Melton, Hinckley, North West Leicestershire, Charnwood, and Harborough. All teams include Social Workers, and Mental Health Social Workers, and most also include an Approved Mental Health Professional (AMHP). The teams provide a service to all service users in their locality.

In addition to the locality based teams there are countywide services providing more specialised support and interventions. These teams include;

Forensic Mental Health – team staffed by Approved Mental Health Professionals (AMHPs) offering specialist forensic social work service.

Mental Health Crisis Resolution – team includes AMHPs and social workers, and is based at the Bradgate Mental Health Unit.

Mental Health Hospitals Team – team includes AMHPs and social workers. The team ensure prompt social care assessments and support planning, to ensure timely and safe discharge.

Mental Health Assertive Inreach Team – provide support to ensure income, and housing for example, do not present a barrier to timely and safe discharge from hospital.

Mental Health Review Team – team made up of social workers and community support workers. The review team follow up on progression and outcomes identified in support plans.

Mental Health Urgent/Duty Team – team made up of social workers.

5.7. Mental Health Wellbeing + Recovery Service

The mental health wellbeing and recovery service is commissioned jointly between, Leicestershire County Council, Leicester City Council, Rutland County Council, and the three CCG's. The service is currently provided by 3 different providers, providing coverage across all districts in the county (and Leicester City and Rutland); Richmond Fellowship (operating as Life Links), Mental Health Matters, and Voluntary Action South Leicestershire (VASL).

The service offers support networks focused on wellness and recovery, encouraging independence and developing own personal support networks. It offers flexibility to choose support based on own personal need. This can be face to face, providing information, advice and navigation services, one to one sessions, and group support sessions; online support including a directory of services, and a 24/7 chat feature allowing questions to be asked/answered; and community recovery support.

5.7 Specialist Substance Misuse Treatment Services

Specialist substance misuse services for Leicestershire and Leicester City are jointly commissioned by Leicestershire County Council (Public Health) and Leicester City Council (Adult Social Care). Additional funding for this service is provided by the Office of Police + Crime Commissioner (OPCC) and NHS England. The integrated substance misuse treatment

service is currently provided by Turning Point. In addition to Senior Recovery Workers, Recovery Workers, and Support Workers, the service includes a Consultant Psychiatrist, and a Counselling Psychologist, and a Dual Diagnosis Senior Recovery Worker. There are close working arrangements with inpatient psychiatric wards, with fortnightly clinics run by the Turning Point Consultant Psychiatrist, and weekly clinics/drop-ins attended by the Dual Diagnosis Senior Recovery Worker. In addition there is a weekly Mental Health Drop-in session at the main service hub in the city centre, but available for any service user. Turning Point are commissioned separately to provide 1.2wte Recovery Workers to the Pro-Active Vulnerability Engagement (PAVE) Team.

5.8 Local Authority – Public Health

The Public Health Department approach involves finding ways to improve the mental wellbeing of the population in Leicestershire. The department does this in a number of ways; assessing population needs, and the supporting evidence base for interventions, direct commissioning/contracting of services, and working with other departments and partners to develop joint initiatives.

The department leads the Leicestershire, Leicester City and Rutland wide Suicide Audit and Prevention Group. The role of the group is to lead on and co-ordinate strategies and actions to reduce the risks and burden of suicide locally. The group has developed the LLR Suicide Prevention Strategy and Action Plan (2017-20).

Key Actions include:

- Promote better mental health
- Promote open discussion about suicide
- Support people bereaved or affected by suicide
- Deliver suicide awareness training
- Work to prevent suicide in health care settings
- Raise awareness with better data
- Influence service providers to implement NICE guidance for treatment of self-harm
- Target support at high risk groups

The strategy and action plan are currently being used to shape the ‘STOP’ Suicide Leicester,

Leicestershire and Rutland programme. This programme will pull together key suicide prevention services and initiatives which will be captured on a website to be launched on World Suicide Prevention Day, September 10th, 2018.

In addition to the suicide prevention work, currently the department commissions and/or contributes to a number of local initiatives aimed at improving mental wellbeing and supporting recovery;

First Contact + - offers access to a range of low level preventative services through a single point of contact. This is an online service ensuring that people can access information, advice and support across a range of issues. This includes a range of health and wellbeing topics including mental health, and advice and support on topics that have the potential to impact on mental wellbeing, such as debt and benefits, and families and relationships. The service provides early identification of needs and brief opportunistic interventions, support for self-help, or referral to a service provider. As well as providing advice pages, and signposting to useful resources, there is an option to self-refer for further contact.

Local Area Co-ordinators (LAC's) – this is a community based intervention delivered in specific areas by Local Area Co-ordinators. Whist the team work with other agencies such as GP surgeries, adult social care, and the police they are independent of these services and work directly with individuals and in communities to improve health and wellbeing. The team work on an asset-based model to increase individual and community capacity, preventing people reaching crisis, and thereby reducing demand on public services. Whilst not a specific mental health service, much of the work undertaken supports improving people's mental wellbeing and addresses issues that impact on individual mental health.

Leicestershire Shared Reading

Leicester Arts Centre- Films to Make you Feel Good

Mental Health Awareness Training

Suicide Awareness Training Sessions

LPT – Recovery College

The department also commissions a number of children and young people/school based mental health services

More information
For further information on Children's Mental Health, please visit the Children and Young People's Mental Health JSNA Chapter:
http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

6. Unmet needs/Gaps

6.1. Local Capacity

6.1.1. *IAPT*

There is a lack of qualified staff completing training programmes, particularly Psychological Wellbeing Practitioners (PWPs), meaning the service carries staff vacancies', and as a result long waiting lists. In addition there is a need for venues to expand delivery across the county. In particularly more clinical hubs are needed across the county.

6.1.2. *Crisis Resolution and Home Treatment Team*

The local service is noticeably short on resources compared to the situation nationally. A business Case in relation to this is currently being developed.

6.1.3. *CMHT*

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

6.1.4. *Acute beds*

Whilst the number of available beds locally 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.

6.2. Accommodation/ Housing Need

Having access to appropriate housing is sometimes a barrier to people moving out of acute hospital beds. A review is currently underway of housing and accommodation and support needs.

6.3. Dual Diagnosis (substance misuse and mental health)

There are high numbers of substance misusers in treatment services who also have mental

health problems, putting a significant demand and expectation on the substance misuse treatment service.

There are pathways and protocols in place between substance misuse services and inpatient psychiatric services at LPT and UHL hospitals with staff of substance misuse services attending inpatient wards. However separate systems, processes and thresholds across services result in potential gaps in provision, and inappropriate referrals and/or hospital stays.

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. Thresholds and roles/levels of expertise in different services mean there is a service provision gap for this group of people. Current models of care often don't meet the needs of this group.

6.4. Liaison Psychiatry

Current capacity pressures in liaison psychiatry services impacts adversely on other service provision. This is particularly evident in relation to substance misuse.

6.5. Employment Support

There is currently a local service provided as part of LPT (Aspiro) who provide advice clinics and employability courses. Whilst this is valued it is recognised that more employment support services are required.

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

- Implement the local 'Prevention Concordat for Mental Health'[116]
- 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), consider use of social prescribing approaches including Firstcontact+

- Target action across health, social care and local districts/boroughs to improve the range and suitability of accommodation to include care and support options for people with mental health needs

- 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 including expanding access to include supporting people with LTC and MUSs

- Continue to work to expanding delivery of IAPT services in line with recommendations from the Five Year Forward View For Mental Health

- 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)

- Develop a 'Core 24' liaison mental health team within the main local acute provider (UHL) (as recommended in The Five Year Forward View For Mental Health). This service to include support for patients with dual diagnosis in acute settings

- Increase access to specialist perinatal mental health support, delivering NICE

recommended interventions

- 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

7.3. Suicide prevention

Get cross-organisational support for the LLR Suicide Audit and Prevention Strategy and Plan and the 'STOP Suicide LLR' campaign

- Improve the real time monitoring of suicides
- Develop a sustainable programme of suicide prevention training that meets the needs of the different professional groups
- Develop the new service to support those bereaved by suicide.

GLOSSARY OF TERMS

CCG	Clinical Commissioning Group
ELRCCG	East Leicestershire and Rutland Clinical Commissioning Group
GP	General Practitioner
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
IDACI	Income Deprivation Affecting Children
IDAOPI	Income Deprivation Affecting Older People
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
LSOA	Lower Super Output Area
MSOA	Middle Super Output Area
NHS	National Health Service
ONS	Office of National Statistics
PHE	Public Health England
WLCCG	West Leicestershire Clinical Commissioning Group

8. APPENDIX 1: Early Help Service

The Early Help Service is a non-statutory service which takes targeted action early and as soon as possible, to tackle problems emerging for children, young people and their families, or with a population most at risk of developing problems. The service user population currently consists of families being supported by Supporting Leicestershire Families, Children's Centres and Youth Offending Services.

In 2017/18 a total of 26,543 individuals were provided with support from the Early Help Service. An individual may be supported by more than one of the Early Help services and during 2017/18, 4,408 were supported by Supporting Leicestershire Families, 22,171 by Children's Centre's and 405 by Youth Offending Services.

Between 2013 and 2017 there was a total of 5,486 casework families identified. Casework families encompass those with the highest needs i.e. supported by a caseworker in the Supporting Leicestershire Families and Children's Centre's took place. A cohort of 787 families took part in an evaluation of the Early Help Service. Below are further details of the context of those families and key evaluation findings in relation to mental health.

8.1. Families with the highest needs supported by the Early Help Service

Within the service, families are placed in one of nine clusters. These clusters (A-I) group to four high level areas of need as shown below some of which have higher and lower levels of mental health needs.

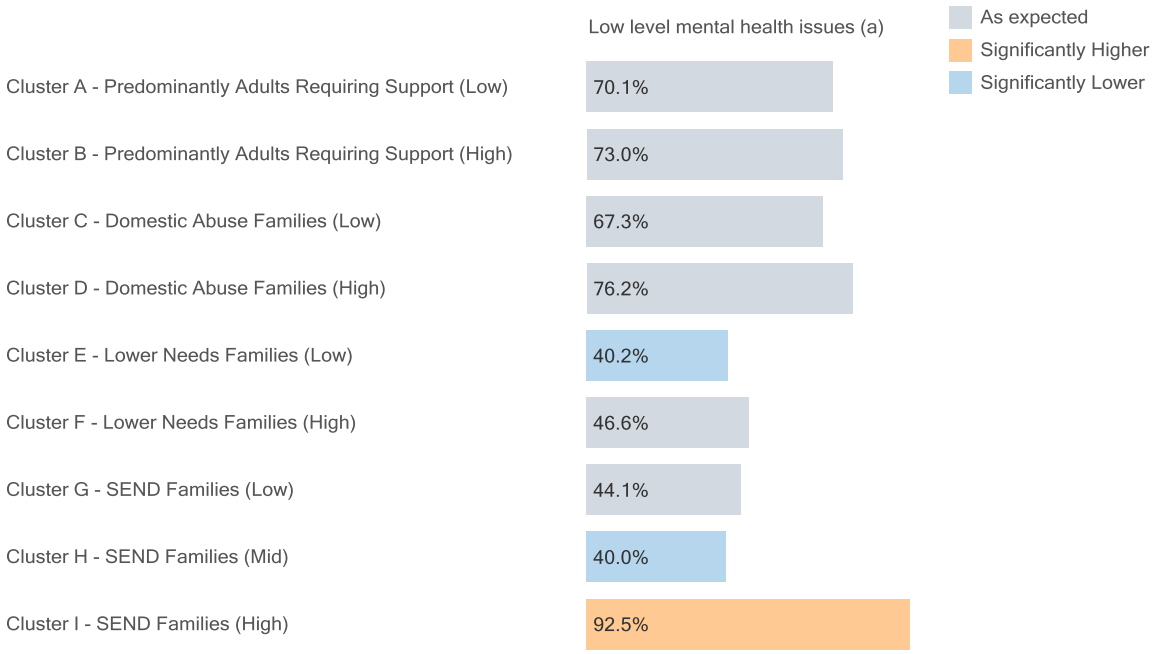
Table 8 is an extract from the evaluation and describes, at a high level, the type of families in each group and the number and percentage of families in each cluster from a subset of 787 families consisting of 4,564 individuals.

Table 8: Number and Percentage of Families in the Early Help Evaluation Featuring in Each Cluster

High level Group	**Predominantly Adults Requiring Support**		**Domestic Abuse Families**		**Lower Needs Families**		**SEND Families**		
Group & level of need	A Low	B High	C Low	D High	E Low	F High	G Low	H Mid	I High
Number	134	141	104	42	107	73	68	65	53
%	17.0	17.9	13.2	5.3	13.6	9.3	8.6	8.3	6.7

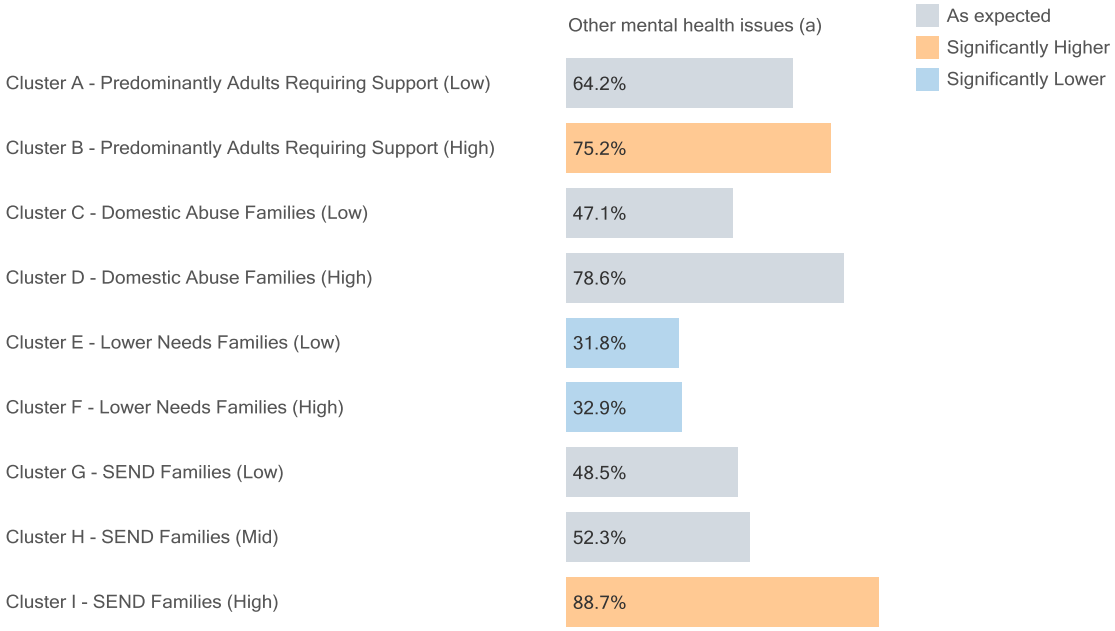
Low level mental health is the biggest adult need (64%) at the start of the Early Help intervention. The percentage of adults with low level mental health issues varies by cluster. The lowest prevalence is in cluster H (SEND families - mid) at 40% and the highest prevalence is in cluster I (SEND families – high) at 92.5%. Clusters E and H have significantly lower levels than expected (i.e. compared to the overall) and Cluster I significantly higher levels than expected.

Figure 13 : Percentage of adults who have low level mental health issues for each cluster



Other mental health issues are the third biggest adult need (59%) at the start of the Early Help intervention. The percentage of adults with other mental health issues varies by cluster. The lowest prevalence is in cluster E (Lower needs families – low) at 31.8% and the highest prevalence is in cluster I (SEND families – high) at 88.7%. Clusters E and F have significantly lower levels than expected (i.e. compared to the overall) and Clusters B and I have significantly higher levels than expected.

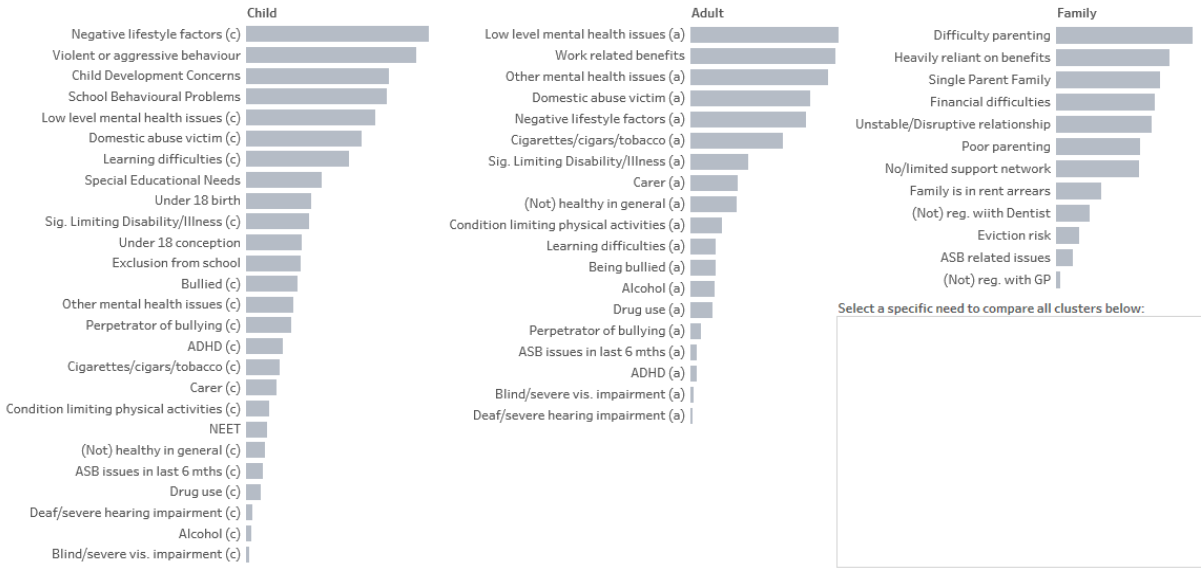
Figure 14: Percentage of adults who have other mental health issues for each cluster



8.2. Needs of families being supported by the Early Help Service

Figure 15 below displays the full range of 57 needs by percentages across three areas of child, adult and family for a representative sample of families being supported by a caseworker from Supporting Leicestershire Families and Children's Centres in the council's Early Help Service. This illustrates the context of child mental health for this population in relation to other needs at a child, adult and family level;

Figure 15: Overall profile of needs and vulnerabilities of families being supported by a caseworker in the Early Help service



8.3. Family Star Progress: Positive Adult Wellbeing

Family Star Plus is a practitioner based tool which enables conversation and family plans to be developed whereby workers and families agree a reading of between 1 and 10 against ten key domains at regular intervals to determine where families' progress is. The ten key domains of Family Star Plus are:

1. Positive experiences with Home and Money
2. Keeping Children Safe
3. Positive Boundaries and Behaviours
4. Positive Family Routines
5. Good or improved Physical Health
6. Positive Adult Wellbeing
7. Positive and supportive Social Networks
8. Meeting Children's Emotional Needs
9. Positive and appropriate Education and Learning
10. Achieving Progress to Work *

Figure 16 shows that 70% of families make progress overall around the Family Star domain of Adult Wellbeing. (This domain is about how adults cope with difficulties, such as those who are feeling very stressed, not coping, are depressed anxious or have problems with drugs, alcohol, domestic abuse or mental health. This will affect their family: this scale will help to discuss what is happening so the service knows how they can help. It also illustrates the variation in progress made in the Adult Wellbeing domain across the nine different Clusters of families.

Most progress is made around Adult Wellbeing by Cluster E (Less complex families - Low) (78%).

Least progress is made around Adult Wellbeing by Cluster I (SEND families - High) (58%).

Figure 16: Family Star Progress –Adults Wellbeing

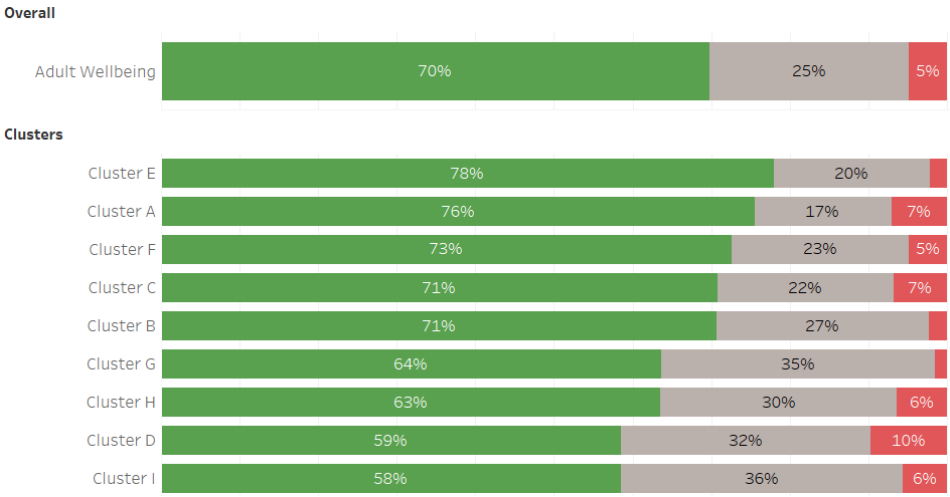
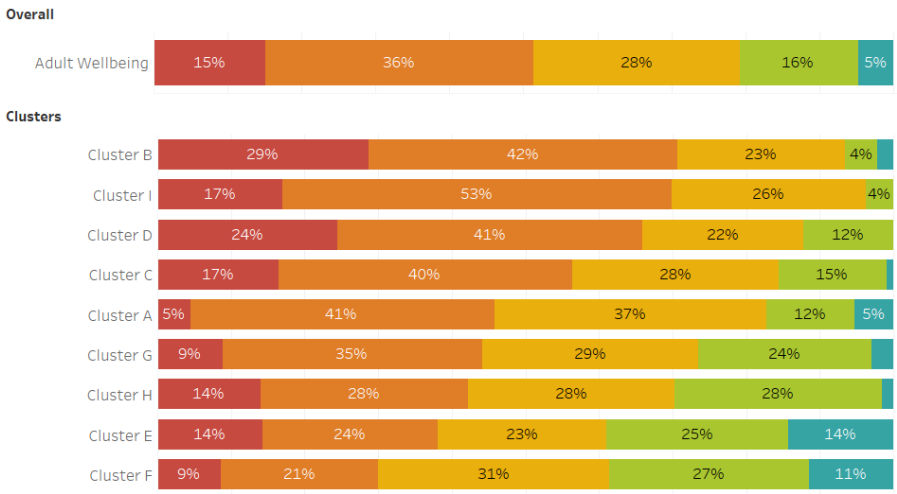


Figure 17 illustrates the differences in start readings against the nine different groups of families for the Family Star domain of Meeting Adult's Wellbeing Needs.

Figure 17: Start reading: Adult Wellbeing



Families in Cluster B (Adults requiring support - High) on average have the lowest start readings, being most likely to start Stuck (29%) or Accepting Help Adults (42%) around Adult Wellbeing.

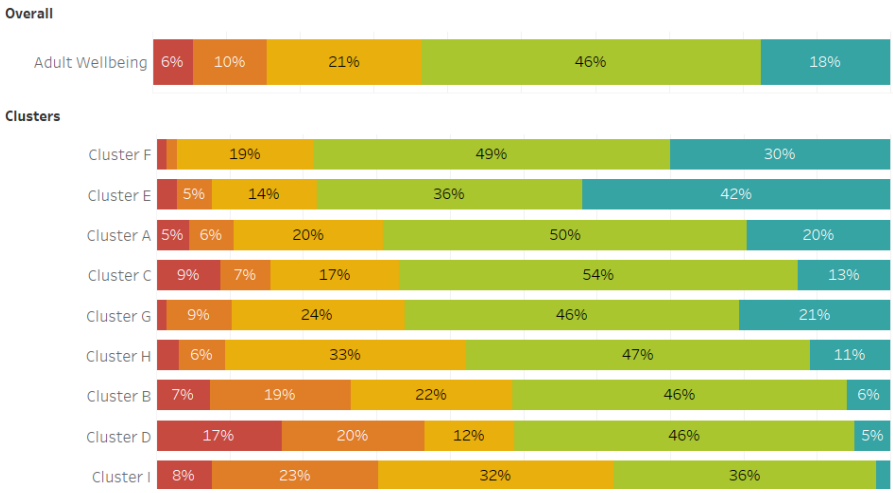
Families in Cluster E (Less complex families - Low) on average have the highest start readings, being most likely to start Finding what Works (25%) or Effective Parenting (14%) around Adult Wellbeing.

Figure 18 illustrates the differences in end readings against the nine different groups of families for the Family Star domain of Adult Wellbeing

Families in Cluster D (Domestic abuse families - High) on average have the lowest end readings, being most likely to end Stuck (17%) or Accepting Help (20%) around Adult Wellbeing.

Families in Cluster F (Less complex families - High) on average have the highest end readings, being most likely to end Finding what Works (49%) or Effective Parenting (30%) around Adult Wellbeing.

Figure 18: End reading – Adults Wellbeing

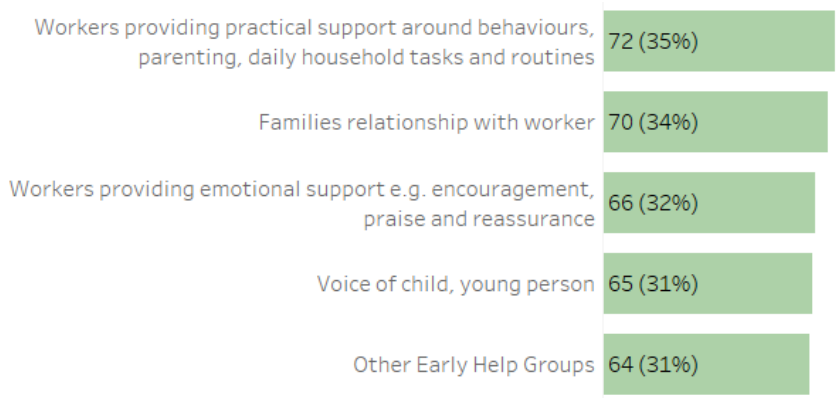


8.4. Most Significant Change: Positive Adult Wellbeing

As part of the evaluation, staff presented 227 cases where they had seen the most significant change as a result of the Early Help casework, 96% said that change was either fairly (11%) or very relevant (85%) to the domain of Adult Wellbeing. Figure 19 and Figure 20 below illustrates the top 5 activities/approaches and enablers for cases where positive Adults wellbeing was identified as relevant to change

Of the most significant change cases submitted by staff where wellbeing outcomes were identified, the top five Early Help activities and approaches linked to these cases were workers providing practical support around behaviours, parenting, daily household tasks and routines; families relationship with the worker; workers providing emotional support e.g. encouragement, praise and reassurance; the voice of the child/ young person; and Early Help groups.

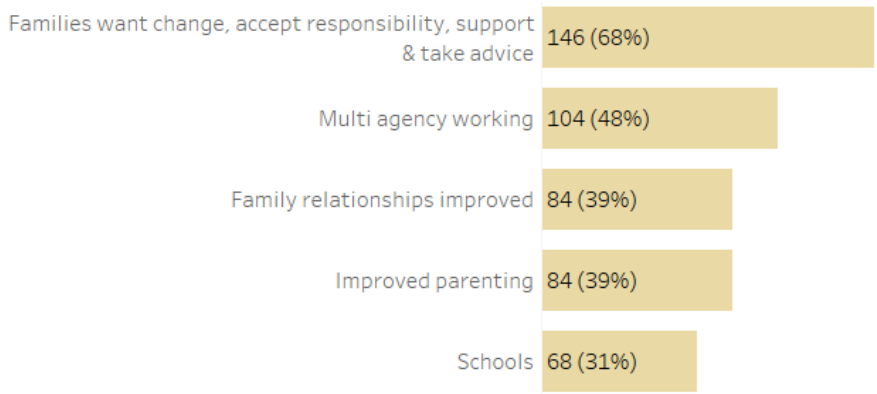
Figure 19: Top 5 Early Help activities and approaches



The top five enablers linked to these cases were families wanting change, accepting responsibility, support and taking advice; multi-agency working; improved family relationships; improved parenting and schools.

The following also featured in these cases: health services for parent's mental health; families managing their health; specific services for drug misuse and domestic abuse; and health diagnosis for families.

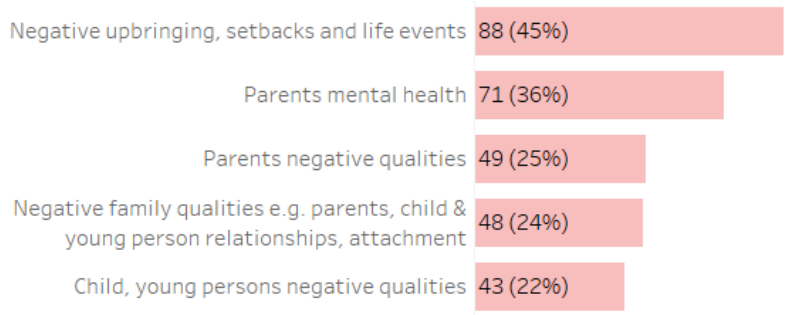
Figure 20: Top 5 enablers



8.4.1. *Barriers and other outcomes for cases where positive adult wellbeing was identified as relevant to change*

The top five barriers to change linked to these cases were negative upbringing, set-backs or life events; parent's mental health; other parent's negative qualities; family negative qualities e.g. family relationships and attachment; and children's negative qualities. The following also featured as barriers in these cases: parents other issues; child/ young person's mental health; isolation; and an unstable home environment

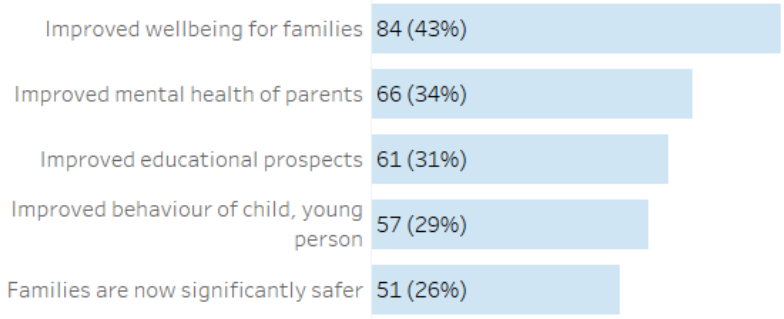
Figure 21: Top 5 barriers to change



The top three outcomes relating to these cases were: improved wellbeing for families; improved mental health of parents; and improved educational prospects.

The following outcomes also related to these cases: improved behaviour of child/ young person; families being significantly safer; progress towards work; improved mental health of child/ young person; an improved future outlook; families less isolated; improved health of child/ young person; improved child development; improved health of parents; and parents and young people in work or apprenticeships.

Figure 22: Top 5 other outcomes



8.4.2. *CHAID (Statistically significant findings) around progress: adult wellbeing*

For these families where there is children's social care involvement after the early help intervention they are over three times more likely to make lower progress around adult wellbeing compared to the overall (18.3%:4.7%).

For these families where there is no children's social care involvement after the early help intervention they are more likely to make higher progress around adult wellbeing compared to the overall (77.6%:66.8%).

Table 9: Adults requiring support (Cluster A-Low) and Domestic Abuse Families (Cluster C- Low)

Predominantly Adults Requiring Support		Domestic Abuse Families		Lower Needs Families		SEND Families		
A Low	B High	C Low	D High	E Low	F High	G Low	H Mid	I High

For these families where there is no children's social care involvement after the Early Help intervention they are less likely to make lower progress compared to the overall (0.6% vs 4.7%).

Table 10: Adults Requiring Support (Cluster B – High), Lower Needs Families (Cluster E – Low) and SEND Families (Cluster G – Low)

Predominantly Adults Requiring Support		Domestic Abuse Families		Lower Needs Families		SEND Families		
A Low	B High	C Low	D High	E Low	F High	G Low	H Mid	I High

For these families where there is a child protection plan after early help intervention, they are less likely to make higher progress around adult wellbeing compared to the overall (51.8%:66.8%).

Table 11: Domestic Abuse Families (Cluster D – High), Lower Needs Families (Cluster F – High) and SEND Families (Clusters H – Mid and I - High)

Predominantly Adults Requiring Support		Domestic Abuse Families		Lower Needs Families		SEND Families		
A Low	B High	C Low	D High	E Low	F High	G Low	H Mid	I High

8.5. Top Barriers to change in cases of most significant change

The table below illustrates some of the significant factors that were found in relation to each Family Star domain which may be worthy of further attention by the Early Help service.

Table 12: A summary of statistically significant findings worthy of further attention around each Family Star Domain

Family Star Plus Domain	Families Making Lower Progress	Families Making Higher Progress
Adult Wellbeing	• Anti-social behaviour • 3+ female adults in household combined with family low level mental health	• A lack of single parent families combined with a lack of anti-social behaviour • Less than 3 adults in households • A lack of anti-social behaviour combined with a lack of child victim of bullying

A (Adults requiring support – Low), C (Domestic abuse families – High), G (SEND families – Low) & H (SEND families – Mid)

Whilst progress for these families was similar to the overall, length of involvement may be an indicator as to whether social care involvement will happen after the Early Help intervention. For families in these groups where the intervention length was more than six months, these families were significantly more likely to have social care involvement.

Families with three or more female adults living in the household for these groups of families may warrant further Early Help attention as they made significantly lower progress than the overall. Negative child lifestyle issues at the start of the intervention was a key indicator for significantly lower progress in these groups of families.

Good adult mental health and good support networks at the start of the intervention was an important factor for families in these groups making good progress even if other factors such as lower level adult mental health e.g. anxiety and being an adult carer.

On the whole, families have a very positive experience of the Early Help service and recognise whole family working. Families mostly recognised support from their Early Help key worker but many also recognise support from multi-agencies

For more information on Family Star Plus see: http://www.outcomesstar.org.uk/using-the-star/see-the-stars/family-star/

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