Worcestershire Health and Well-being Board

Joint Strategic Needs Assessment

Mental Health Profile

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Wyre Forest Clinical Commissioning Group
Redditch and Bromsgrove Clinical Commissioning Group
South Worcestershire Clinical Commissioning Group

Contents

Executive Summary

Ensuring good mental health across the population and throughout life is a major contributor to wellbeing and is about more than just the absence of mental disorder.

The World Health Organization (WHO) defines health as "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The WHO state that mental health can be affected by a range of socioeconomic factors that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach.[1]

Our mental health is determined by many factors and it is the responsibility of not only individuals or services, but also families, friends, employers and the wider community to enable people to develop and importantly maintain good mental health.

Taking a preventative approach to improving the public's mental health has been shown to make a valuable contribution to achieving a fairer and more equitable society.

The Prevention Concordat for Better Mental Health Programme was one of the recommendations in the 'Five Year Forward View for Mental Health'[2] published in 2016. The programme aims to facilitate local and national action around preventing mental health problems and promoting good mental health.

As part of the programme, Health and Well-being Boards are encouraged to sign the **'Prevention Concordat for Better Mental Health'** ('the concordat') which commits the Board to carry out specific actions centred on the prevention of mental health problems and promotion of good mental health. The production of this profile contributes to satisfying commitments which are part of the concordat. There are also clear links to Worcestershire's 2016-2021 Health and Well-being Board strategy priority to improve 'Good mental health and well-being throughout life'.

The chapters which form this Mental Health Profile are summarised below.

Understanding Place

The determinants of mental health are not limited to an individual's attributes but include social, cultural, economic, political and environmental factors such as someone's living standards, working conditions, social protection and community social support. This section explores how such factors, sometimes referred to as 'the wider determinants of health', impact people's mental health in Worcestershire. There is a central theme running

[1] World Health Organization Mental health action plan 2013 – 2020. Available at: https://www.who.int/mental_health/publications/action_plan/en/ (accessed 30/04/2019)
[2] Independent Mental Health Taskforce to the NHS in England (2016). Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

through this chapter of structural and social inequality adversely impacting on mental health.

Deprivation, generally described as a relative disadvantage in terms of material and social factors (which can include money, resources and access to life opportunities), increases risk of poorer mental health. Worcestershire is a generally affluent County relative to England, but this can mask areas of deprivation and health need. Wyre Forest district has the highest proportion of the overall population experiencing income deprivation and Bromsgrove district the lowest. Wyre Forest district has the highest proportion of children experiencing income deprivation and Redditch district the highest proportion of the older population experiencing income deprivation.

Insecure, poor quality housing and homelessness is associated with poverty and is a social determinant of mental health. Results from the 'Worcestershire Homelessness Review 2016' confirmed that the main reasons for homelessness were:

- Family and friends being unable to accommodate
- End of assured short-hold tenancies
- Breakdown of relationships, both violent and non-violent

The quality and affordability of housing in Worcestershire varies between different tenures. Worcestershire has a high proportion of households within the private sector (around 70%) and this sector generally has the highest number of unhealthy homes.

Crime is another area explored in this chapter. Most crimes are committed by people who do not have mental health problems and people with mental health problems are three times more likely to be a victim of crime than the general population. The recent trend in recorded incidents of violent crime in Worcestershire has been upwards but is currently significantly lower than England. Anti-social behaviour constitutes the largest proportion of recorded crime in Worcestershire followed by violent crime. According to the 2018 Viewpoint Survey, Malvern Hills district had the highest proportion of respondents that felt safe during the day and Wyre Forest and Redditch districts the lowest.

The social interaction of people receiving and providing care in Worcestershire is important to understand and is considered in further detail in subsequent chapters. Only half of adult social care users (49.7%) and two-fifths of adult carers (38.4%) said they had as much social contact as they would like. This is significant particularly because the quality and quantity of social relationships affects health behaviours, physical and mental health, and risk of mortality. Certain people or groups are more vulnerable to social isolation than others, depending on factors like physical and mental health, level of education, employment status, wealth, income, ethnicity, gender and age or life-stage.

Community Well-being is the combination of social, economic, environmental, cultural, and political conditions identified by individuals and their communities as essential for them to flourish and fulfil their potential. Recognising assets helps value community strengths and ensures everyone has access to them. It builds on the positives and ensures that health action is co-produced equally between communities and services. Detail about specific community approaches which help to build community assets and well-being is provided at the end of this chapter.

Understanding People

This section focuses on adult mental health and specifically on the impact of the local population structure and risk factor distribution on mental health needs. Common Mental Health Disorders (CMD) are most frequently reported by women and working age adults, but other groups show increased risk too, including black, Asian and minority ethnic groups (BAME), people with physical disabilities, people with learning disabilities, prison population and offenders, LGBT people, carers, people with sensory impairment, homeless people and military veterans.

One focus of health promotion is getting the right amount and type of physical activity which positively impacts on stress, self-esteem, anxiety, dementia and depression and is recommended in the treatment of depression. However, those with severe mental health problems are less likely to engage in physical activity and are more likely to be physically unwell. There is a two-way relationship between depression and obesity. Obese individuals have a 55% increased risk of depression and people experiencing depression had a 58% increased risk of becoming obese. 62% of Worcestershire adults are overweight, including obese.

Mental health issues can result from illicit drug use or drinking too much alcohol and they can also cause people to take illicit drugs and drink too much. An estimated 1.17% of the Worcestershire population suffer from Alcohol Dependence and the estimated prevalence of opiate and/or crack cocaine use in Worcestershire is 7.7 per 1,000 population.

Certain demographic factors, including age, are key drivers of health need and demand for health/mental health services. Worcestershire has an older population than England, and over the next 5 years (by 2024) the number of residents over 75 years is predicted to increase by 22%, which may in turn drive demand for mental health services.

Protective factors for good mental health are explored within this chapter, and include stopping smoking, eating a good diet (including 5-a-day), physical activity, reducing alcohol consumption and stopping drug misuse.

Perinatal Mental Health

The physical and mental health of the mother and the family environment before, during and following pregnancy, infancy and childhood is of fundamental importance to mental health. While the relationship between mother and child is particularly important, the mental health of fathers and other caregivers should also be considered. Paternal and maternal depression is shown to have a negative impact on how parents interact with children and can have long-term consequences if left untreated.

Worcestershire has a lower General Fertility Rate than England. There are approximately 6,000 births every year in Worcestershire and despite having a lower overall birth rate than England, Worcestershire has a consistently higher birth rate in our most deprived areas.

Perinatal mental health problems affect between 10% to 20% of women during pregnancy and the first year after having a baby. Risk factors for perinatal mental health issues include mothers living in deprived areas or on low incomes, teenage mothers, maternal obesity, traumatic birth, stillbirth, miscarriage, neonatal death, relationship difficulties, women who have been subject to childhood/domestic abuse or neglect, women with a pre-existing psychiatric diagnosis and new mothers with an increased risk of depression.

Smoking at the time of delivery is a risk factor for current and future diminished health of the mother and her unborn child. Rates of smoking at the time of delivery are consistently higher in Worcestershire (12.5% smoking) compared with England (10.8%).

Services available to pregnant women are described in this section, including antenatal mental health screening and perinatal psychiatry pathways. There is a well-established, multi-disciplinary, specialist Perinatal Mental Health Service (PMHS) in Worcestershire. Worcestershire Health and Care Trust has over 10 years of experience of running a specialist PMHS. The service supports women experiencing moderate to severe perinatal mental health difficulties. There is also an established perinatal mental health training programme developed for midwives and health visitors. Further work is ongoing to enhance the Perinatal Mental Health Service in Worcestershire ensuring that it is meeting national standards.

Children and Young People

The last survey of the mental health of children and young people in England in 2017 found that one in eight (12.8%) of 5 to 19 year olds had at least one mental disorder when assessed. Prevalence of clinically diagnosed mental health conditions rose with the age of the child from 5.5% of 2 to 4 year olds to 16.9% of 17 to 19 year olds.

50% of those with a lifetime mental illness experienced symptoms before they were 14. Promoting emotional health and well-being and preventing poor mental health in children and young people is high priority and cost saving.

Around 8.8% of children and young people in Worcestershire are estimated to have a mental health disorder (compared with 9.2% in England), 3.4% have emotional disorders, 5.3% have conduct disorders and 1.4% have hyperkinetic disorders. There are several known risk factors which can contribute to increased risk of mental ill-health in children, including gender, socioeconomic status, ethnicity, disability, sexual orientation and whether they are a child looked after or in the youth justice system - all can have an impact on their development. Conversely, there are several protective factors against mental ill-health including secure attachment, supportive parenting, good standard of living and supportive network.

Linked to risk factors previously mentioned, adverse childhood experiences (ACEs) have a strong influence on a child's mental health, such as physical, sexual & domestic abuse, parental separation and emotional neglect. Where there are multiple ACEs, the risk is increased further. A newer issue is cyber bullying which contributes to risk of mental ill-health, with one survey reporting around 18% of 11-15 year olds experiencing bullying via

electronic communication over a two-month period. The chapter goes on to discuss children in need and children with a child protection plan, first time entrants to the youth justice system, and not in employment, education or training (NEET).

Mental health services for children and young people are described and access segmented by age, sex and socioeconomic class. Between 2015 and 2018, there was a slightly higher proportion of girls than boys referred to Child and Adolescent Mental Health Services (CAMHS; 53.0% vs 47.0% respectively). Rates of referral to this service are higher in more deprived areas.

Working-Age Adults

This section focuses on the treatment of mental health problems in working-age adults.

When considering the mental health needs of the working-age population there are a wide range of conditions to include and this report covers these under two broad headings: **common mental health problems** and **severe mental illness.**

In Worcestershire 5.2% of respondents to the 2016/17 GP Patient Survey reported a long-term mental health problem.

The recorded prevalence of depression in Worcestershire is just over 1 in 10 of the GP registered population (10.8%) equating to 52,818 people. There has been an increasing trend in recent years.

Standardised prescribing costs of hypnotics and anxiolytics (indicated for severe anxiety and severe insomnia) have been above the England average for several years across all three Clinical Commissioning Groups (CCGs).

At higher levels of need, treatment should be provided by Improving Access to Psychological Therapies (IAPT) services. IAPT is an NHS England programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with common mental health problems. Although all three Worcestershire CCGs meet the current target set by NHS England which is 15% of people with depression and anxiety accessing appropriate services each year, none yet meet the 2020/21 target of 25%.

Housing service commissioners and providers have a key role in improving mental health outcomes - providing both settled housing and the services people need to maintain their homes as independently as possible. They can support people at risk of mental ill health to build resilience, as well as providing specialist support for people with mental health problems. Adults in Worcestershire in contact with secondary mental health services on the care programme approach who are recorded as living independently (with or without support) is better than the national average, but there may be a declining trend.

Living Well in Older Years

Good mental health and well-being are just as important in our older age as in our younger years. This section explores factors relating to mental health and well-being in older people. It covers the demographics of older people, the prevalence of mental health conditions, risk factors and protective factors for mental health, services currently available and best practice.

Depression is regarded as the most common mental health problem in later life and is associated with worse general health. A systematic review found a prevalence rate for major depression ranging from around 4% to 9%, and for depressive disorders ranging from around 4% to just over 37%.

Dementia is a progressive condition that varies from person to person and each will experience dementia in a different way. Dementia prevalence increases with age. It is currently estimated that there are 8,273 people aged 65+ with dementia in Worcestershire, and this figure is projected to increase substantially with an ageing population.

There are numerous risk factors that affect mental health in older people which are discussed in detail in the chapter, including if their partner died in the past two years, caring responsibilities, living alone and loneliness, low income and having an age-related disability. Income deprivation affecting older people (aged 60+) is most common in Redditch (16.6% affected), followed by Worcester City (15.1% affected). Fuel poverty and living in a cold home also has a significant effect on the mental health of older people – this affects the greatest proportion of households in Malvern Hills (15.6%). The risk of loneliness by area is presented in this chapter alongside the main risks in each area (e.g. income deprivation, long term illness etc.). Enfield and Smallwood in Redditch, Droitwich East in Wychavon and Gorse Hill North in Worcester are the three highest ranking areas for risk of loneliness.

Protective factors are described in the final part of this chapter, largely drawing on results from Worcestershire County Council's Viewpoint Survey. This provides a view of the proportion of older respondents who currently volunteer or would consider volunteering - 10.6% of respondents to the survey who were 65+ currently volunteer in the countryside and open spaces and a further 9.8% would consider doing so. The survey also asked questions relating to social capital and community safety, for example, 78% of older respondents feel that they belong to their local area.

Finally, a brief description of recently re-designed services is provided, such as the dementia assessment and support team memory services, older adult community mental health teams and 'Healthy Minds' service.

Understanding Place

Introduction

The determinants of mental health are not limited to an individual's attributes but include social, cultural, economic, political and environmental factors such as someone's living standards, working conditions, social protection and community social supports.[3] This section explores how such factors, sometimes referred to as the wider determinants of health, impact people's mental health in Worcestershire.

Understanding these social factors in a local area can help to quantify levels of risk, protection and resilience within a community. It can help to identify vulnerable groups and consider what interventions could help to reduce vulnerability and develop resilient communities. Greater community resilience has the potential to:

- reduce the prevalence of mental health problems
- increase the prevalence of good mental health
- improve recovery and support for individuals who have become unwell[4]

Deprivation and Inequality

Deprivation, generally described as a relative disadvantage in terms of material and social factors (which can include money, resources and access to life opportunities), increases risk of poorer mental health.[5] The relationship between deprivation and mental health runs in both directions and the two can become mutually reinforcing.[6] There is evidence that people who live in deprived areas are more likely to need mental healthcare but less likely to access support and to recover following treatment[7] which can lead to increased health inequalities.

Published in 2010, the Marmot Review was an authoritative report that outlined the scale of health inequalities in England. The report presented clear evidence that the conditions in which people are born, grow, live, work, and age are responsible for health inequalities.[8]

[3] Health in all policies: health, austerity and welfare reform A briefing from the board of science :https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/improving%20health/public%20and%20population%20health/bos-health-in-all-policies-austerity-briefing-2016.pdf?la=en

[4] Public Health England. Better Mental Health: JSNA Toolkit. Understanding Place. Available at: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/2-understanding-place

[7] On poverty, politics and psychology: the socioeconomic gradient of mental healthcare utilisation and outcomes: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/on-poverty-politics-and-psychology-the-socioeconomic-gradient-of-mental-healthcare-utilisation-and-outcomes/B32422389DD988666B8E118F5FC4C9FF

[2,3], [8,6] Marmot Review 2010, Fair Society, Healthy lives: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

Populations with large differences in wealth and resource between individuals are associated with higher levels of poor mental health in the population as a whole.

There is a particularly pronounced link between inequality and severe mental illness. For example, the prevalence of psychotic disorders amongst people in the lowest fifth of household income is nine times higher than those in the highest fifth[9].

Worcestershire is a predominantly rural county with some urban areas.[10] According to Public Health England (PHE), the health of the rural population is on average better than that of urban areas; however, it is known that a lack of statistical information on health outcomes in rural areas often masks the detail of inequalities that exist within them. There is evidence suggesting that rural areas can be very diverse in relation to their level of affluence and their health outcomes.[11]

The Indices of Multiple Deprivation (IMD) 2015 provide a set of relative measures of deprivation in England based on 37 separate indicators, organised across seven distinct domains. The domains are described in more detail below:

The **Income Deprivation Domain** measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).

The **Employment Deprivation Domain** measures the proportion of the working-age population in an area involuntarily excluded from the labour market. This includes people who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities.

The **Education, Skills and Training Deprivation Domain** measures the lack of attainment and skills in the local population. The indicators fall into two sub-domains: one relating to children and young people and one relating to adult skills. These two sub-domains are designed to reflect the 'flow' and 'stock' of educational disadvantage within an area respectively. That is, the 'children and young people' sub-domain measures the attainment of qualifications and associated measures ('flow'), while the 'skills' sub-domain measures the lack of qualifications in the resident working-age adult population ('stock').

The **Health Deprivation and Disability Domain** measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation.

[9] Public Health England. Better Mental Health JSNA Toolkit. Understanding Place. Available at: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/2-understanding-place#deprivation-and-inequality

[10] Office of National Statistics https://www.ons.gov.uk/methodology/geography/geographicalproducts/ruralurbanclassifications/2011ruralurbanclassification

[11] Department for Environment, Food and Rural Affairs (Defra) (2013), Statistical Digest of Rural England:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/221038/pb13822-stat-digest- rural-201302.pdf

The **Crime Domain** measures the risk of personal and material victimisation at local level.

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.

The **Living Environment Deprivation Domain** measures the quality of the local environment. The indicators fall into two sub-domains. The 'indoors' living environment measures the quality of housing; while the 'outdoors' living environment contains measures of air quality and road traffic accidents.

There are also two supplementary indices, which are subsets of the Income Deprivation Domain (described above):

The **Income Deprivation Affecting Children Index (IDACI)** measures the proportion of all children aged 0 to 15 living in income deprived families.

The **Income Deprivation Affecting Older People Index (IDAOPI)** measures the proportion of all those aged 60 or over who experience income deprivation. All forms of deprivation by domain type are considered risk factors to poor mental health.

The domains are combined, using appropriate weighting, to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower Layer Super Output Area (LSOA)[12], or neighbourhood, in England. Every such neighbourhood in England is ranked according to its level of deprivation relative to that of other areas[13].

Although the IMD 2015 is designed to provide measures of relative deprivation for small areas (LSOAs) a range of summary measures for larger areas are available[14].

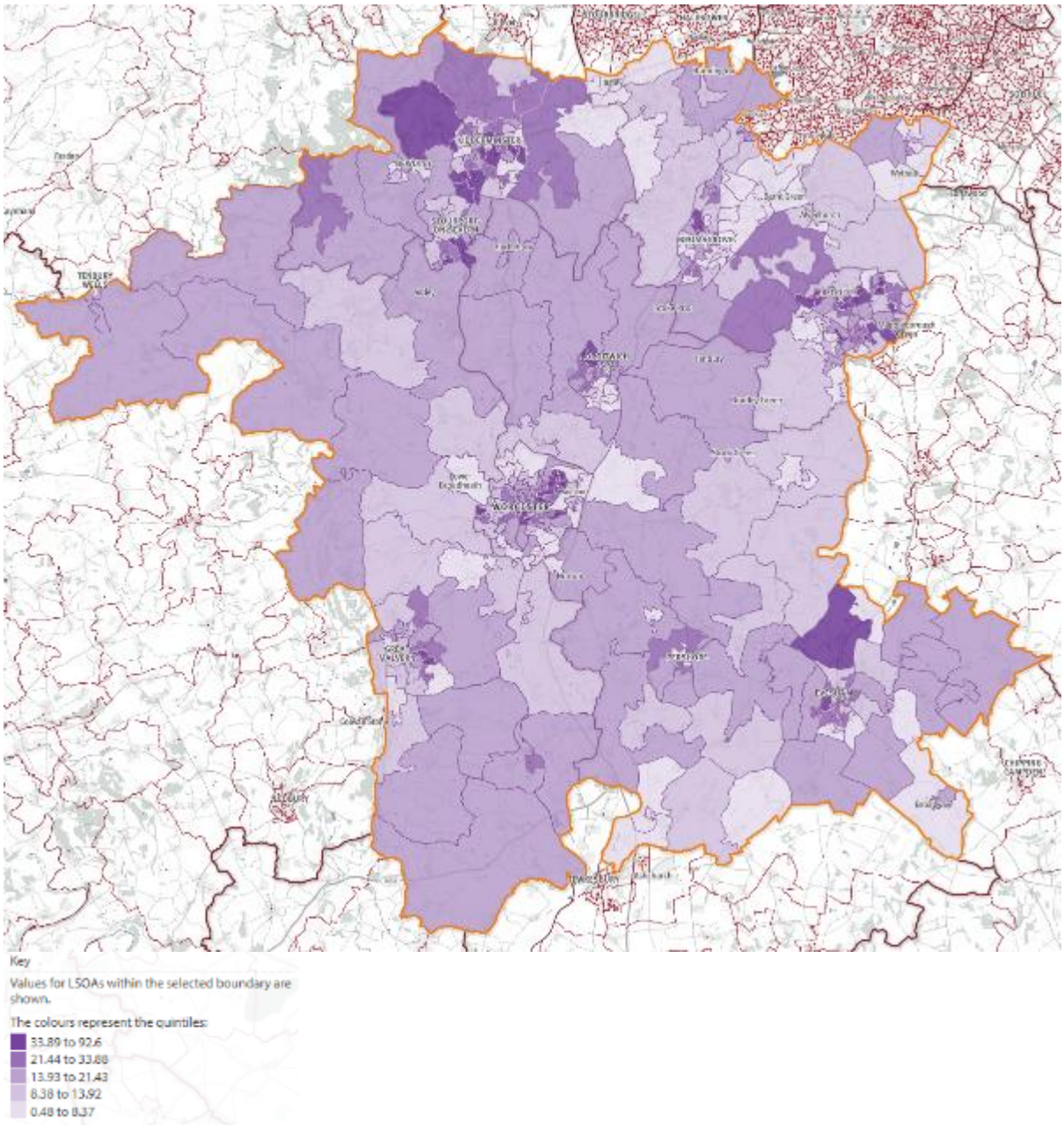
[12] Lower-Layer Super Output Areas (LSOAs) are small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households.

[13] Department for Communities and Local Government. The English Indices of Deprivation 2015. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf

[14] Scores for geographies larger than LSOAs are population weighted averages of the LSOAs in that area.

Figure 1 maps the relative deprivation of LSOAs in Worcestershire. Darker coloured areas are relatively more deprived than lighter coloured areas. Broadly speaking the north of the county is more deprived than the south.

Figure 1 Index of Multiple Deprivation (IMD) 2015 - Worcestershire Map



Source: Public Health England. SHAPE. Available at: https://shapeatlas.net/place/

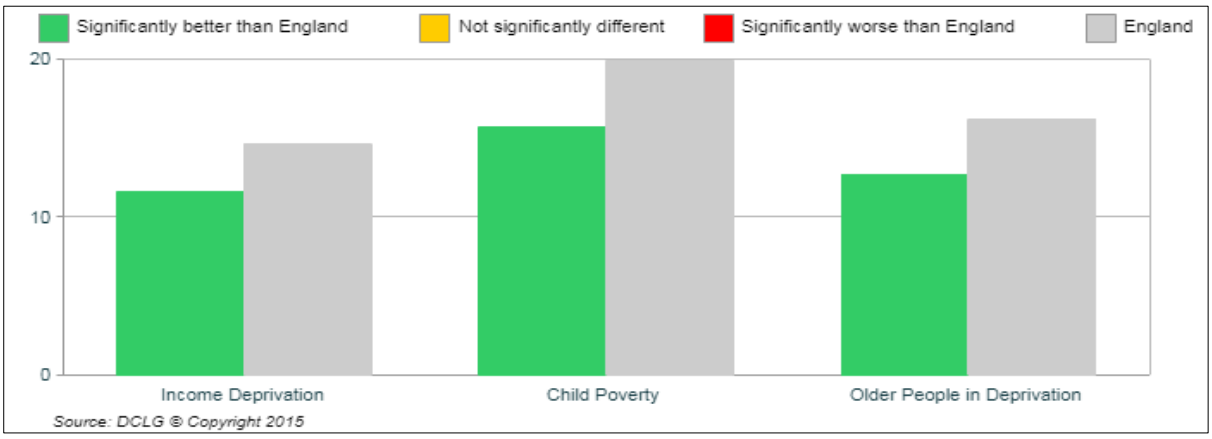
Poverty and Financial Insecurity

There is considerable evidence that shows a clear link between poverty and mental health.[15] Poverty can be both a causal factor and a consequence of mental ill health. Lack of money and unemployment are risk factors that may lead to unmanageable financial debt and consequently poorer mental health.[16] Anxiety is often exacerbated by money concerns and there are several mental health conditions that can lead to periods of impulsivity in spending.

Child poverty is an important risk factor for mental health because there is evidence showing that the development of early cognitive ability is strongly associated with later educational success, income and health.[17]

The deprivation domain that relates most directly to poverty and financial insecurity is Income Deprivation and its supplementary indices for children and older people (IDACI and IDAOPI). The average score for an area can be interpreted as the proportion of the relevant population experiencing income deprivation. It is important to note that although Figure **2** shows that on all three measures Worcestershire is significantly better than England, there are still many people in Worcestershire who live with income deprivation, children living in poverty, and older people in deprivation.

Figure 2 Proportion of the population Experiencing Income Deprivation in Worcestershire



Source: Local Health http://www.localhealth.org.uk/

Index	Worcestershire	England
Income Deprivation	11.6%	14.6%

[15] Mental Health Foundation: Poverty and mental health A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy 2016

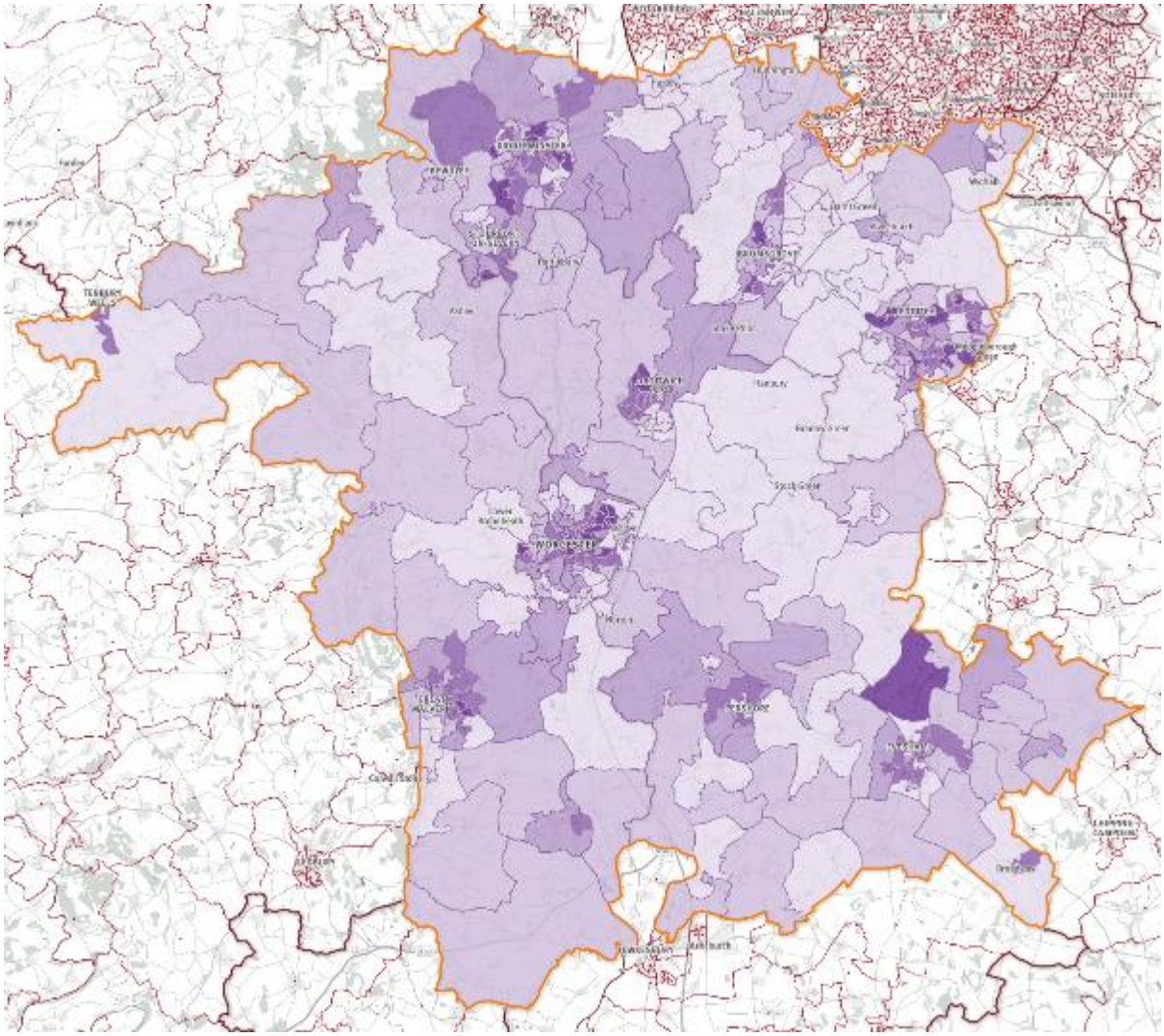
[16] The relationship between personal debt and specific common mental disorders https://academic.oup.com/eurpub/article/23/1/108/464719

[17] Marmot: Fair lives (2010) http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

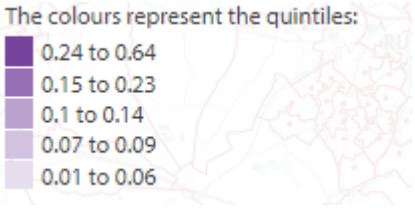
Income Deprivation Affecting Children (IDACI)	15.7%	19.9%
Income Deprivation Affecting Older People (IDAOPI)	12.7%	16.2%

Error! Not a valid bookmark self-reference. shows income deprivation is mainly clustered in and around the larger towns.

Figure 3 Income Deprivation Score 2015 - Worcestershire Lower Super Output Areas (LSOAs)[18]



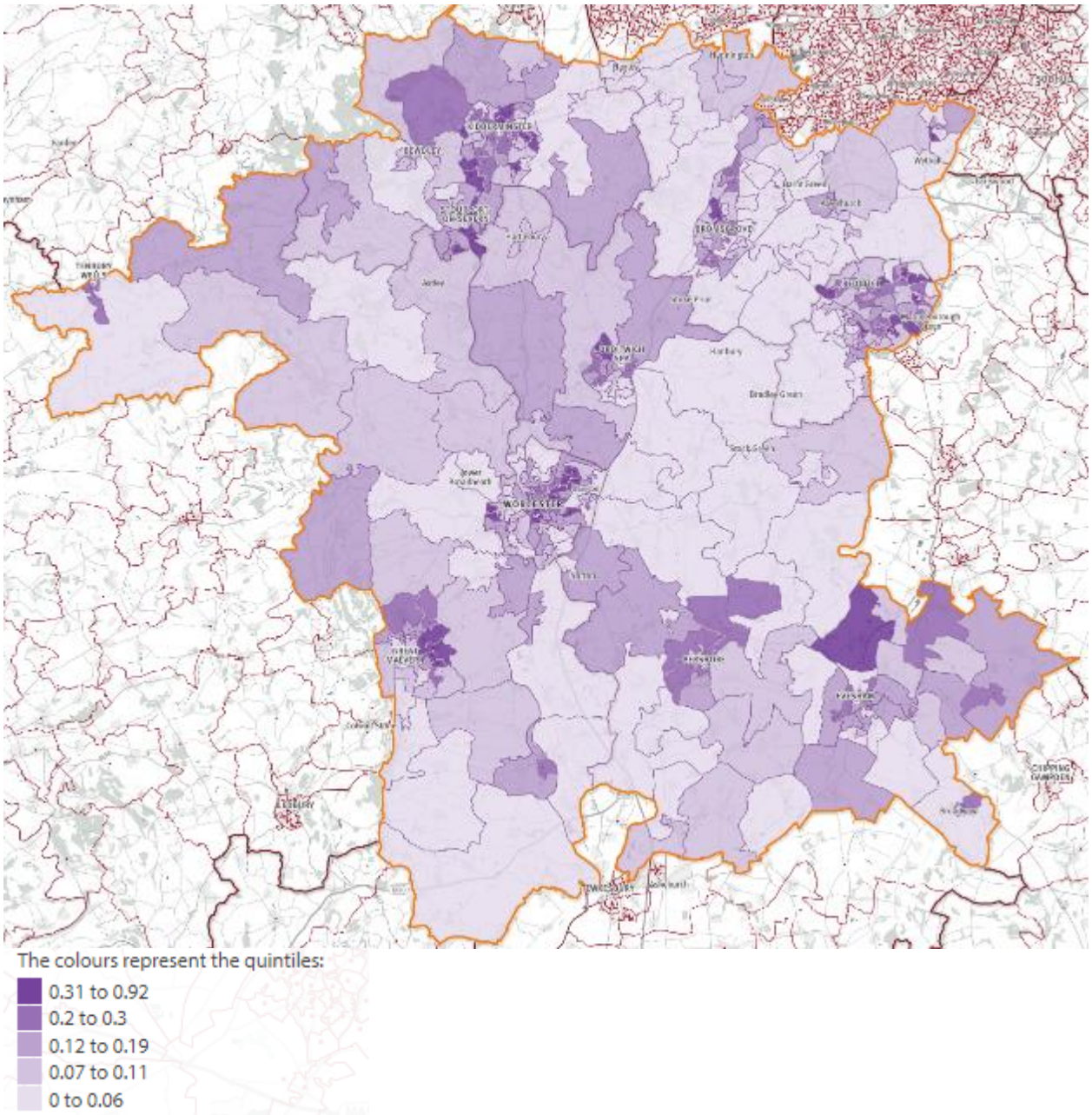
[18] The domain has two sub-domains at LSOAs showing Income Deprivation Affecting Children (IDACI) and Income Deprivation Affecting Older People (IDAOP). LSOAs stand for Lower Layer Super Output Areas are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales.



Source: PHE SHAPE https://shapeatlas.net/place/

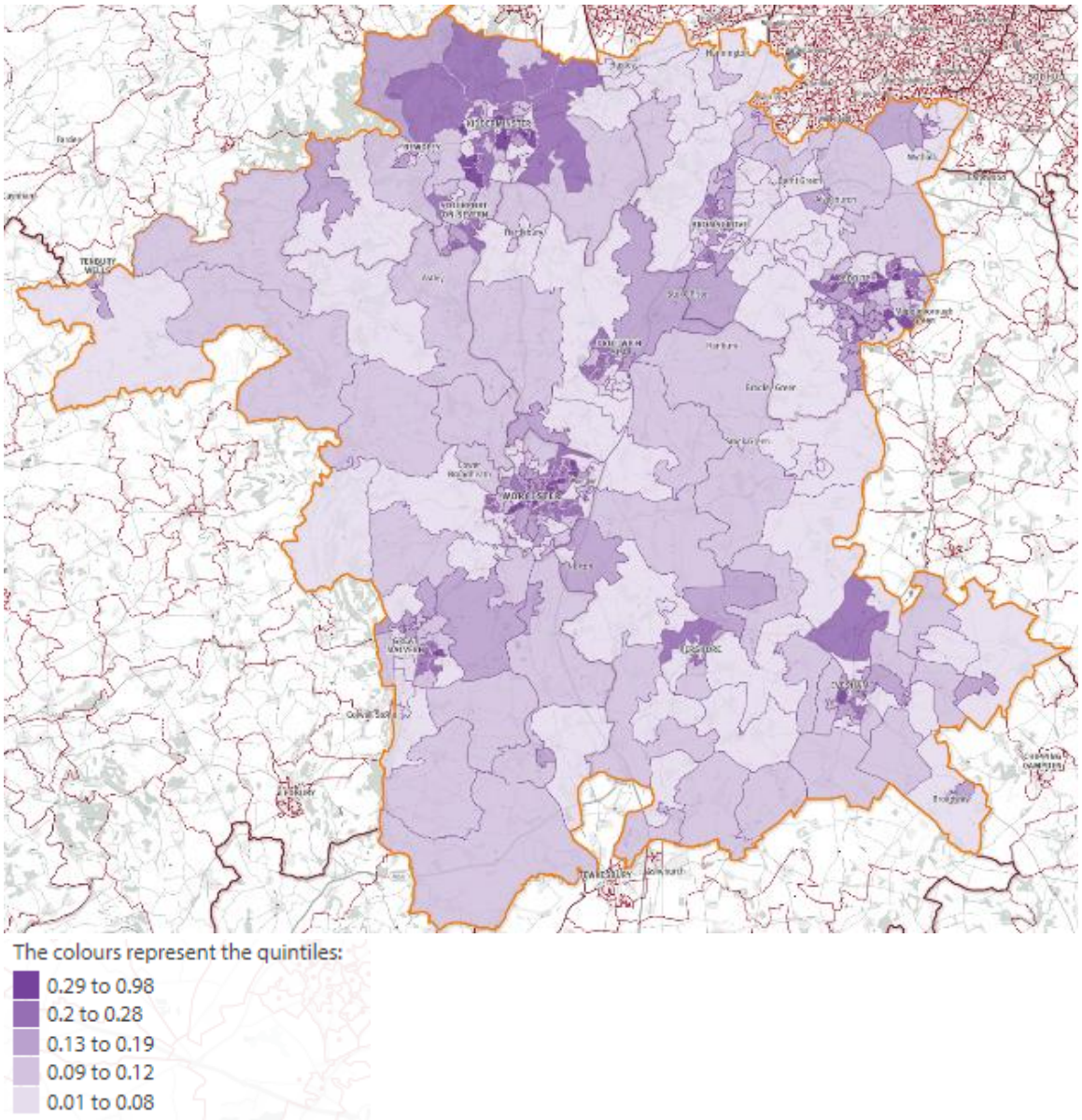
Figure 4 and Figure 5 show some variation in how deprivation affecting children and older people is geographically distributed – deprivation affecting children is more diffuse than deprivation affecting older people, which seem to be more tightly clustered around the larger towns. Figure 5 shows a higher concentration of income deprivation affecting older people in the central and northern areas of the county particularly around Worcester City and Kidderminster. Worcestershire is an affluent County relative to England, and this can mask inequalities in health across the social gradient. Careful consideration of the effect of deprivation amongst vulnerable groups is most important to prevent the inequalities gap widening.

Figure 4 Income Deprivation Affecting Children (IDACI) 2015 - Worcestershire Lower Super Output Areas (LSOAs)



Source: PHE SHAPE https://shapeatlas.net/place/

Figure 5 Income Deprivation Affecting Older People (IDAOPI) 2015 - Worcestershire Lower Super Output Areas (LSOAs)



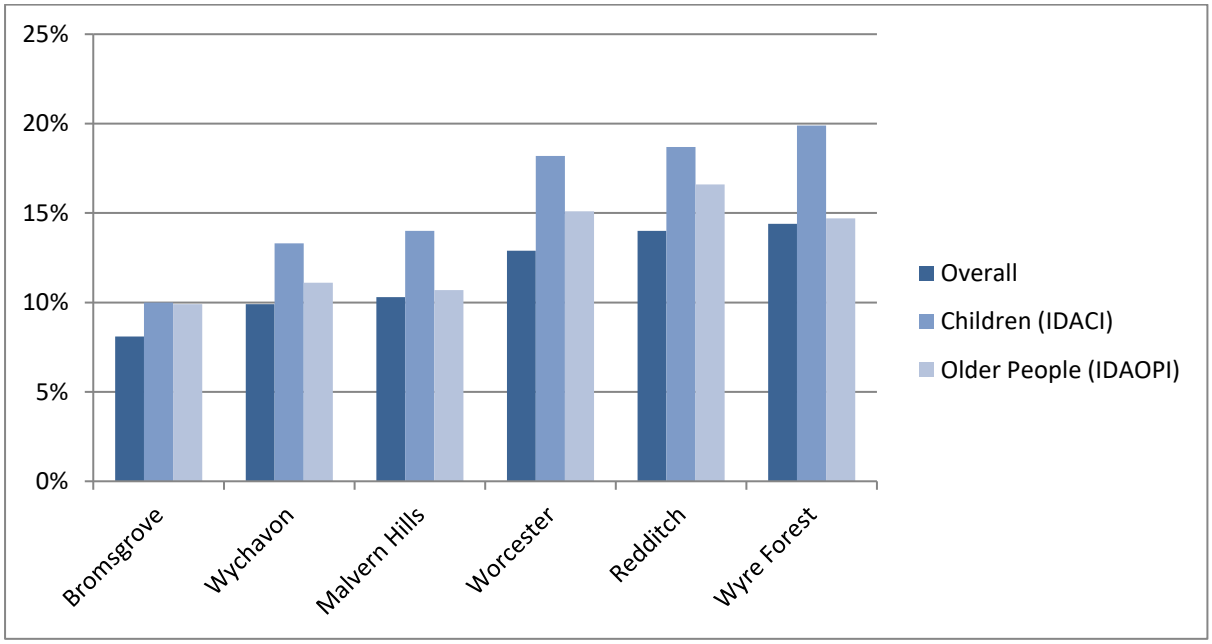
Source: PHE SHAPE https://shapeatlas.net/place/

Table 1 Percentage of the Population Affected by Income Deprivation (2015) – Worcestershire Districts

District	Overall	Children (IDACI)	Older People (IDAOPI)
Bromsgrove	8.10%	10.00%	9.90%
Malvern Hills	10.30%	14.00%	10.70%
Redditch	14.00%	18.70%	16.60%
Worcester	12.90%	18.20%	15.10%
Wychavon	9.90%	13.30%	11.10%

Wyre Forest	14.40%	19.90%	14.70%

Figure 6 Percentage of the Population Affected by Income Deprivation (2015) - Worcestershire Districts



Source: Department of Communities and Local Government

Table 1 and Figure 6 show the variation in the proportion of the population experiencing income deprivation by district and age group.

- Wyre Forest has the highest proportion of the overall population experiencing income deprivation and Bromsgrove the lowest.
- Wyre Forest has the highest proportion of children experiencing income deprivation and Redditch district the highest proportion of the older population experiencing income deprivation.
- For all districts the proportion of children experiencing income deprivation is higher than the overall population and the older population.
- The difference in income deprivation affecting children and other age groups is particularly marked in Wyre Forest district.

Further specific action is warranted in Worcester, Redditch and Wyre Forest to improve the lives and opportunities for people living in these districts, particularly for children and older people.

Homelessness and Housing

Homelessness is associated with severe poverty and is a social determinant of mental health.[19] There is considerable evidence that suggests homelessness increases the risk of poor mental health, severe ill health and disability, lower educational attainment, long-term unemployment and poverty.[20] People with poor mental health often become homeless as they may struggle, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.[21] Generally people experiencing homelessness find it difficult to access health services, including mental health care.[22]

Nationally, people who are homeless are twice as likely to have a common mental health condition, and 15 times likely to be psychotic than the general population.[23] They are also over nine times more likely to complete suicide than the general population.[24]

The homelessness review 2016 carried out by Worcestershire County Council in accordance with the Homelessness Act 2002, provided a comprehensive assessment of the nature and extent of homelessness across the six Worcestershire districts. The purpose of the review was to:

- Establish the extent of homelessness in the County
- Assess its current and likely future trends
- Identify what level of resources are available, to prevent and tackle homelessness

Results from the Worcestershire Homelessness Review 2016 confirmed that the main reasons for homelessness were:

- Family and friends being unable to accommodate
- End of assured short hold tenancies
- Breakdown of relationships, both violent and non-violent

The review highlighted that a higher number of households with more complex needs including mental health, physical health and other support needs are typically harder to sustainably rehouse.

[19] PHE Fingertips https://fingertips.phe.org.uk/search/homelessness#page/6/gid/1/pat/6/par/E12000005/ati/101/are/E07000237/iid/92641/age/-1/sex/-1

[20] Mental Health Foundation: https://www.mentalhealth.org.uk/a-to-z/h/housing-and-mental-health

[21] Mental Health Foundation: https://www.mentalhealth.org.uk/blog/homelessness-and-mental-health

[22] St Mungo's Broadway, Homeless Health Matters https://www.mungos.org/homelessness/publications-and-research/

[23] THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[24] Homelessness knowledge hub http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf

Worcestershire Homelessness – Key Indicators

Table 2 Key Homelessness Indicators

	England	West Midlands	Worcs	Worcs - count	Worcs vs. England
1.15i) Statutory homelessness – eligible homeless people not in priority need per 1000 households 2016/17 (mostly single homeless)	0.8	1.1*	1.0	240	**Significantly higher**
1.15ii) Statutory homelessness – households in temporary accommodation per 1000 households 2016/17	3.3	1.1	0.4	110	**Significantly lower**
Homelessness applications – total decisions made: rate per 1,000 households 2015/16	5.0	6.6	4.9	1198	**Similar**
Family homelessness – rate per 1000 households 2016/17	1.9	2.7	1.9	467	**Similar**
Homeless young people aged 16-24 per 1000 households 2016/17	0.56	0.81	0.75	186	**Significantly higher**

Source: Public Health Outcomes Framework
https://fingertips.phe.org.uk/search/homeless

- In 2016/17 the Worcestershire county rate of eligible homeless people 'not in priority need' was 1.0 per 1000 households (240 people) significantly higher than the England average (0.8 per 1000 households).
- There is a significantly lower than national rate of statutory homeless households in temporary accommodation recorded in Worcestershire in 2016/17 (110 households, 0.4 per 1000 households.
- This is a good outcome as people living in temporary accommodation have high rates of some infections and skin conditions; and children have high rates of accidents.
- The rate of homelessness applications in Worcestershire in 2015/16 is 4.9 per 1000 (1,198 people), this is similar to the national rate of 5.0.
- The family homelessness rate is similar to that nationally 1.8 per 1000 (449 households) compared to 1.9 for England.
- The rate of homeless young people aged 16-24 in 2016/17 is 0.75 per 1000 (186 people), which is significantly higher than the national level of 0.56.

Figure 7 Homelessness Applications Trend - Worcestershire (2011/12 to 2015/16)

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2011/12		1,369	5.9*	-	-	7.8*	5.0
2012/13		1,347	5.6*	-	-	7.4*	5.1
2013/14		1,342	5.5*	-	-	7.1*	5.0
2014/15		1,413	5.8*	-	-	7.1*	4.9
2015/16		1,198	4.9*	-	-	6.6*	5.0

Source: Department for Communities and Local Government

Source: Public Health Outcomes Framework
https://fingertips.phe.org.uk/search/homeless

The rate of homelessness applications in Worcestershire has remained at or above the England level since 2011/12, though for the last three years levels are no longer significantly higher. The gap between Worcestershire and England rates has been narrowing since 2012 and in 2016 Worcestershire improved from a rate of 5.9 per 1,000 to 4.9 per 1,000 which is similar to England's rate of 5.0 per 1,000 households.

Figure 8 Homelessness Applications - Worcestershire Districts - Total decisions made 2015/16

Homelessness applications – total decisions made: rate per 1,000 households 2015/16 — Crude rate - per 1000

Area	Count	Value	95% Lower CI	95% Upper CI
England	114,770	5.0	5.0	5.0
Worcestershire	1,198	4.9*	-	-
Malvern Hills	55	1.7	1.2	2.2
Bromsgrove	118	3.0	2.5	3.6
Wychavon	219	4.3	3.7	4.9
Redditch	212	6.0	5.2	6.9
Wyre Forest	262	6.0	5.3	6.8
Worcester	332	7.7	6.9	8.5

Source: Department for Communities and Local Government

Source: Public Health Outcomes Framework
https://fingertips.phe.org.uk/search/homeless

- Worcester district has the highest rate of homelessness applications of all the districts at 7.7 per 1000 households and this is significantly higher than the national rate.
- Malvern Hills district has the lowest rate of homelessness applications at 1.7 per 1,000 households and this is significantly lower than the national rate.
- Redditch and Wyre Forest have a homelessness applications rate of 6.0 per 1,000 household whilst Bromsgrove and Wychavon have a rate of 3.0 and 4.3 per 1,000 households respectively.

There are many homelessness services provided across Worcestershire. These include services provided and commissioned by the districts and those provided by the voluntary sector. Such support and services include all, but are not limited to, the following:

- Advice and Assistance - offered to anybody who makes an approach and dealt with on a case by case basis
- Homelessness Assessment - generally carried out under the terms of the Housing Act 1996 part VII[25]
- Temporary Accommodation - this service is only offered to those households to whom a duty is owed under homelessness legislation
- Strategic and Partnership - focusses on single homeless and childless couples as well as working more generally across housing and homelessness issues across all districts. Support given includes homeless prevention/help to stay in your home, access to items that will enable a tenancy to be sustained, help with certain bills and housing costs that will enable a tenancy to be sustained, access to financial assessments, money advice, food banks and charitable organisations
- Young Persons - also known as 'The Positive Pathway', aim to prevent young people from becoming homeless. The scheme provides an integrated advice, mediation, referral and assessment service and supported accommodation in conjunction with Children's Services
- Discretionary Welfare and Emergencies – mainly in Worcester City where the homelessness prevalence is higher, the service helps with goods or vouchers but not cash to help individuals or families facing exceptionally difficult circumstances or an emergency. The scheme offers no entitlement or statutory rights and prioritises the greatest needs of the most vulnerable people particularly those that can't meet their immediate short-term needs or where they need help to keep their independence or re-integrate within the community

[25] The Housing Act 1996 https://www.legislation.gov.uk/ukpga/1996/52/part/VII

Housing

Insecure, poor quality and overcrowded housing causes stress, anxiety, and depression, and exacerbates existing mental health conditions. The evidence available shows that:

- Adolescents living in cold housing are at a significantly greater risk of developing multiple mental health conditions[26]
- Older people living in cold homes are susceptible to social isolation[27]
- People living in hostels, prison, hospitals and the streets are more vulnerable to mental health problems than the general population[28]

The physical and mental health effects of poor housing disproportionately affect vulnerable people, especially older people, which can be made worse if they are living isolated lives, often without a support network.
With particular focus on mental well-being and health, the physical and built environment can shape mobility, social networks and the interactions that can promote individual and community inclusion or create forms of exclusion.

In some cases, poor housing may cause people to be alienated from their neighbourhood because of, for example, fear of crime brought about by poorly designed housing.

Housing Tenure and Affordability - Worcestershire

There is increasing evidence of a direct association between unaffordable housing and poor mental health, over and above the effects of general financial hardship.[29] The type of housing tenure may be an important factor in determining how individuals experience and respond to housing affordability problems.[30]

Figure **9** illustrates the breakdown of property by tenure in Worcestershire.

[26] Minimum home temperature thresholds for health in winter – A systematic literature review https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/468196/Min_temp_threshold_for_homes_in_winter.pdf

[27] Public Mental Health Priorities: Investing in the Evidence https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

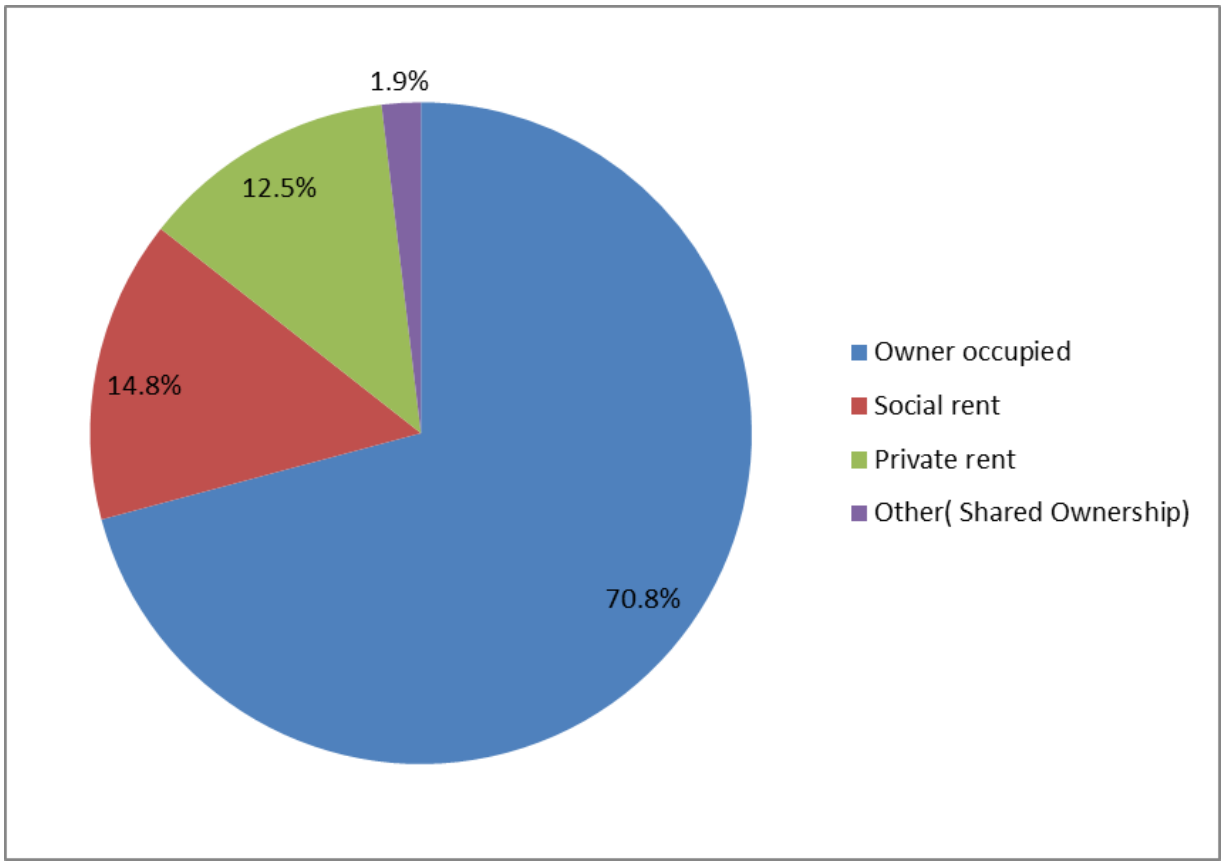
[28] Homelessness and mental health: adding clinical mental health interventions to existing social ones can greatly enhance positive outcomes https://www.emeraldinsight.com/doi/abs/10.1108/17465721111154284

[29] Mason K.E., Baker E., Blakely T., Bentley R.J. Housing affordability and mental health: does the relationship differ for renters and home purchasers? 10.1016/j.socscimed.2013.06.023

[30] Bentley R., Baker E., Mason K., Subramanian S.V., Kavanagh A.M. Association Between Housing Affordability and Mental Health: A Longitudinal Analysis of a Nationally Representative Household Survey in Australia. Am. J. Epidemiol https://academic.oup.com/aje/article/174/7/753/115870

The quality and affordability of housing in Worcestershire varies between the different tenures. Worcestershire has a high proportion of households within the private sector which generally has the highest number of unhealthy homes.

Figure 9 Worcestershire Housing Stock



Source: Worcestershire County Council, 2017
https://www.worcester.gov.uk/documents/10499/5660094/Worcestershire+Strategic+Housing+Partnership+Document.pdf/95830938-7f91-83ae-3839-d43ff6356163

Table 3 Worcestershire - Types of Housing Tenure

Owner Occupation	Private Rent	Social/Affordable Rent
70.8% homes in Worcestershire	12.5% of homes in Worcestershire	14.8% homes in Worcestershire
Shrinking tenure: future unknown?	Growing tenure and expected to continue	Shrinking tenure and will continue
Highest number of unhealthy homes	Highest prevalence of unhealthy homes	Healthiest homes

Least accessible homes	Second most accessible homes	Highest % accessible homes
Least overcrowded and most under-occupied	Second most overcrowded & least under-occupied	Most overcrowded and least under-occupied
Most affordable tenure – if you are able to put down a deposit or are if you are already a home owner	Least affordable tenure (housing costs)	Second most affordable tenure (housing costs)
Highest number of older households	Higher proportion of working age and family households	Higher proportion of older households

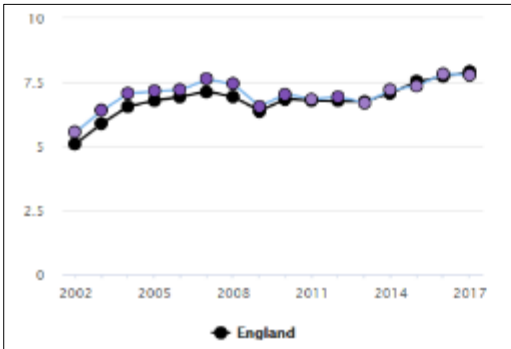
Source: Worcestershire County Council, 2017
https://www.worcester.gov.uk/documents/10499/5660094/Worcestershire+Strategic+Housing+Partnership+Document.pdf/95830938-7f91-83ae-3839-d43ff6356163

The 2016 Affordable Housing Adopted Supplementary Planning Document (SPD) for Malvern Hills, Worcester and Wychavon districts provides policies that relate to the provision of affordable housing. It is a guide intended to help developers, landowners, and applicants applying for planning permission, registered providers and others who are seeking to provide or benefit from affordable housing.
To maximise positive health outcomes and reduce risk factors related to housing Health Impact assessments (HIAs) are incorporated into local planning in South Worcestershire. HIAs can influence the planning of housing and other developments to reduce mental wellbeing risk factors. Locally, there are opportunities for improving health particularly through improving:

- neighbourhood design,
- the quality of housing,
- planning for an ageing population,
- access to quality food,
- the environment,
- sustainable transport, infrastructure and road safety.

The affordability of home ownership can be measured by the ratio of median house price to median gross annual residence-based earnings. A higher ratio indicates that on average, it is less affordable for a resident to purchase a house in their local authority district. Figure 10 shows that Worcestershire has followed a similar trend to that seen nationally with housing becoming increasingly less affordable.

Figure 10 Affordability of Home Ownership



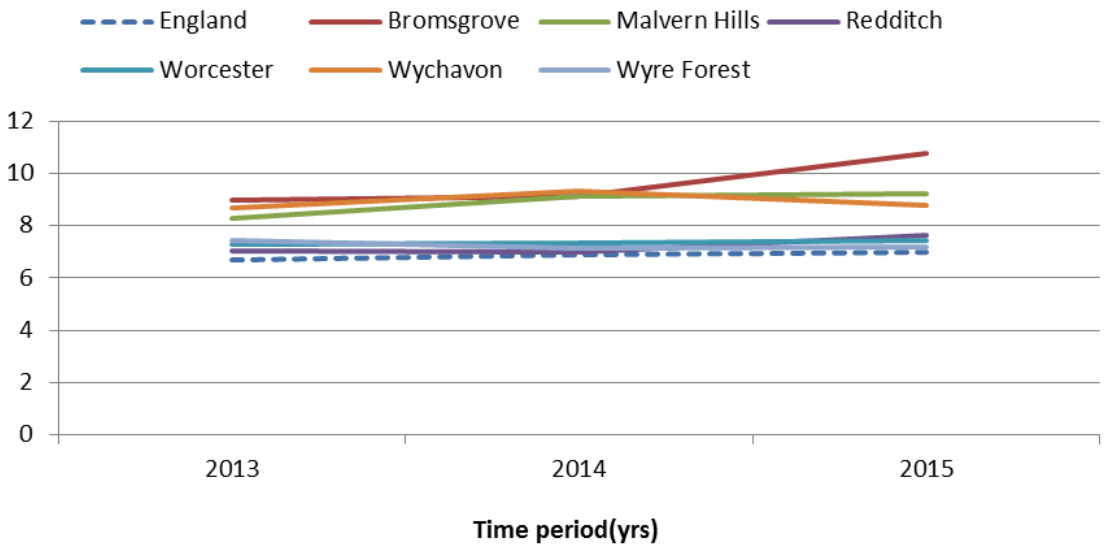
Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2002		110,500	5.6	-	-	4.4	5.1
2003		132,550	6.4	-	-	5.2	5.9
2004		152,000	7.1	-	-	6.0	6.6
2005		162,000	7.2	-	-	6.2	6.8
2006		165,000	7.2	-	-	6.3	7.0
2007		175,500	7.6	-	-	6.5	7.1
2008		176,000	7.4	-	-	6.1	6.9
2009		165,000	6.6	-	-	5.8	6.4
2010		174,000	7.0	-	-	6.2	6.9
2011		172,000	6.9	-	-	5.9	6.8
2012		174,000	6.9	-	-	5.9	6.8
2013		175,000	6.7	-	-	5.8	6.8
2014		183,725	7.2	-	-	6.2	7.1
2015		195,000	7.4	-	-	6.3	7.5
2016		207,000	7.8	-	-	6.4	7.7
2017		220,000	7.8	-	-	6.6	7.9

Source: Data is sourced from the ONS and based upon House Price Statistics for Small Areas (HPSSAs) and Annual Survey of Hours and Earnings data

Source: Public Health Outcomes Framework https://fingertips.phe.org.uk/search/housing

Figure 11 Housing Affordability - Worcestershire Districts 2013-15 (Ratio)



Source: Public Health Outcomes Framework https://fingertips.phe.org.uk/search/housing

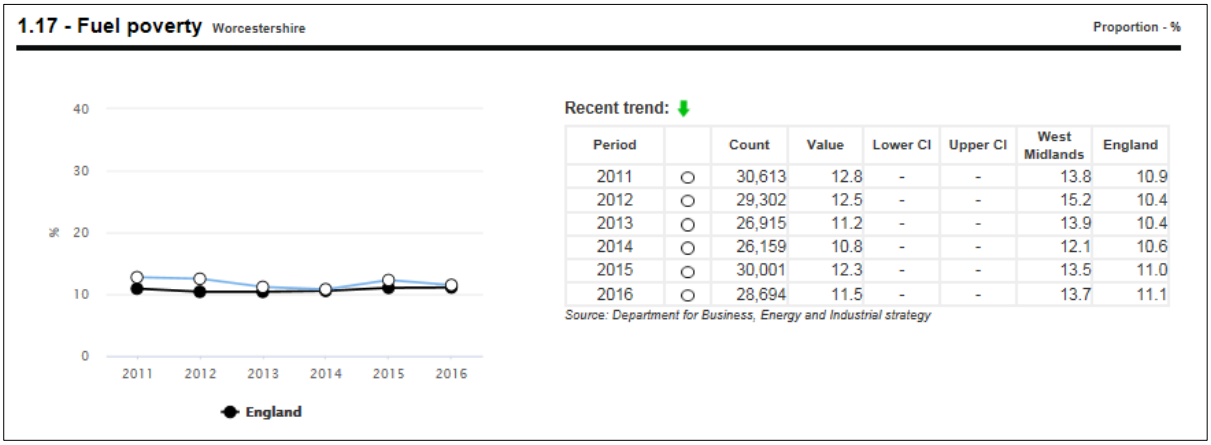
- The ratio of lower quartile house price to lower quartile earnings relates to the respondents' place of work rather than their place of residence.
- A higher ratio means housing is less affordable.
- Bromsgrove has the highest affordability ratio at 10.8 compared to England's 7.0.
- Redditch, Worcester and Wyre Forest have affordability ratios similar to England.
- Malvern Hills and Wychavon are also relatively high with ratios of 9.2 and 8.8.

It will be interesting to see if the introduction of the Affordable Housing Adopted Supplementary Planning Document (SPD) and the Health Impact assessments (HIAs) incorporated into local planning will yield better housing affordability.

Fuel Poverty

Fuel poverty is a good indicator to show financial insecurity. A household is in fuel poverty if they are on a low income and struggle to pay heating costs (this may be due to an inefficient heating system and/or poor insulation).

Figure 12: **Fuel Poverty % of Households 2011-2016**



Recent trend: ⬇

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2011	○	30,613	12.8	-	-	13.8	10.9
2012	○	29,302	12.5	-	-	15.2	10.4
2013	○	26,915	11.2	-	-	13.9	10.4
2014	○	26,159	10.8	-	-	12.1	10.6
2015	○	30,001	12.3	-	-	13.5	11.0
2016	○	28,694	11.5	-	-	13.7	11.1

Source: Department for Business, Energy and Industrial strategy

Source: Public Health England https://fingertips.phe.org.uk/

- In 2016, Worcestershire had worse fuel poverty rates compared to England at 11.5% of households in fuel poverty compared to 11.1% nationally.
- The recent trend in Worcestershire has been downwards.
- Worcestershire had 12.8% of households in fuel poverty in 2011 compared to 11.5% in 2016.

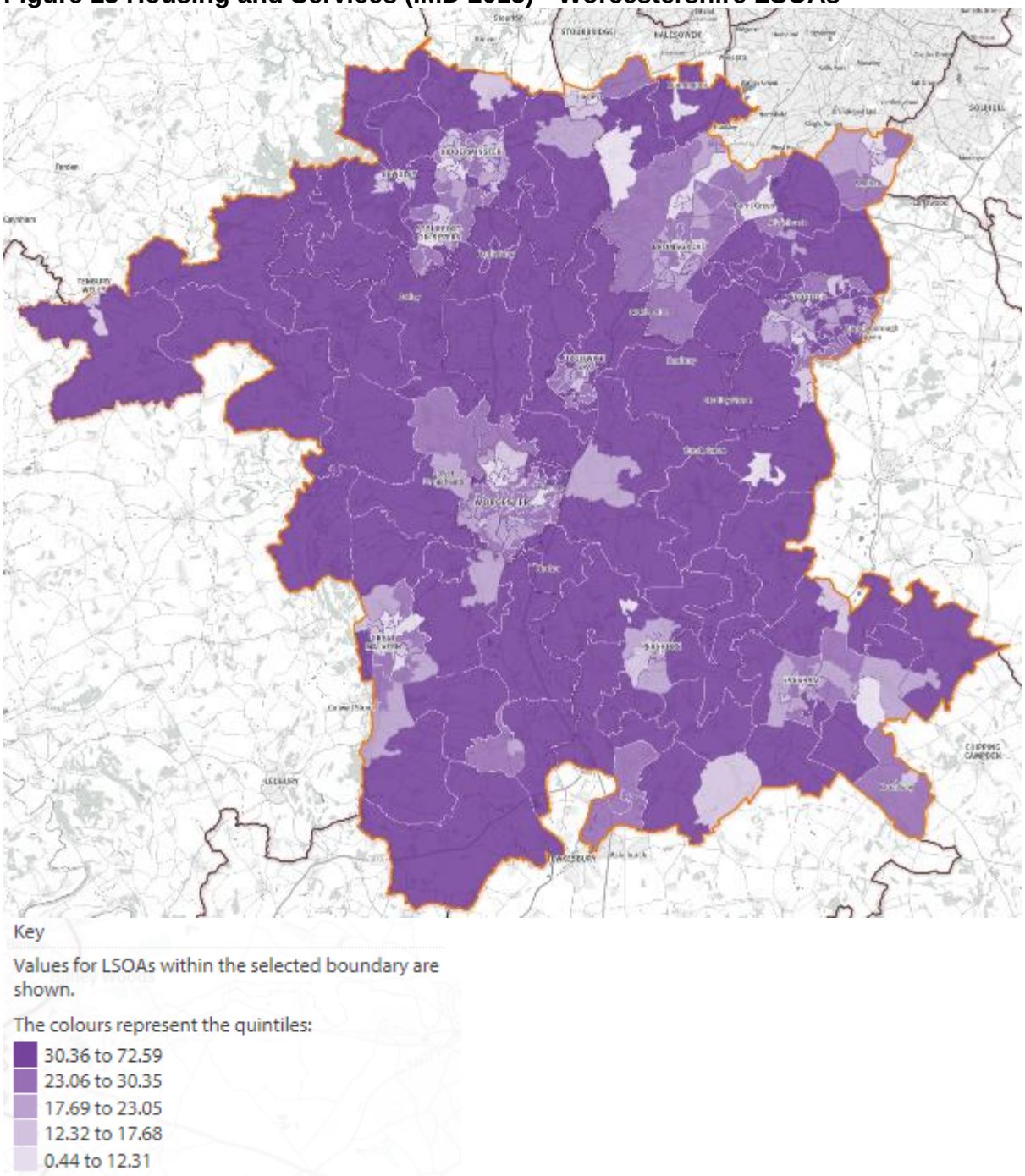
Barriers to Housing and Services (IMD 2015)

The Barriers to Housing and Services Domain of the IMD measures the physical and financial accessibility of housing and local services. The indicators that comprise the measure 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.[31]

[31]The English Indices of Deprivation 2015; https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Figure 13 shows where Worcestershire LSOAs sit within national rankings on this index. The darker the shade the more deprived the area on this measure. It can be seen that more rural LSOAs face greater deprivation in terms of barriers to housing and local services. Deprivation within rural areas can be compounded by factors such as car ownership and needing to travel further to services, which can further add to the cost of living.

Figure 13 Housing and Services (IMD 2015) - Worcestershire LSOAs



Source: Public Health England. SHAPE. Available at: https://shapeatlas.net/place/

Education and Lifelong Learning

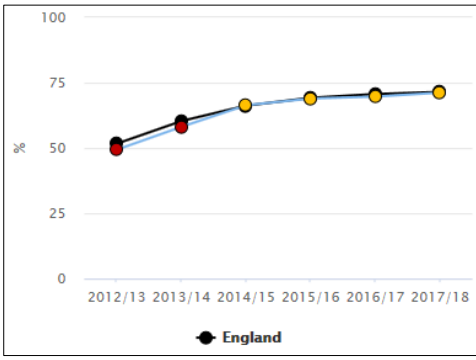
Education is an important part of early years development and significant in determining adult health and well-being. Education improves peoples' life chances, increases their ability to access health services and enables them to live healthier lives. Differences in development by social background emerge early in life and children from deprived backgrounds are more at risk of poorer development.[32]

For adults, lifelong learning opportunities can increase the ability of those with low educational attainment to exert control of their lives. Participation in adult learning can help promote well-being and protect against age-related cognitive decline in older adults. Community-based adult education programmes can be a form of social prescribing for mild-to-moderate anxiety and depression and have been found to reduce symptoms by offering access to social networks and activities.

Education can also improve levels of health literacy. This can be defined as 'the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health'. People with low health literacy experience a range of poorer health outcomes and are more likely to engage in behaviours that risk their health. Practitioners can increase levels of health literacy by improving people's access to health information, for example by using accessible language.

School readiness is a key measure of early years development across a wide range of developmental areas.

Figure 14 Percentage of Children Achieving a Good Level of Development at the End of Reception %



Recent trend: ⬆

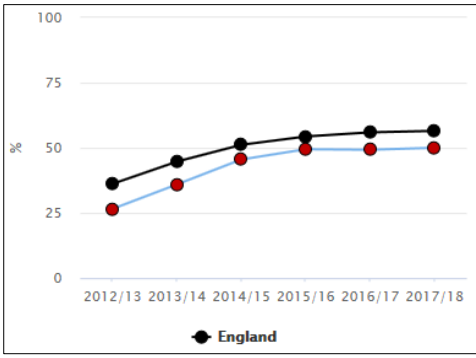
Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13	●	3,030	49.4	48.1	50.6	50.0	51.7
2013/14	●	3,598	58.1	56.9	59.4	58.4	60.4
2014/15	●	4,246	66.4	65.2	67.6	64.3	66.3
2015/16	●	4,450	69.0	67.9	70.1	67.1	69.3
2016/17	●	4,638	69.7	68.6	70.8	68.6	70.7
2017/18	●	4,605	71.2	70.1	72.3	69.8	71.5

Source: Department for Education (DfE), EYFS Profile: EYFS Profile statistical series

Source: Public Health Outcomes Framework https://fingertips.phe.org.uk/search/education

[32] Early years foundation stage profile results: 2017 to 2018 https://www.gov.uk/government/statistics/early-years-foundation-stage-profile-results-2017-to-2018

Figure 15 Percentage of Children with Free School Meal Status Achieving a Good Level of Development at the End of Reception %



Recent trend: ↑

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13	●	228	26.6	23.8	29.7	36.1	36.2
2013/14	●	319	36.0	32.9	39.2	44.3	44.8
2014/15	●	350	45.6	42.1	49.1	51.0	51.2
2015/16	●	400	49.5	46.1	52.9	54.2	54.4
2016/17	●	385	49.3	45.8	52.8	55.7	56.0
2017/18	●	370	50.1	46.5	53.7	57.1	56.6

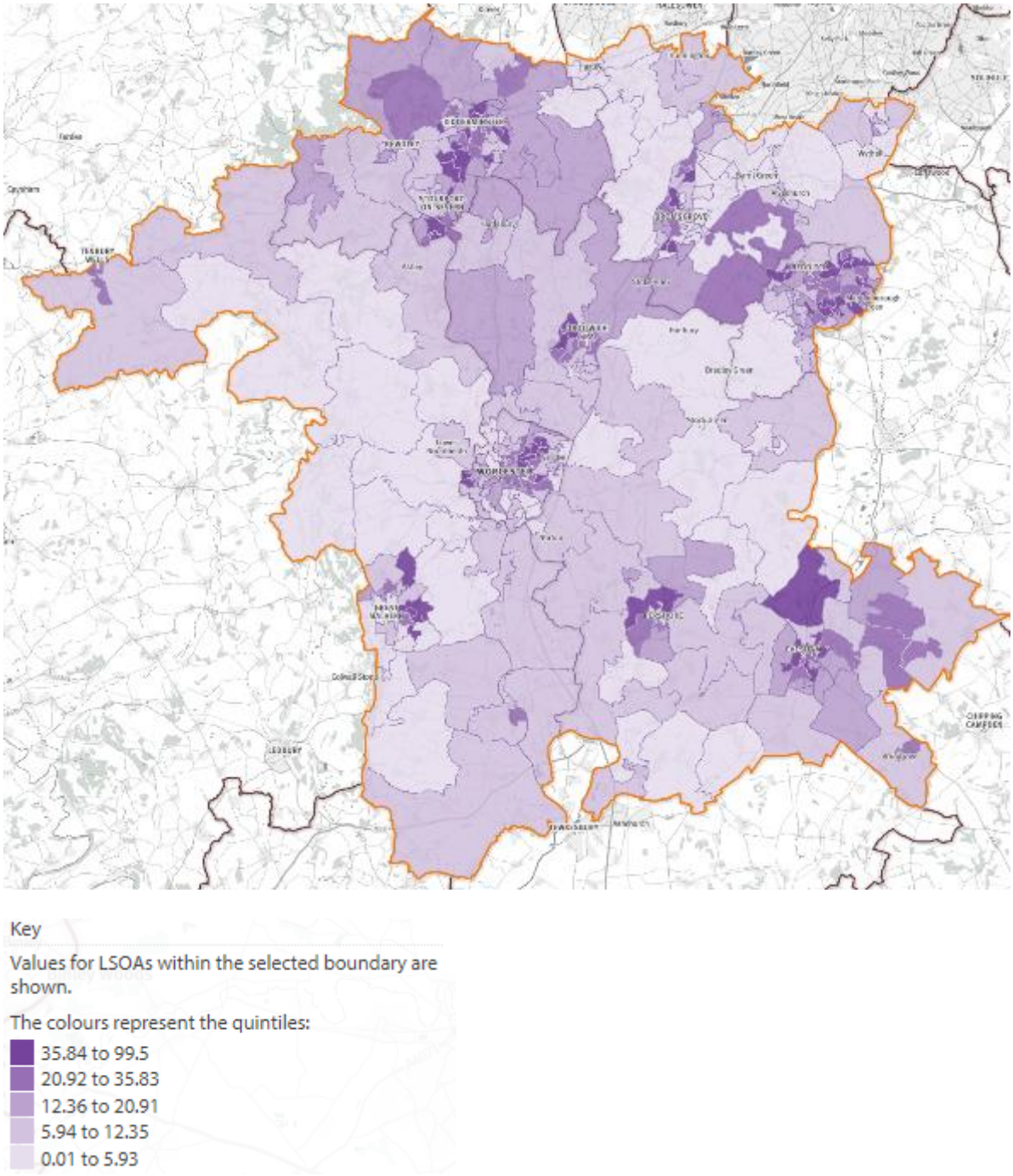
Source: Department for Education, Early Years Foundation Stage Profile (EYFS Profile): Early Years Foundation Stage Profile statistical series

Source: Public Health Outcomes Framework https://fingertips.phe.org.uk/search/education

Worcestershire is similar to England for the percentage of children achieving a good level of development at the end of reception, however, this is not the case for children with free school meal status. For these children the percentage achieving a good level of development at the end of reception is significantly worse than England as a whole. Both measures have recently showed improvement, but inequalities persist. The persistent pattern of lower levels of development at the end of reception may be a negative force against social mobility and reinforcing deprivation within families.

Figure 16 shows how Worcestershire LSOAs rank nationally for education, skills and training deprivation. Darker coloured areas are relatively more deprived. There are pockets of education, skills and training deprivation particularly around the larger towns and towards the north of the county.

Figure 16. Education, Skills and Training Deprivation - Worcestershire LSOAs

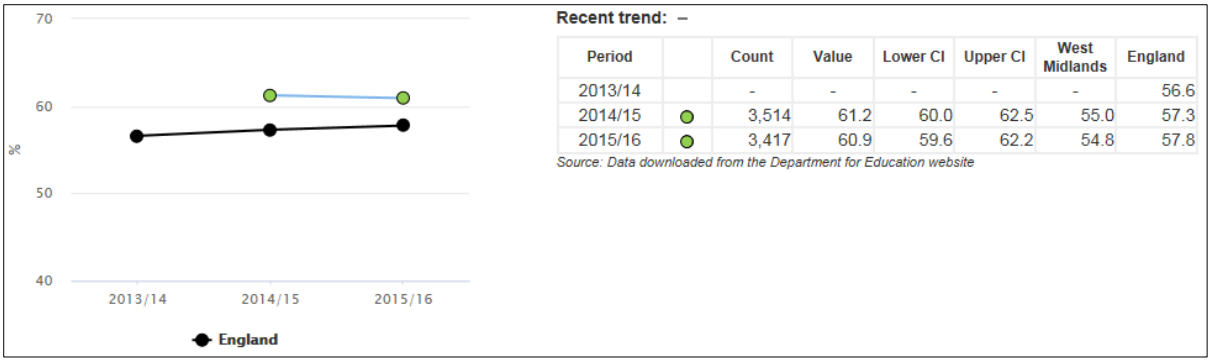


Source: PHE SHAPE https://shapeatlas.net/place/

Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstance. Reducing educational inequalities involves understanding the interaction between the social determinants of educational outcomes, including family background, neighbourhood and relationships with peers, as well as what goes on in schools.
The Marmot review stresses the importance of investing in the early years and the benefits it has on improving early cognitive and non-cognitive development and children's readiness for school. It is important that children and young people can develop skills for life and for work as well as attain qualifications particularly at the GCSE level.

Children with poorer mental health are more likely to have lower educational attainment.

Figure 17 GCSE Attainment (5 A*-C including English and Maths); %



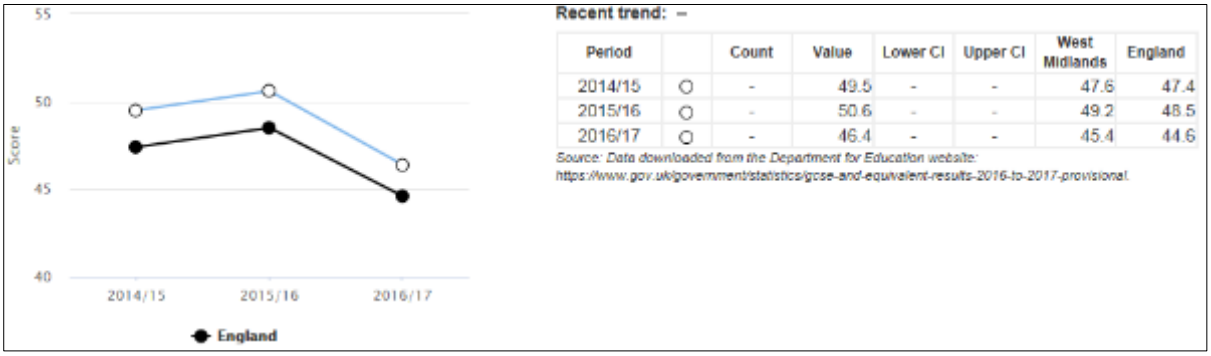
Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14		-	-	-	-	-	56.6
2014/15	●	3,514	61.2	60.0	62.5	55.0	57.3
2015/16	●	3,417	60.9	59.6	62.2	54.8	57.8

Source: Data downloaded from the Department for Education website

Source: Public Health Outcomes Framework https://fingertips.phe.org.uk/search/education

Figure 18 Attainment 8; Average (Mean) Score



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2014/15	○	-	49.5	-	-	47.6	47.4
2015/16	○	-	50.6	-	-	49.2	48.5
2016/17	○	-	46.4	-	-	45.4	44.6

Source: Data downloaded from the Department for Education website:
https://www.gov.uk/government/statistics/gcse-and-equivalent-results-2016-to-2017-provisional

Source: Public Health Outcomes Framework https://fingertips.phe.org.uk/search/education

In 2015/16 Worcestershire's GCSE attainment was better than the England average with 60.9% of pupils achieving 5A* to C including maths and English compared to 57.8% nationally.

The average attainment 8 score[33] for Worcestershire of 46.4 was similar to England's 44.6 in 2016/17. However, using a mean score masks some variation in achievement by district as it is known that Malvern Hills achieves better than England on this measure.
The place where children and young people spend their learning time gives a key opportunity for health improvement, nurturing their physical and mental health, and enabling them to maximise the benefit of the education offer, which brings lifelong health benefit.[34]

Institutions of learning, for example, universities, colleges, schools and nurseries have an important role in promoting mental health through developing skills that help people to function and make decisions in life. Well implemented interventions can promote resilience and develop the coping skills of all pupils while also targeting help to those with mental health problems.[35]

Robust evidence shows that interventions taking a "whole school approach" have a positive impact in relation to many mental health risk factors including: body mass index (BMI), physical activity, alcohol and substance misuse, and bullying.

A whole school approach goes beyond learning and teaching in the classroom to pervade all aspects of the life of a school including:

- culture, ethos and environment: the health and wellbeing of students and staff is promoted through the 'hidden' or 'informal' curriculum, including leadership practice, the school's values and attitudes, together with the social and physical environment
- learning and teaching: using the curriculum to develop pupils' knowledge, attitudes and skills about health and well-being
- Partnerships with families and the community: proactive engagement with families, outside agencies, and the wider community to promote consistent support for children and young people's health and well-being

[33] Attainment 8 measures the achievement of a pupil across 8 qualifications. These qualifications are:

1. A double weighted maths element that will contain the point score of the pupil's English Baccalaureate (EBacc) maths qualification.
2. An English element based on the highest point score in a pupil's EBacc English language or English literature qualification. This will be double weighted provided a pupil has taken both qualifications.
3. An element which can include the three highest point scores from any of the EBacc qualifications in science subjects, computer science, history, geography, and languages. For more information see the list of qualifications that count in the EBacc. The qualifications can count in any combination and there is no requirement to take qualifications in each of the 'pillars' of the EBacc.
4. The open element contains the three highest point scores in any three other subjects, including English language or literature (if not counted in the English slot), further GCSE qualifications (including EBacc subjects) or any other technical awards from the DfE approved list: http://www.gov.uk/government/collections/performance-tables-technical-and-vocational-qualifications).

[34] Director of Public Health Report 2018
http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1498/jsna_director_of_public_health_annual_reports

[35] Faculty of Public Health. http://www.fph.org.uk/uploads/Thinking%20Ahead.pdf

Employment and Working Conditions

Good employment is a protective factor for mental health and can be a vital element of recovery from mental health problems whilst unemployment and unstable employment are risk factors for mental health.

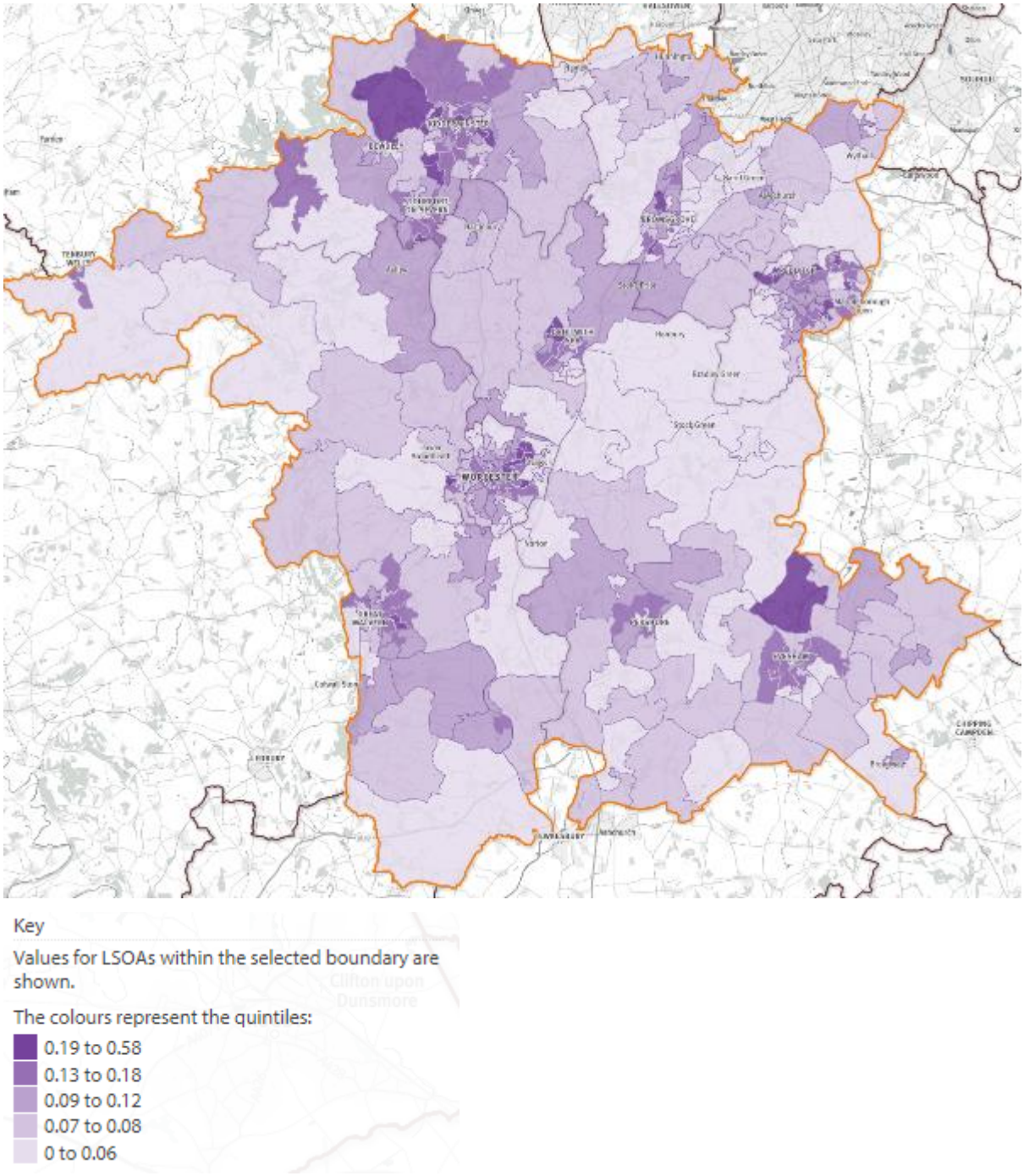
People who are unemployed are between four and 10 times more likely to report anxiety and depression and to complete suicide.[36]

Workplaces can provide opportunities that promote well-being and support people to 'build resilience, develop social networks and develop their own social capital'.[37] However, it is important to distinguish between 'good work' and 'bad work' as some forms of employment and work, can be abused by authorities and lead to financial insecurity, anxiety, stress and other forms of mental and physical ill-health.[38]

There is a case for business and communities to provide a culture of participation, equality and fairness and to develop social networks needed for promoting resilience and social capital.[39] Social capital is explained in more detail in later in this section.

[36] Waddell G, Burton A (2006). Is Work Good for Your Health and Well-being? London: http://iedereen-aandeslag.nl/wp-content/uploads/2016/07/hwwb-is-work-good-for-you.pdf
[37] HM Government (2016). No Health Without Mental Health https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
[38] University of Cambridge (2014) Zero-hours contracts are 'tip of the iceberg' of damaging shift work, say researchers https://www.cam.ac.uk/research/news/zero-hours-contracts-are-tip-of-the-iceberg-of-damaging-shift-work-say-researchers
[39] NICE (2015) Workplace health: management practices: NICE guideline https://www.nice.org.uk/guidance/ng13

Figure 19 Employment Deprivation (2015) - Worcestershire



Source: PHE SHAPE https://shapeatlas.net/place/

Table 4 Employment Related Indicators - Worcestershire vs England

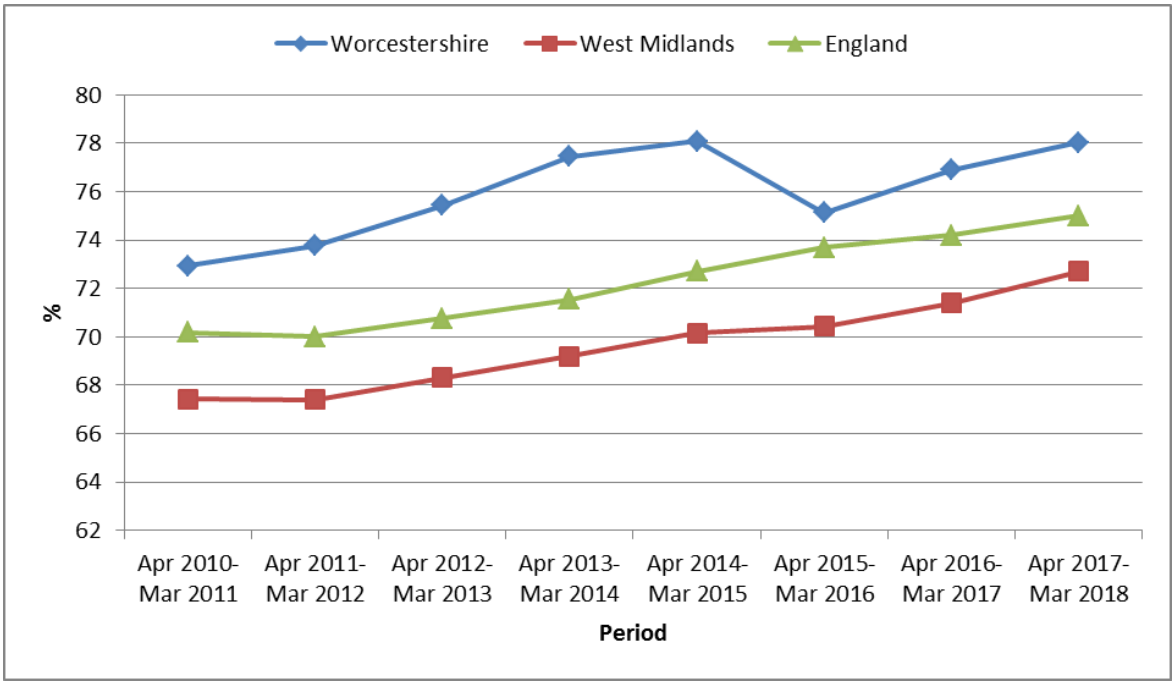
Indicator	Period	England	Worcestershire		Recent Trend
Percentage of people aged 16-64 in employment	2017/18	75.2	78.0	Better	Increasing
Unemployment	2017	4.4	3.7	Similar	-
Employment and Support Allowance (ESA) claimants	2018	5.4	4.8	Better	Decreasing
Economic inactivity rate	2016/17	21.8	20.1	Similar	Increasing
ESA claimants for mental and behavioural disorders: rate per 1,000 working age population	2016	27.5	24.0	Lower	Increasing

Source: Public Health Outcomes Framework https://fingertips.phe.org.uk/search/employment

- Worcestershire has a better rate of employment for the 16-64 aged population and the rate is increasing.
- The economic inactive rate is similar to England; however, recent trend is increasing.
- The overall unemployment levels are similar in Worcestershire compared to England.
- The rate of Employment and Support Allowance (ESA) claimants in Worcestershire was better than England in 2018 and the trend was decreasing. New claims for income-related ESA now have to claim Universal Credit and so claims for ESA will follow a decreasing trend as a result.
- The rate of ESA claimants for mental and behavioural disorders was lower amongst the working age population in 2016 but the trend was increasing. There is no current or recent data to review the trend.

The proportion of the population in Worcestershire who are in employment age groups is similar to England.

Figure 20 Employment Rates - Aged 16-64 (2011-2018)



Source: Office for National Statistics, 2017. Annual Population Survey

Table 5 Employment Rate by Age Group – 2017

Age Group	Worcestershire	West Midlands	England
16-24	55.5	50.0	**53.6**
25-49	86.7	81.0	**83.4**
50-64	70.8	69.8	**71.0**
50+	42.4	40.2	**41.6**
65+	**13.5**	**9.8**	**10.5**

Source: Office for National Statistics, 2017, Annual Population Survey

When broken down by age group the proportion of the 25-49 and 65+ age groups in employment is significantly higher in Worcestershire than both the West Midlands and England.

In Worcestershire, in 2016/17, 36.0% of people with a long-term health condition were employed compared to 29.4% in England. But recently there has been a significant increase in the gap in the employment rate between those with long-term health conditions and the overall employment rate.

Crime, Safety and Violence

Most crimes are committed by people who do not have mental health problems - people with mental health problems are three times more likely to be a victim of crime than the general population.

The major determinants of violence are socio-economic factors and substance misuse. Violence and abuse are closely connected to other issues such as poor health, child poverty, social exclusion and economic and educational disadvantage.

Being a victim of crime, or exposure to violent or unsafe environments can increase the risk of developing a mental health problem. The most serious example is child abuse, which can have a sustained detrimental impact on mental health.

Being a survivor of domestic abuse also increases the risk of mental health problems and there are high rates of mental health conditions (particularly Post Traumatic Stress Disorder; PTSD) among people who have been raped and among women who have undergone female genital mutilation.

Many people in contact with justice services with mental health problems will additionally be experiencing other issues such as difficulty accessing good quality homes, employment and income. This may result in their mental health deteriorating.

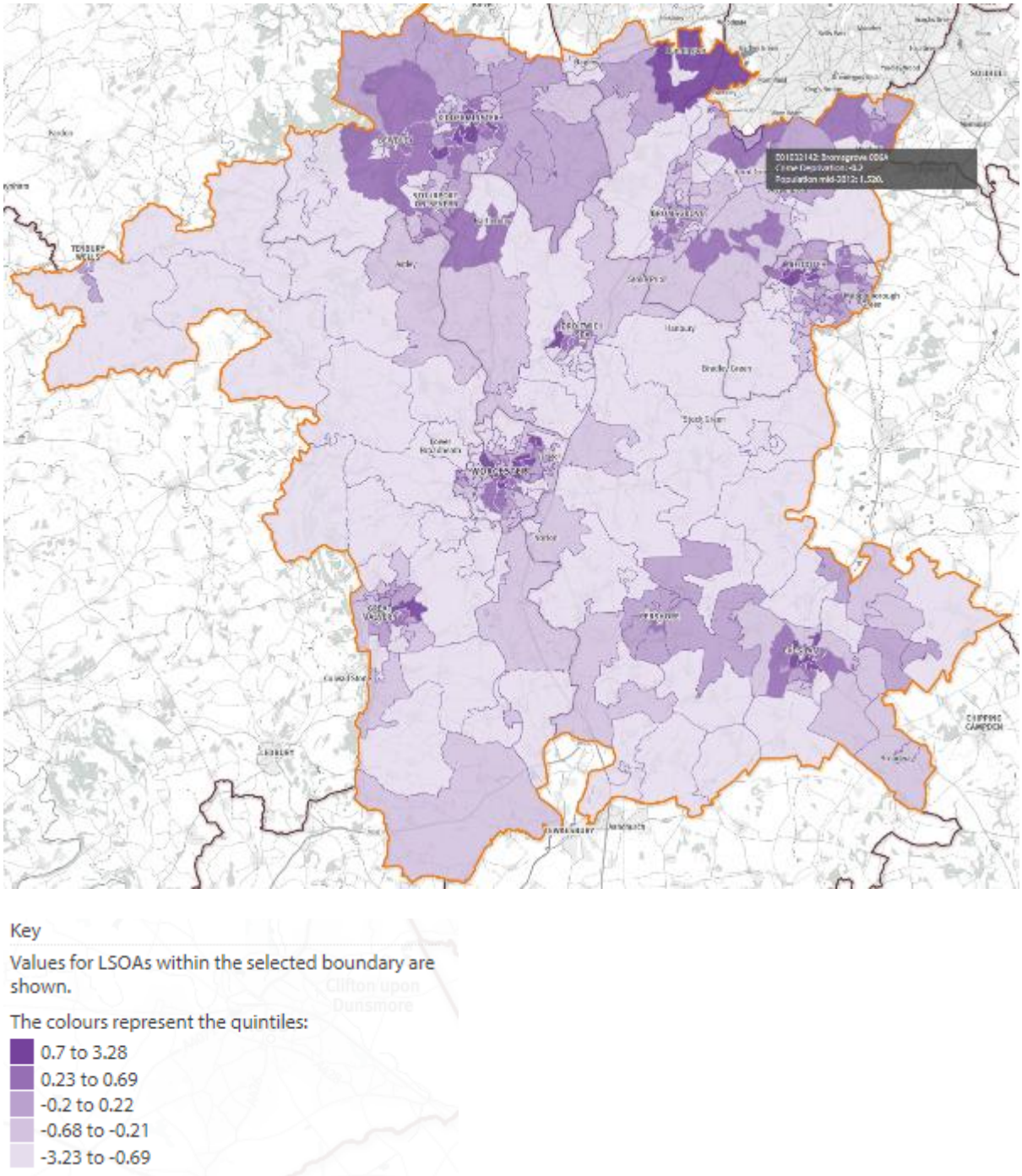
Addressing the links between mental health and crime requires partnership work between a range of agencies including education, health, public health, police, the judiciary, places of custody and the range of community organisations which help people in contact with justice services.

Crime by its very nature is usually secret and consequently under-reported.[40]

Figure 21 shows how Worcestershire LSOAs rank nationally for crime deprivation. The darker coloured areas are relatively more deprived on this measure. Crime deprivation is clustered around the larger towns and in the north of the county.

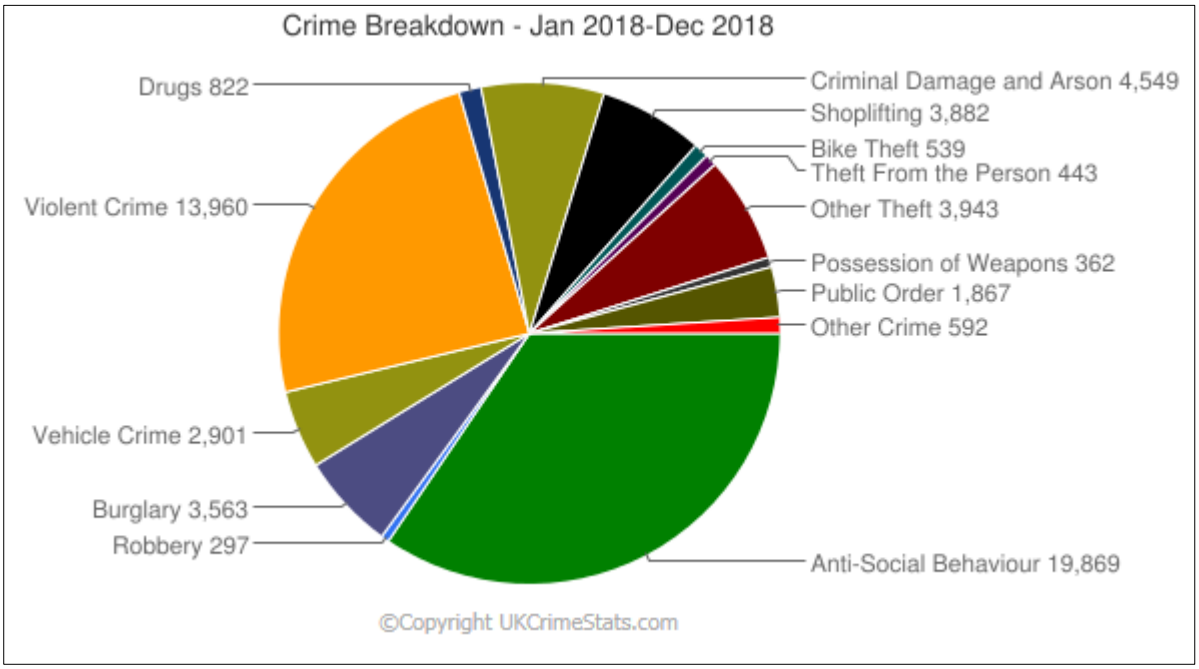
[40] UK crime stats: http://www.ukcrimestats.com/Subdivisions/CTY/2246/

Figure 21 Crime Deprivation (2015)



Source: PHE SHAPE https://shapeatlas.net/place/

Figure 22 Recorded Crime and Anti-Social Behaviour - Worcestershire 2018

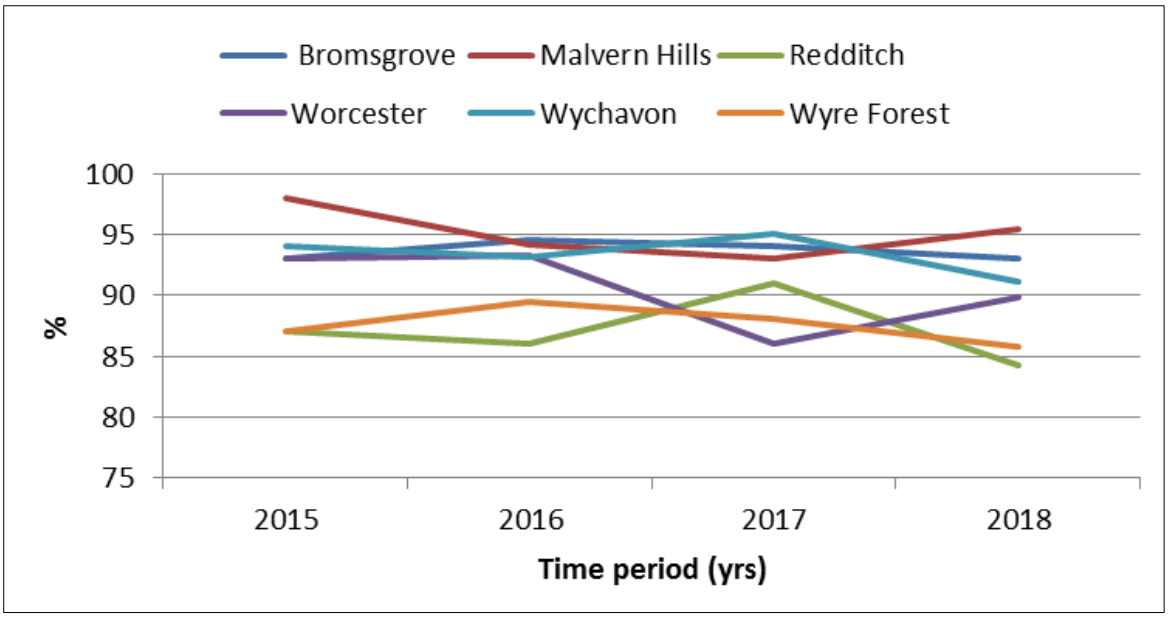


Source: UK crime stats: http://www.ukcrimestats.com/Subdivisions/CTY/2246/

Anti-social behaviour constitutes the largest proportion of recorded crime in Worcestershire with 19,869 incidents recorded in 2018. The next commonest type of crime recorded was Violent Crime (13,960 incidents) followed by Criminal Damage and Arson (4,549 incidents).

Questions on whether people living in Worcestershire feel safe in their community are included in The Worcestershire County Council Viewpoint Survey.

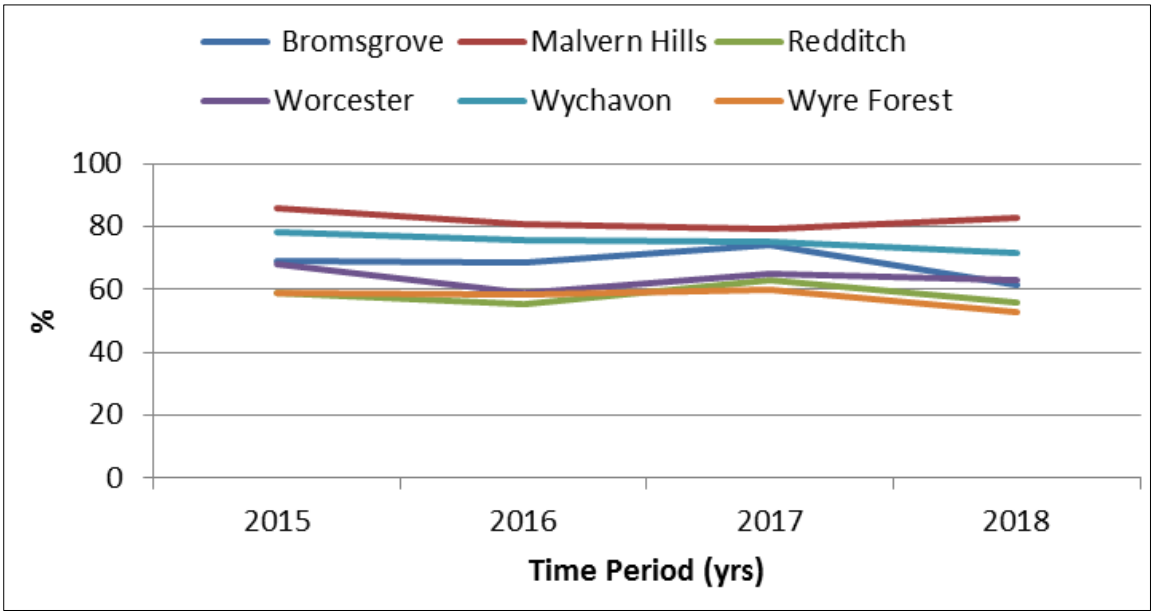
Figure 23 Viewpoint Survey Question - Do You Feel Safe During the Day?



Source: Worcestershire County Council

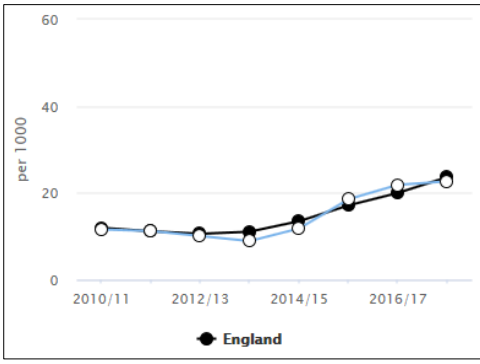
In 2018 Malvern Hills had the highest proportion of respondents that felt safe during the day and Wyre Forest and Redditch districts the lowest.

Figure 24 Viewpoint Survey Question- Do You Feel Safe at Night?



Respondents didn't feel as safe in their local areas at night.

Figure 25 Violent Crime (Including Sexual Violence) – Offences per 1,000 population Worcestershire 2010-2018



Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010/11	○	6,544	11.6	11.4	11.9	12.4	12.0
2011/12	○	6,352	11.3	11.0	11.5	10.8	11.2
2012/13	○	5,729	10.1	9.9	10.4	10.4	10.6
2013/14	○	5,091	8.9	8.7	9.2	11.2	11.1
2014/15	○	6,788	11.9	11.6	12.1	12.8	13.5
2015/16	○	10,709	18.6	18.2	18.9	17.0	17.2
2016/17	○	12,688	21.9	21.5	22.3	19.6	20.0
2017/18	○	13,251	22.7	22.3	23.1	21.9	23.7

Source: Figures calculated by PHE Knowledge and Intelligence Team (North West) using crime data supplied by the Home Office and population data supplied by Office for National Statistics (ONS).

Source: Public Health Outcomes Framework https://fingertips.phe.org.uk/

The recent trend in recorded incidents of violent crime in Worcestershire has been upwards. Currently the rate is significantly lower than for England.

In Worcestershire, to date, the focus of work on violence has been on domestic abuse, sexual violence and honour-based violence. Further work is needed to fully understand the other areas of interpersonal violence within a Worcestershire context.[41] The Worcestershire domestic violence strategy 2017-20 seeks to address all forms of violence and abuse regardless of age, gender and sexual orientation.

Domestic Violence - West Mercia

Table 6 shows data on the recorded incidents of domestic violence (monthly and yearly) in Worcestershire over four years. However, research suggests only 40% of domestic abuse incidents are reported to the police therefore these figures are likely to be an underestimate of the true numbers of incidents.

Table 6 Domestic Violence (recorded incidents) - Worcestershire 2014/15 to 2017/18

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2014/15	632	699	724	807	740	711	730	752	793	769	629	733	8719
2015/16	804	847	787	894	867	796	800	809	832	860	814	837	9947
2016/17	815	860	869	977	863	830	916	799	940	857	833	862	10421
2017/18	934	972	1005	1089	1017	898	809	792	897	875	810	851	10949

Source: West Mercia Police

- There were 10,949 incidents reported in 2017/18 up from 10,421 in 2016/17 averaging 912 and 868 per month respectively.

[41] Worcestershire County Council
http://www.worcestershire.gov.uk/info/20379/domestic_abuse_and_sexual_violence/885/domestic_abuse

Social Isolation and Loneliness

In Worcestershire approximately, half of adult social care users (49.7%) and two-fifths of adult carers (38.4%) said they had as much social contact as they would like.[42] This is significant particularly because the quality and quantity of social relationships affects health behaviours, physical and mental health, and risk of mortality.

Certain people or groups are more vulnerable to social isolation than others, depending on factors like physical and mental health, level of education, employment status, wealth, income, ethnicity, gender and age or life-stage.

Intuitively it might be expected that social isolation is likely to be greater in more rural areas and there is evidence to support this hypothesis. More information on social isolation and loneliness is included in the 'Living Well in Older Years' section although it should be noted that social isolation and loneliness are not exclusively experienced by older people.

[42] Annual Summary, Worcestershire: http://worcestershire.moderngov.co.uk/documents/s17447/7a%20DPH%20report%202018%20v1%209.pdf

Community Well-being and Social Capital

Figure 26 shows the multitude of factors that are significant determinants of mental health and well-being for individuals. Many of these are at a community level.

It has been suggested that 'Community Well-being' is the combination of social, economic, environmental, cultural, and political conditions identified by individuals and their communities as essential for them to flourish and fulfil their potential.[43,44]

In a recent Worcestershire 'Viewpoint' survey 50% of respondents agreed that the community needs to share more responsibility for the health and well-being of people.

Figure 26 Factors that Influence Well-being: The Health Map

Source: Dahlgren & Whitehead 1991 (Adapted) Public Health England

Local authorities have a role to play in helping individuals and communities to develop social capital. There is growing recognition that although disadvantaged social groups and communities have a range of complex and inter-related needs, they also have assets at the social and community level that can help improve health, and strengthen resilience to health problems.[45] To build social capital and utilise community-based assets to improve health and well-being, local authorities can, support volunteering opportunities, focus upon

[43] Wiseman and Brasher, 2008; Community Wellbeing in an Unwell World: Trends, Challenges, and Possibilities Journal of Public Health Policy, Volume 29, Number 3, Page 353 https://link.springer.com/article/10.1057%2Fjphp.2008.16

[44] What Works wellbeing: https://whatworkswellbeing.org/blog/what-is-community-wellbeing/

[45],[6,7] The Kings Fund: https://www.kingsfund.org.uk/projects/improving-publics-health/strong-communities-wellbeing-and-resilience

reducing social isolation, support creation of informal social networks through groups and activities as well as mapping and developing community assets.[46]
The 2017-2018 Director of Public Health Annual Report for Worcestershire, 'Prevention is Better than Cure', advocates engaging with local communities to build local health assets by bringing people together, with the support of all sectors, to build resilient communities with informed residents who can help themselves and each other.[47] The report points to the use of asset-based approaches across the county to strengthen community engagement and contribute towards positive health and well-being. These approaches seek to bolster well-being at individual and community levels, helping to increase resilience to the wider corrosive effects of the social determinants of health and risky behaviours.[48]

Figure 27 Community-centred Approaches for Health and Well-being

Source: Public Health England 2018: https://publichealthmatters.blog.gov.uk/2018/02/28/health-matters-community-centred-approaches-for-health-and-well-being/

[47] Director of Public Health Report 2018 http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1498/jsna_director_of_public_health_annual_reports

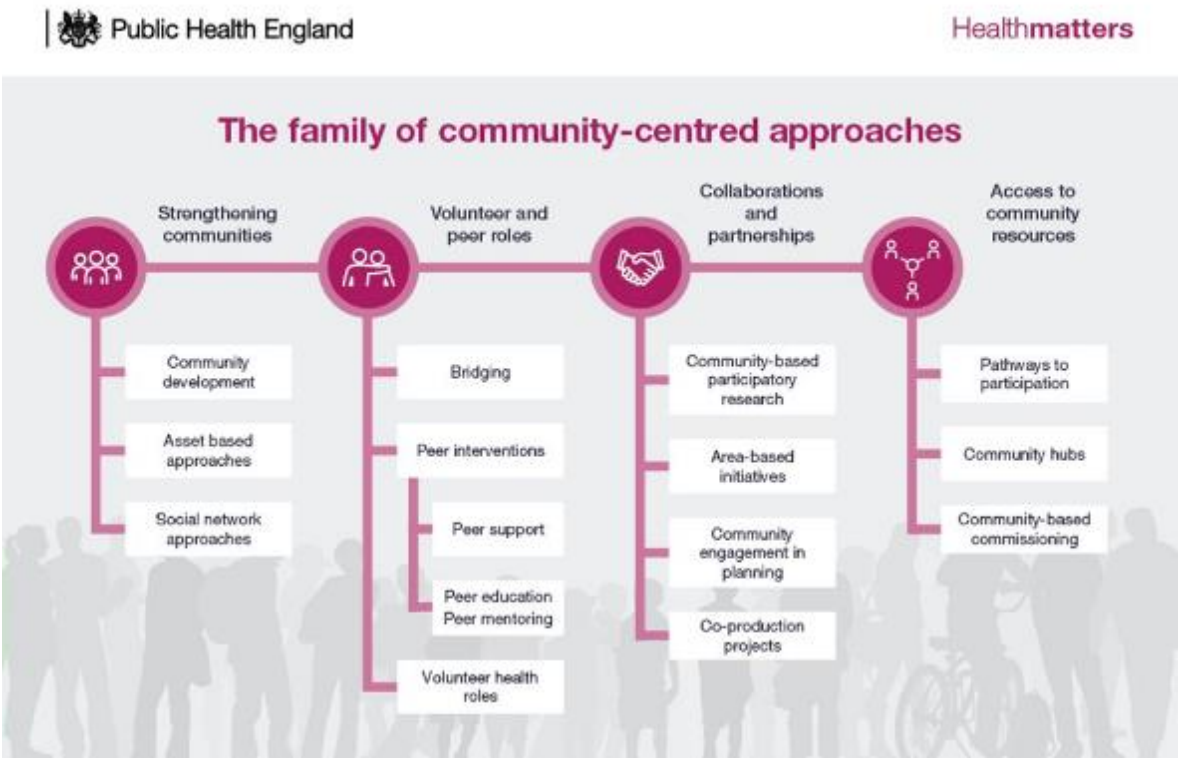
Recognising assets helps value community strengths and ensure everyone has access to them. It builds on the positives and ensures that health action is co-produced equally between communities and services.
Public Health England guidance on community-centered approaches groups these into a framework of four families. The 'family' of approaches is a framework to represent some of the practical and evidence-based options that can be used to improve community health and well-being, they are:

- Strengthening Communities – including: community development, asset-based approaches, social action and social network approaches.
- Volunteer and Peer Roles – including bridging roles such as: health trainers, peer support and volunteer health roles.
- Collaborations and Partnerships – including: community-based participatory research, area-based initiatives such as healthy cities, community engagement in planning and co-production (a term used to describe engaging community members and service users as equal partners in service design and delivery).
- Access to Community Resources - including approaches that improve pathways to participation such as: social prescribing, community hubs and community-based commissioning.

Community-centred approaches seek to draw on and strengthen community capacity to take collective action that will in turn lead to changes in health or the social determinants of health. Approaches can be applied at a neighbourhood level to address health inequalities and used to work with specific communities experiencing the effects of social exclusion. To develop community-centred approaches to health and well-being, there is a need to:

- develop a whole-system approach across sectors
- ensure genuine co-design and co-delivery
- map and mobilise local assets
- commission across the four strands of the family
- measure community outcomes that matter
- integrate community-centred, asset-based approaches as part of place-based commissioning and strategic planning

Figure 28 Public Health England Guidance on Community-centered Approaches[49]



Worcestershire has good examples of community-centred practice. The challenge is the scaling-up of a whole-system community-centred approach that is built 'bottom-up' from grassroots community organisations and members.

Childhood is an important factor in determining adult health and well-being and focus is given towards making sure that colleges, schools and nurseries are health promoting places.[50]

In Worcestershire, there are lower levels of deprivation, long-term unemployment and young people who are not in education; training or employment, in addition to this GCSE attainment is higher than England average. In contrast, there are significantly higher levels of people with long-term health problems; a higher proportion of people aged 65+ who live alone, high levels of unpaid carers and higher levels of young people aged 16-24 years old who are homeless.

[49] Public Health England Guidance: https://www.gov.uk/government/publications/health-matters-health-and-well-being-community-centred-approaches/health-matters-community-centred-approaches-for-health-and-well-being

[50] Director of Public Health Report 2018 http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1498/jsna_director_of_public_health_annual_reports

Parks and Open spaces are vital for our well-being and getting together outdoors can offer opportunities to create and nurture friendships[51]. There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental well-being and cognitive function through both physical access and usage. Worcestershire has safe high-quality green spaces that is utilised for sports and leisure. Worcestershire residents can access high quality green spaces such as open countryside, woodlands and nature reserves. According to Natural England there are over 11,750 hectares of strategic natural green spaces in Worcestershire that can be used by the public. However, the latest information available suggests that only around 14.2% (83,500 people) in Worcestershire use outdoor space for exercise/health reasons, compared to 17.9% nationally.

There are several local initiatives available across Worcestershire promoting exercise and use of green spaces. Many of these initiatives rely on volunteers. In 2017/18 there were 31,528 walks undertaken in Worcestershire as part of the Health Walk programmes[52] and there are approximately 280 volunteer walk leaders currently registered, without whom this would not be possible.[53] Despite higher than average opportunities to free to access open spaces and leisure facilities the number of physically active adults in Worcestershire is similar to the national average at 67% compared to 66%.

There is a lower proportion of adult population considered inactive in Worcestershire than the national average (21.1% compared to 22.2% in 2017). However, between 2015/16 and 2016/17 the population considered active declined and there was an increase in the adult population considered inactive.

Examples of 'Community Centred' Initiatives in Worcestershire

Social Prescribing

Social Prescribing is a way of linking patients in primary care with sources of support within the community. It provides health professionals with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. In Worcestershire a pilot of social prescribing is currently ongoing. More information on this initiative is included in the 'Working Age Adults' section.

Befriending

In Worcestershire there are several organisations providing befriending services, usually through volunteers. Such befriending services for older people offer regular home visits or outings by someone who will be a companion and offer friendship. Companionship can also be gained through attendance at clubs or day centres, where there will be others in a similar situation.

The Reconnections Service

[51] Department for Digital, Culture, Media and Sport: A connected society A strategy for tackling loneliness – laying the foundations for change (2018)

[52] Worcestershire Working Networks: https://www.walkingforhealth.org.uk/walkfinder/west-midlands/worcestershire-walking-network

[53] Worcestershire County Council; Walk Leader: https://www.walkingforhealth.org.uk/volunteer-roles/walk-leader

The Reconnections Service is funded through a Social Impact Bond with joint funding from the County Council and the Clinical Commissioning Groups and targets loneliness by recruiting and training volunteers, who then maintain their own community links and prevent social isolation.

The 'Go On' Worcestershire Partnership

The 'Go On' Worcestershire Partnership was established in 2014 to provide targeted local training and support to enable as many people as possible to have the opportunity to go confidently on line. Digital champions have been trained through the partnership, to support others in safe use of the internet, but there is considerable scope for more recruitment and for active identification of other places where training of volunteers and supported internet use are possible.

SHAPE

SHAPE is a 12-week programme that aims to help people under the care of Worcestershire Health Care Trust Adult Mental Health Services maintain or lose weight, stop smoking, start exercising and introduce healthier eating and to support them to achieve personal health goals.

Worcestershire Partnership Recovery

Worcestershire Partnership Recovery (WRP) provides an integrated alcohol and substance misuse service across Worcestershire. By working in collaboration with Mutual Aid groups, the WPR offers continuing support for people seeking recovery from alcohol or drug dependence, and for those directly or indirectly affected by dependence, such as partners, close friends, children and other family members. The percentage of service users achieving successful completion of alcohol treatment in Worcestershire has improved considerably since August 2015 and is now higher than England average.

Local Assets

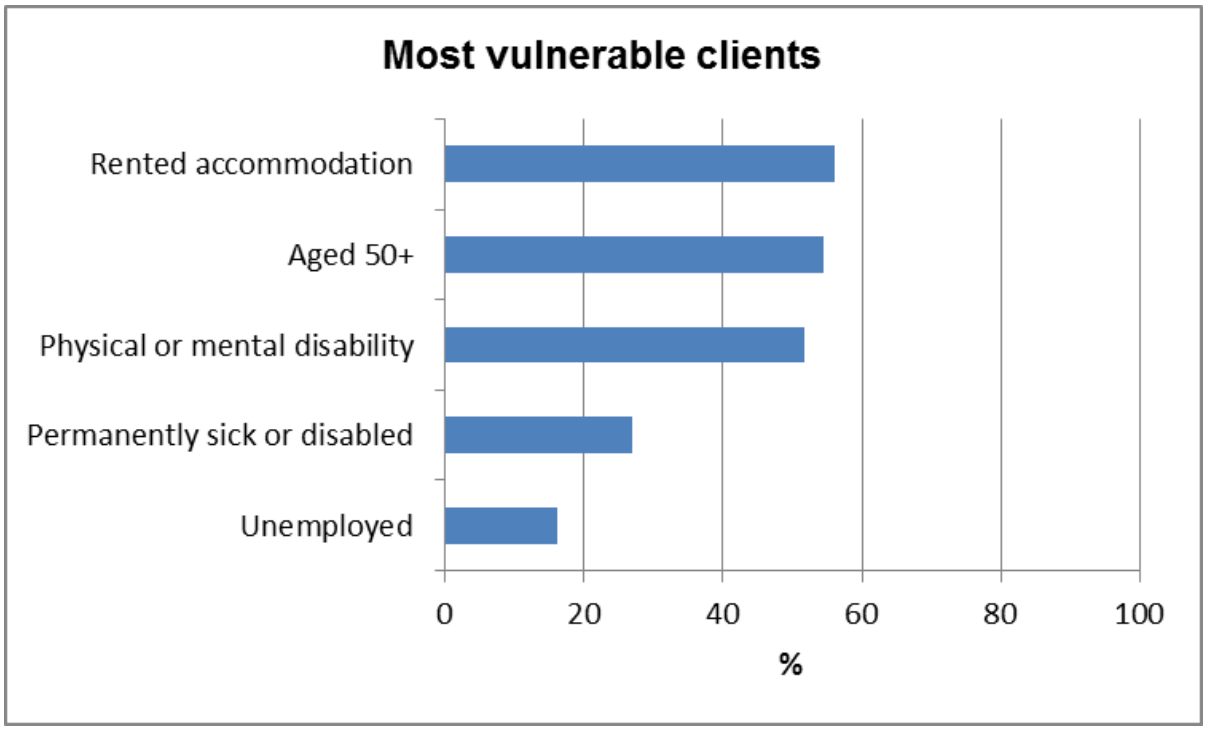
The following local assets are particularly relevant to the area of mental health.

Worcestershire Advice Network (WAN)

The Worcestershire Advice Network (WAN) is a partnership that consists of four Citizens Advice Centres (Worcester, South Worcestershire, Wyre Forest and Bromsgrove & Redditch), three Age UK district branches (Worcester, Droitwich and Bromsgrove, Redditch & Wyre Forest) and two DIAL (Disability Information and Advice Line) branches covering North and South Worcestershire.

The partnership aims to provide supported access to information and advice for people across the county, ensuring that vulnerable people have their information and advice needs met appropriately. Since July 2016 WAN has provided information and advice to help over 76,000 adults with nearly 165,000 advice issues and continues to provide a vital source of support to Worcestershire residents. Advice and information are provided either through face-to-face contact or over the telephone. The three biggest advice issues relate to benefits, debt and housing. According to available data, the partnership has reached out to some of the most vulnerable clients as illustrated in Figure 29.

Figure 29 Worcestershire – Characteristics of Clients



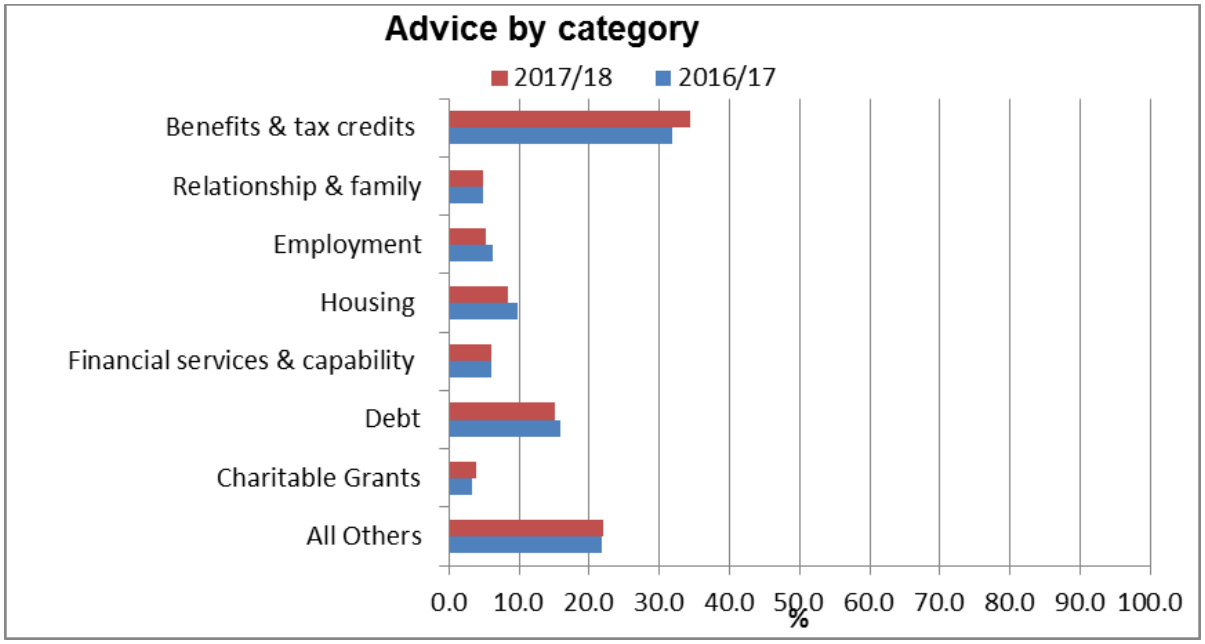
Worcestershire Advice Network (WAN) http://worcestershireadvicenetwork.org.uk/

The WAN partnership also offers services such as Befriending, Help at Home, Social and Lunch clubs and Computer classes. These services all contribute to enabling clients to remain independent, live at home longer, reduce social isolation and learn new skills.

The latest survey on services provided conducted by the partnership had 1,236 respondents and revealed the following results:

- 94% of clients surveyed stated that the advice given had made a lot/some difference to their peace of mind and well-being
- 93% of clients felt that they were better able to make financial decisions following WAN advice
- 80% of clients stated that the advice given had made a lot/some difference to their health and comfort
- 98.5% of clients were very/fairly happy with the service they received

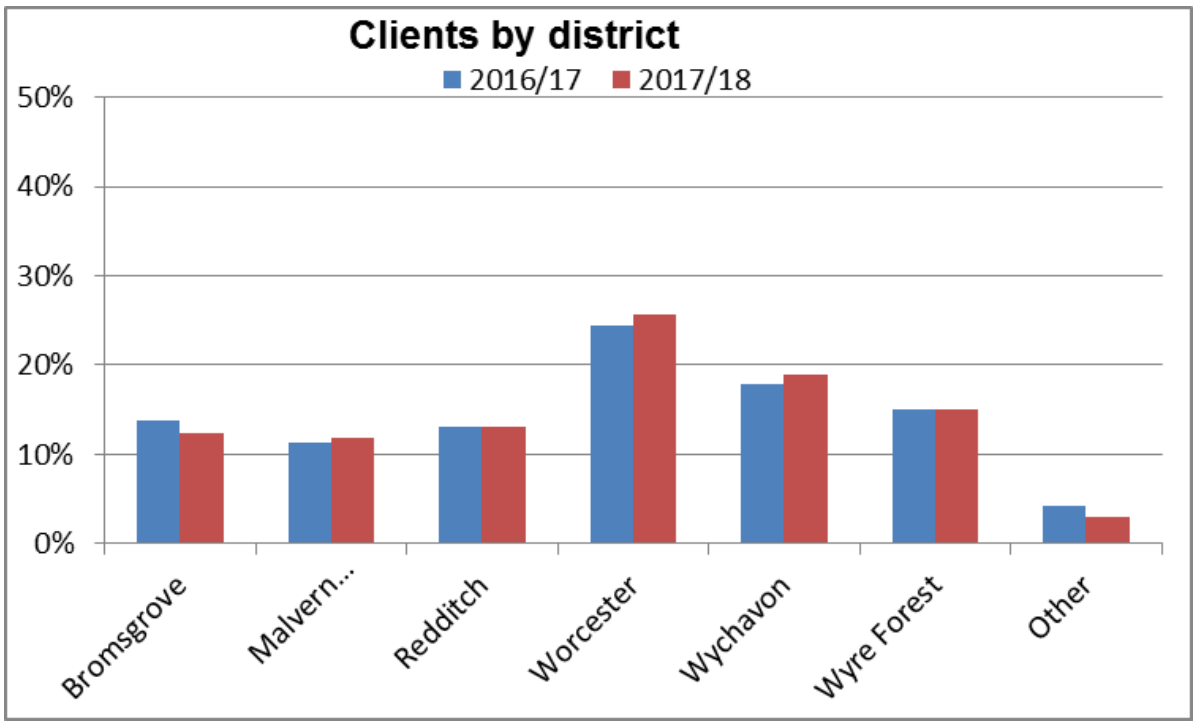
Figure 30 Advice by category WAN partnership 2016/17-2017/18



Worcestershire Advice Network (WAN) http://worcestershireadvicenetwork.org.uk/

Financial-related advice is the most common category of advice given to Worcestershire residents and, within this, advice on benefits and tax credits makes up the largest proportion followed by debt-related concerns. Other advice given relates to employment, housing and relationship and family issues.

Figure 31 Worcestershire Districts 2016/17-2017/18



Worcestershire Advice Network (WAN) http://worcestershireadvicenetwork.org.uk/

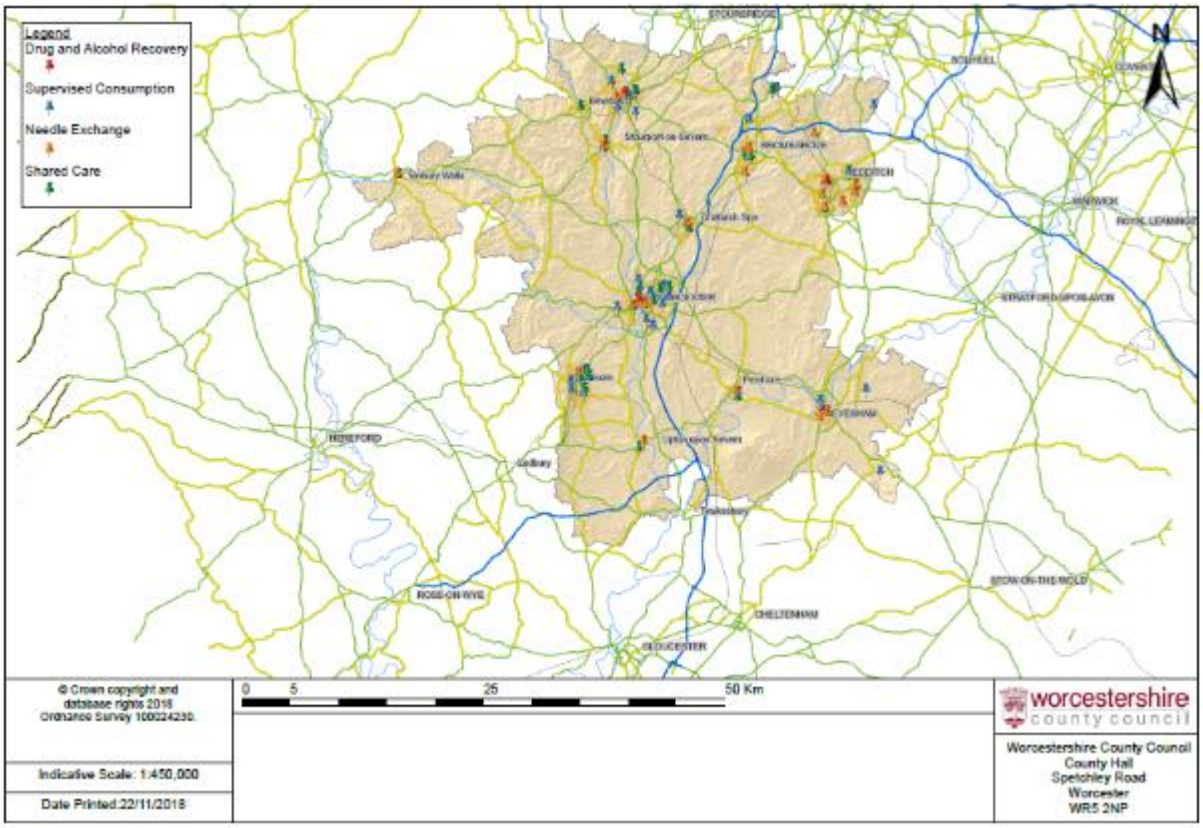
The highest percentage of clients receiving advice from the WAN partnership resided in Worcester District (followed by, in decreasing order, Wychavon, Wyre Forest, Redditch, Bromsgrove and Malvern Hills districts). The distribution of clients may be influenced by the location of centres and how accessible they are.

Worcestershire Recovery Partnership Services

Swanswell Charitable Trust (a subsidiary of Cranstoun Group) is commissioned to provide an integrated substance misuse service across Worcestershire.[54]
This includes, community-based drug and alcohol services, GP shared care and community pharmacy services such as needle and syringe exchange and supervised consumption.
Service users are supported to access further supportive services relating to housing, benefits and debt management as required. Figure 32 shows the geographical distribution of services in Worcestershire.

[54] Swanswell Charitable Trust: https://www.swanswell.org/

Figure 32 Worcestershire Recovery Partnership Services



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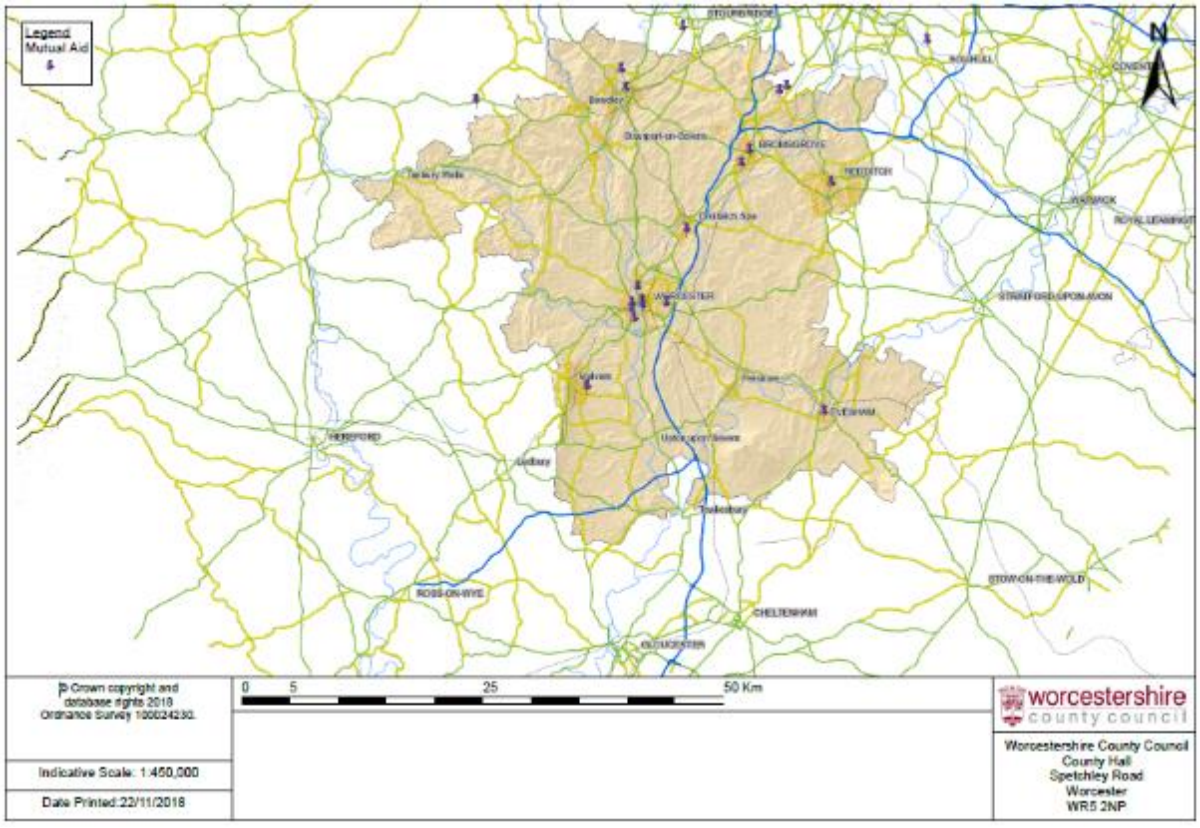
Source: Worcestershire County Council Public Health: http://gis2/publichealth/

Mutual Aid Groups

Mutual Aid groups are peer support, voluntary or volunteer led structures that offer continuing support for people seeking recovery from alcohol or drug dependence, and for those directly or indirectly affected by dependence, such as partners, close friends, children and other family members[55]. In Worcestershire, various examples of mutual aid are available including Alcoholics Anonymous (AA), Cocaine Anonymous (CA) and Narcotics Anonymous (NA). The map below shows the distribution of Mutual Aid services in Worcestershire. Figure 33 show the geographical distribution of these groups.

Figure 33 Mutual Aid Services



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Source: Worcestershire County Council Public Health: http://gis2/publichealth/

[55] PHE Facilitating access to mutual aid https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669051/Facilitating_access-to-mutual-aid-_FAMA_.pdf

Evidence and Further Information

Deprivation and Inequality

LGA: Being mindful of mental health: The role of local government in mental health and wellbeing: sets out the important role councils play in supporting the mental wellbeing of their communities, including the LGA's vision of what a 'mentally healthy' place looks like.

NICE: Health inequalities and population health (Local government briefing) 2012: briefing summarising NICE's recommendations for local authorities and partner organisations on population health and health inequalities.

Marmot review report - Fair society, health lives 2010: report from the Marmot review, which proposes an evidence-based strategy to address the social determinants of health which can lead to health inequalities.

Poverty and Financial Insecurity

Citizens Advice: A debt effect? How is unmanageable debt related to other problems in people's lives?: investigates the relationship between high levels of debt and a range of wider issues including unemployment, low pay, physical health problems and poor mental health.

Joseph Rowntree: We can solve poverty: sets out recommendations on actions to solve poverty.

Mental Health Foundation: Poverty and mental health: review examining the relationship between poverty and mental health.

Money and mental health policy institute: The missing link – how tackling financial difficulty can boost recovery rates in IAPT: puts forward the case that the IAPT programme should seek to recognise, and develop ways to mitigate, the impact of financial difficulty.

PHE Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill Health This includes a section on the effectiveness of providing debt advice to promote mental health.

Housing and Homelessness

Centre for Mental Health: More than shelter: this briefing paper presents a series of key themes for consideration in the future development of supported accommodation for adults with severe mental health problems, including those with multiple needs and substance misuse and those facing homelessness.

Homeless Link website: resources include audit tool for needs assessment and a Prevention Opportunities Mapping and Planning Toolkit (PrOMPT) which supports gathering information that can be used to redesign services and improve prevention.

Mental Health Foundation: Mental health and housing: report on types of supported accommodation that successfully meet the needs of people with mental health problems - to recommend effective housing solutions.

PHE: Homelessness: applying all our health: provides an overview of the issues that are associated with homelessness and highlights interventions that can be implemented at population, community, family and individual levels.

PHE: Homes for health: these resources can help local authorities, health and social care commissioners and decision makers make plans to improve health and wellbeing through the places people live. Resources specific to housing conditions, suitability and homelessness, and building healthy communities are included.

PHE: Spatial planning for health: an evidence resource for planning and designing healthier places: this review provides public health planners and local communities with evidence informed principles for designing healthy places.

Education and Lifelong Learning

Department for Education: Mental health and behaviour in schools: departmental advice for school staff: strategies to promote resilience and support pupils at risk of developing mental health problems in schools.

Mental Health Foundation: Learning for life: Adult learning, mental health and wellbeing: outlines evidence for adult learning interventions for anxiety and depression.

NICE: Social and emotional wellbeing in primary education/NICE: Social and emotional wellbeing in secondary education: guidelines to promoting social and wellbeing in children in the educational setting.

PHE Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill Health: includes sections on the effectiveness of school-based social and emotional wellbeing programmes and programmes to address bullying of young people.

PHE/Institute for Health Equity: Reducing the number of young people not in employment, education or training (NEET): outlines interventions to reduce the number of young people NEET and evidence for the cost-effectiveness of interventions.

PHE: Supporting mental health in schools and colleges: survey and case studies with schools on activities to support pupils' mental health and wellbeing.

Employment and Working Conditions

Business in the Community & PHE: Mental health toolkit for employers: online toolkit to help organisations support mental health & wellbeing of employees.

Centre for Mental Health: Individual placement and support (IPS): a web page outlining the IPS approaches, including links to the relevant evidence base and examples of successful implementation.

Department for Work and Pensions: Work, health and disability green paper: Government consultation paper highlighting the important relationship between work and health. Includes proposed improvement strategies.

Flexible working conditions and their effects on employee health and wellbeing: Cochrane review which evaluates the effects of flexible working interventions on the physical, mental and general health and wellbeing of employees and their families.

Mind 'Mental health at work' web resources: resources, training information and webinars for individuals and employers. Includes resources about supporting staff who are experiencing a mental health problem.

NICE Guidance: Mental wellbeing at work and workplace health: specific NICE guidance publications have been developed to promote mental wellbeing at work.

Recommendations vary according to organisation type and size and links to relevant related guidance are made within the pathway. A comprehensive resource page is also available along with an accompanying guide.

PHE Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill Health: includes sections on the effectiveness of interventions to promote health and wellbeing in the workplace and prevent stress, depression and anxiety problems.

PHE Guidance: Workplace health: applying 'All our health': evidence and guidance to help healthcare professionals encourage people to live healthy lifestyles at work. Also includes a wide range of references to relevant NICE publications and sources of employment indicators.

SCIE: Mental health, employment and the social care workforce: summarises evidence on what prevents people with mental health problems from working or retaining work in social care and what can be done to enable them to work.

Workplace wellbeing charter: online resource providing information for workplaces on how to assess and improve their workplace wellbeing.

Crime, Safety and Violence

Mental Health Crisis Care Concordat website: aims to improve responses to people in mental health crisis, many of whom come into contact with the police. It brings key partners together to agree shared actions.

Police and Crime Bill: contains provisions that prohibit people aged under 18 being held in police custody under the Mental Health Act, ensures adults are only detained in exceptional circumstances and also reduces the maximum permitted detention time to 24 hours.

NHS England: Liaison and Diversion resources: offers a wide range of information on the liaison and diversion approach, including resources for services to use.

NICE Guidance: Mental health of adults in contact with the criminal justice system: guideline covering assessing, diagnosing and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system.

PHE: Annual Health and Justice report: reports on health in prisons and other places of detention.

Rebalancing act: produced by Revolving Doors Agency and PHE, working with the Home Office and NHS England. Supports collaborative work to improve health, reduce offending and health inequalities among people in contact with the criminal justice system.

Standards for Prison Mental Health Services: framework by which to assess the quality of prison mental health services via a process of self and peer review.

Community Well-being and Social Capital

Kings Fund: Strong communities, wellbeing and resilience: provides information on asset-based approaches used by local authorities to help build social capital in individuals and communities.

NICE Guidance: Community engagement: improving health and wellbeing and reducing health inequalities: guideline covering community engagement approaches to reduce

health inequalities, ensure health and wellbeing initiatives are effective and help local authorities and health bodies meet their statutory obligations.

PHE: Guide to community-centred approaches for health and wellbeing: this guide outlines a 'family of approaches' for evidence-based community-centred approaches to health and wellbeing

What works centre for wellbeing: systematic reviews, case studies and policy recommendations. Includes report "Measuring wellbeing inequality in Britain" and community wellbeing programmes.

Understanding People

Introduction

This section of the Mental Health Needs Assessment (MHNA) focuses on adult mental health and specifically on the impact of the local population structure and risk factor distribution on mental health needs.

Common Mental Health Disorders (CMD) are most frequently reported by women and working age adults. The following groups have been identified as being at increased risk of mental health problems:

1. **Black, Asian and Minority Ethnic Groups (BAME)**

In Worcestershire 3.9% of the population are from BAME groups; 2.8% of men and 4.9% of women.

2. **People living with physical disabilities**

Around 30 per cent of all people with a long-term physical health condition also have a mental health problem, most commonly depression/anxiety. 17.9% of the Worcestershire population have a diagnosed physical disability. Worcestershire population projections predict an aging population. As physical disability increases with age it is likely that the proportion of people living with a physical disability will increase.

3. **People living with learning disabilities**

Between 25 and 40% of people with learning disabilities are estimated to suffer from poor mental health. 0.4% of the Worcestershire population have a diagnosed learning disability.

4. **Prison population and offenders**

As many as 9 out of 10 prisoners report some kind of mental health problem. The prisoner population in Worcestershire (September 2018) stands at 1,634.

5. **Lesbian, Gay, Bisexual and Transgender (LGBT) people**

Members of the LGBT community are more likely to experience depression, suicidal thoughts, self-harm and alcohol and substance misuse. The size of the LGBT community in Worcestershire is Unknown. In the West Midlands 93.8% of people identify as heterosexual.

6. Carers

Unpaid carers are more likely to suffer from stress, anxiety and depression as a result of their caring role. 2.42% of the Worcestershire population provide 50+ hours of unpaid care per week.

7. People with sensory impairment

Sensory impairment affects communicative abilities, social interaction, and limits input from the surrounding environment, all of which may negatively impact a person's mental health.

8. Homeless people

Psychological issues such as complex trauma, substance misuse and social exclusion are common amongst the homeless population. 32% of single homeless people report a mental health problem. The rate of statutory homelessness in Worcestershire is 2.7 per 1000 residents.

9. Military veterans

The Government has limited data on the number of veterans with mental health conditions across the UK. NHS England only began to record widely the number of veterans accessing its mental health services from April 2017. Post-service factors, such as the difficulty in making the transition to civilian life, marital problems, and loss of family and social support networks may make this group vulnerable to mental health issues.

Positive health behaviours, such as not smoking, eating healthy food, and engaging in physical activity, can promote psychological wellbeing, improve physical health, prevent mental health problems, and support recovery among people who are unwell. When compared to the general population, adults with a CMD are twice as likely to smoke and adults with a serious mental illness (schizophrenia or bipolar disorder) are three times more likely to smoke.

In Worcestershire 37% of adults with serious mental illness (SMI) smoke whereas only 16.8% of the total Worcestershire adult population smoke. Fruit and vegetable consumption can provide an indication of a well-balanced diet. The average number of portions of fruit consumed daily by adults (16+) in Worcestershire is 2.68. The average number of portions of vegetables consumed daily is 2.76. These are similar to the national averages.

Physical activity can positively affect stress, self-esteem, anxiety, dementia and depression and is recommended in the treatment of depression. However, those with severe mental health problems are less likely to engage in physical activity and are more likely to be physically unwell. 67.2% of Worcestershire adults undertake the recommended 150+ minutes of moderate intensity exercise per week. 21.1% undertake less than 30 minutes of moderate intensity exercise per week.

There is a two-way relationship between depression and obesity. Obese individuals have a 55% increased risk of depression and people experiencing depression had a 58% increased risk of becoming obese. 62% of Worcestershire adults are overweight, including obese.

Mental health issues can result from illicit drug use or drinking too much alcohol, they can also cause people to take illicit drugs and drink too much. An estimated 1.17% of the Worcestershire population suffer from Alcohol Dependence. Estimated prevalence of opiate and/or crack cocaine use in Worcestershire is 7.7 per 1,000 population.

Mental health issues can result in self-harm, para-suicide or suicide. There is a national ambition to reduce suicide rates by 10% by 2020/21. To help meet this Worcestershire Health and Well-being Board has a suicide prevention strategy which it is currently working to. The rate of emergency admissions for self-harm in Worcestershire (159.7/100,000) is below the national rate whereas the suicide rate in Worcestershire (10.8/100,000) is higher than the national rate.

Worcestershire Health and Care NHS Trust is the main provider of acute and community mental health services to the population of Worcestershire. Mental health services for adults in Worcestershire include:

• Acute wards and psychiatric intensive care units

• Long stay/rehabilitation mental health wards

• Community-based mental health services

• Mental health crisis services and health-based places of safety

• Community mental health services for people with learning disabilities or autism

Data from the Worcestershire Health and Care Trust shows that 62.1% of adults referred to their Worcestershire Healthy Minds service were female and 96.2% of recorded ethnicities were white.

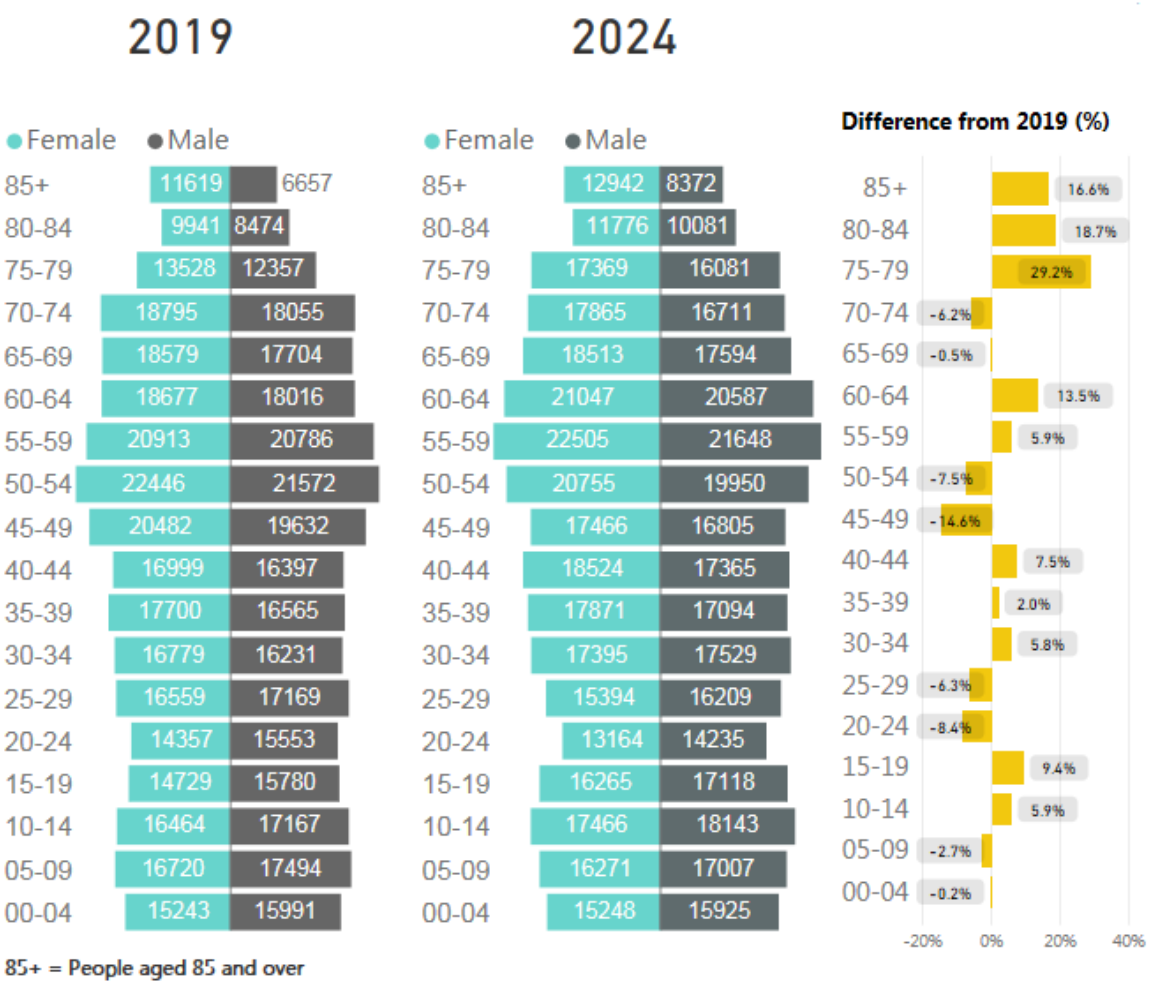
Population Demographics and Vulnerable Groups

This section of the Mental Health Needs Assessment (MHNA) focuses on adult mental health and specifically on the impact of the local population structure and risk factor distribution on mental health needs.

The age and gender structure of the local population is a key driver of health need and demand for health services. Allocation of resources for mental health is based on modelling mental health condition prevalence against age, gender and other factors.

The age and gender profile of Worcestershire is described below. The age and gender profile of Worcestershire is presented in Figure 34 below. Worcestershire has an older population than average for England at present. Over the next 5 years (by 2024) the number of residents over 75 years is predicted to increase by 22%. The numbers of residents in the younger age groups are set to either increase by a much smaller proportion or decrease as shown in Figure 34 below.

Figure 34 Worcestershire Age and Gender Profile and Population Projections

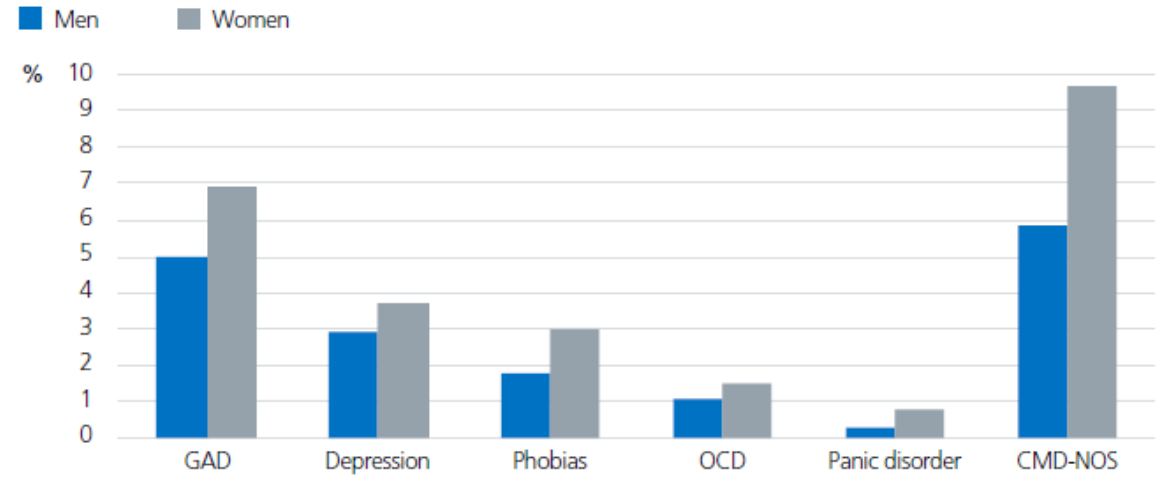


Source: Population Projections Dashboard Published by Worcestershire County Council

A survey of 7,500 people aged 16 and above was conducted in England during 2014 to identify the burden of mental health in the population. The Adult Psychiatric Morbidity Survey (APMS) was published by the Office of National Statistics, commissioned by NHS Digital, funded by the Department of Health, and carried out by The National Centre for Social Research and the University of Leicester[56]

Figure 35 and Figure 36 describe the distribution of common mental disorders (CMDs) in adults (over 16 years) in England by gender (Figure 35) and age group (Figure 36) as identified by AMPS.

Figure 35 Prevalence of Common Mental Disorders by Gender in those Over 16 years in England



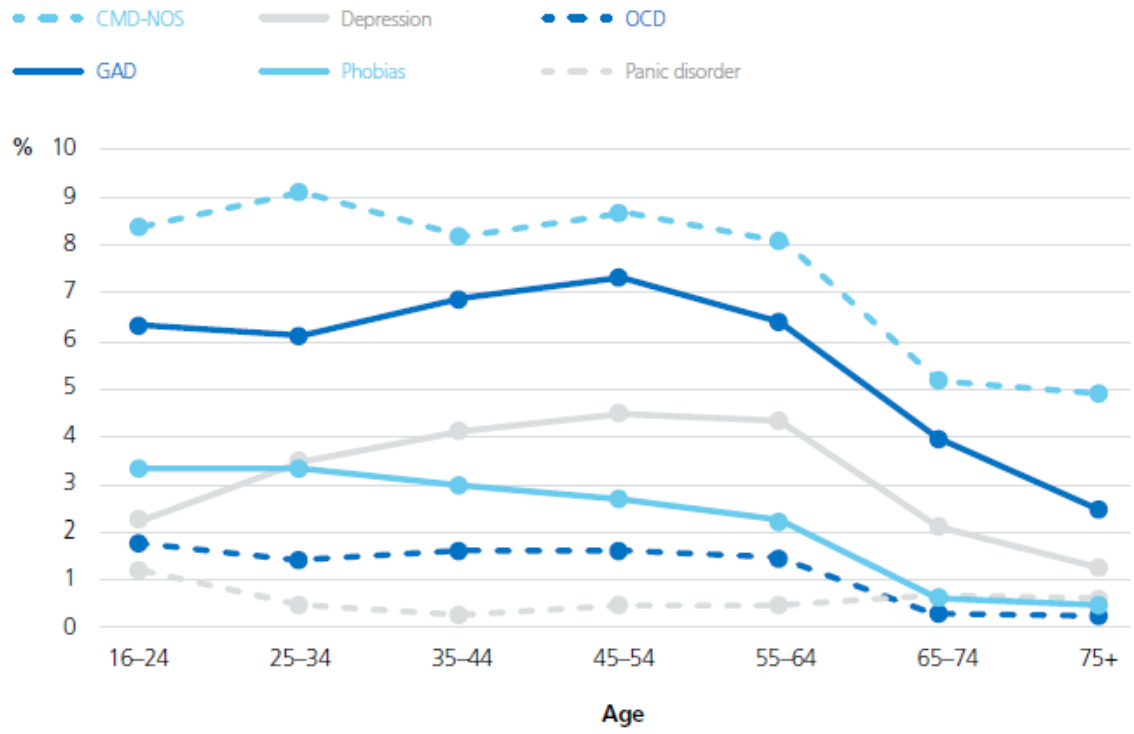
GAD: Generalised Anxiety Disorder
OCD: Obsessive Compulsive Disorder
CMD-NOS: CMD not otherwise specified

Source: Image adapted from The Adult Psychiatric Morbidity Survey 2014

For all CMDs the majority of sufferers are female. General Anxiety Disorder (GAD) is the most common CMD in both males and females.

[56] Stansfeld, S. et al., 2016. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey.* [Online]
Available at: https://www.gov.uk/government/statistics/adult-psychiatric-morbidity-survey-mental-health-and-wellbeing-england-2014
[Accessed 10 10 2018].

Figure 36 Prevalence of Common Mental Disorders in England by Age



GAD: Generalised Anxiety Disorder
OCD: Obsessive Compulsive Disorder
CMD-NOS: CMD not otherwise specified

Source: Image adapted from The Adult Psychiatric Morbidity Survey 2014

The prevalence of each CMD varies by age. In general, CMD prevalence is constant from early adulthood until 55-64 years, after which it decreases. The exception to this is depression. The prevalence of depression is relatively low in early adulthood and steadily increases, peaking at age 45-54.

Certain population subgroups are more exposed and vulnerable to unfavourable social, economic, and environmental circumstances. These subgroups are at higher risk of mental health problems. The following groups have been identified at being of high risk of mental health problems[57]:

- Black, Asian and Minority Ethnic Groups (BAME)
- people living with physical disabilities
- people living with learning disabilities

[57] PHE, 2017 Understanding place: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/3-understanding-people#population-demographics-and-vulnerable-groups

- prison population and offenders
- Lesbian, Gay, Bisexual and Transgender (LGBT) people
- Carers
- people with sensory impairment
- homeless people
- refugees, asylum seekers and stateless persons

The prevalence of these high-risk groups in Worcestershire are described below.

Black, Asian and Minority Ethnic Groups (BAME)

The APMS found that the prevalence of CMD in women varied significantly by ethnic group. Ethnicity did not appear to effect prevalence rates in men. Using age-standardised figures, CMDs were most common in Black and Black British women (29.3%)[58]. Non-British White women were found to be less likely than White British women to have a CMD (15.6%, compared with 20.9% respectively). When looking at specific CMDs, depression appeared to be more prevalent among Black women, while panic disorder appeared to be more prevalent among women in Black, Asian and mixed/other ethnic groups, although differences in rates were not statistically significant[59].

In England 13.6% of the population are from BAME groups with an even gender split[60]. In Worcestershire 3.9% of the population are from BAME groups; 2.8% of men and 4.9% of women.[61]

[58],[3] Stansfeld, S. et al., 2016. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey.* [Online]
Available at: https://www.gov.uk/government/statistics/adult-psychiatric-morbidity-survey-mental-health-and-wellbeing-england-2014
[Accessed 10 10 2018].

[60] NOMIS, 2016. *Annual population Survey (APS).* [Online] Available at: https://www.nomisweb.co.uk/articles/932.aspx [Accessed 30 10 2018].
[61] NOMIS, 2016. *Annual population Survey (APS).* [Online] Available at: https://www.nomisweb.co.uk/articles/932.aspx [Accessed 30 10 2018]

Table 7 provides a summary of BAME prevalence in Worcestershire districts. The proportion from a BAME group is highest in Redditch and Worcester. The proportion of women from a BAME group is higher than in men.

Table 7 Proportion of the Population (age 16+) in a BAME group: Estimates based on the Annual Population Survey (2016)

Area	Count	% Total Population	% of Males	% of Females
Worcester	4000	5.2	3.8	6.4
Wychavon	2000	2.0	-	3.9
Wyre Forest	2600	3.2	-	4.8
Redditch	4400	7.0	7.4	6.6
Malvern Hills	2300	3.8	3.3	4.4
Bromsgrove	2500	3.3	2.7	3.9
Worcestershire	17,800	3.9	2.8	4.9
West Midlands region	733,000	15.9	15.5	16.3
England	6,012,200	13.6	13.3	13.8

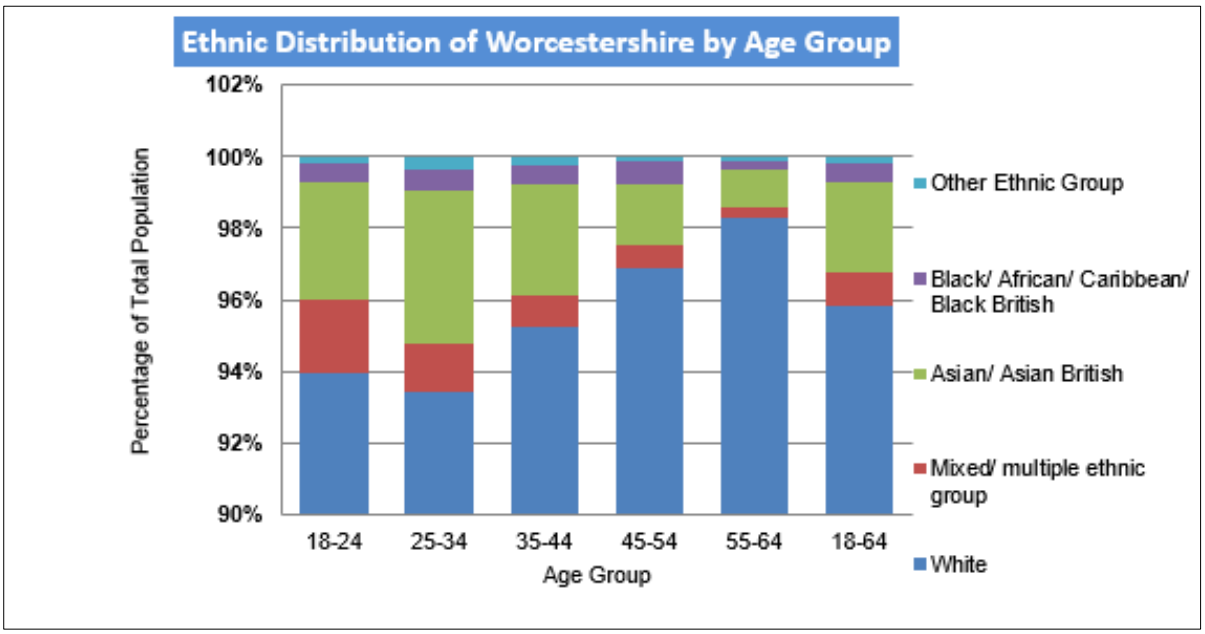
*Individuals were recorded as belonging to an ethnic minority group if they stated their ethnicity as Mixed/multiple, Asian/Asian British, Black/African/Caribbean/Black British, or Other.

- Estimate unreliable as the group sample size was small (3-9)

Source: Annual population survey (APS) 2016

Figure 34 demonstrates the variability in the proportion of BAME adults by age group. Young adults have the highest proportion of BAME individuals.

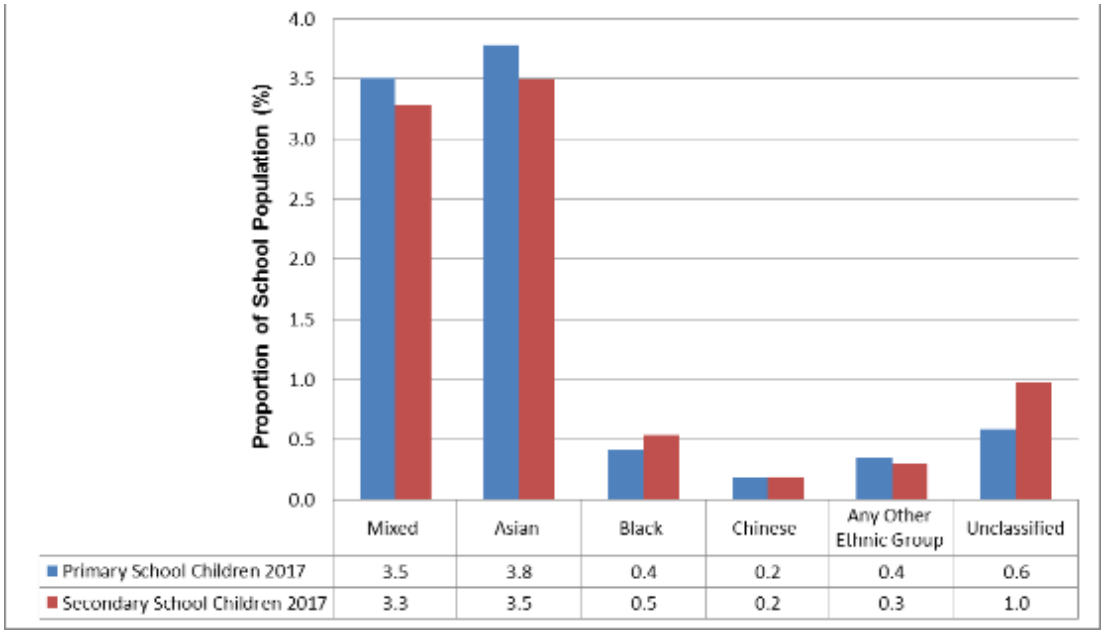
Figure 37 The Prevalence of Different Ethnic Groups in Worcestershire According to the 2011 Census (Total and Age Stratified).



Source: Office for National Statistics (ONS)

According to the 2017 census of school children attending state run schools, 91.1% of children attending Primary Schools and 91.2% attending Secondary Schools are White. Hence, 8.9% of Children in state run Primary Schools and 8.8% of Children in state run Secondary schools are from Ethnic Minority groups. Figure 38 demonstrates the proportion of children in the different BAME groups. The majority of BAME children were of Mixed or Asian ethnicity.

Figure 38 Prevalence of Different Ethnic Minority Groups in Worcestershire School Children



Source: January 2017 school census (state schools)

People living with learning disabilities and physical disabilities

Physical health problems significantly increase the risk of poor mental health, and mental health problems can exacerbate physical illness. Around 30 per cent of all people with a long-term physical health condition also have a mental health problem, most commonly depression/anxiety[62]

According to the Mental Health Foundation:

- Between 25 and 40% of people with learning disabilities are estimated to suffer from poor mental health
- The prevalence of dementia is much higher amongst older adults with learning disabilities compared to the general population (21.6% vs 5.7% aged 65+)
- People with Down's syndrome are at particularly high risk of developing dementia, with an age of onset 30-40 years younger than the general population
- Prevalence rates for schizophrenia in people with learning disabilities are approximately three times greater than for the general population (3% vs 1%)

[62] Naylor, C., 2012. *The Kings Fund: Long-term conditions and Mental Health: The cost of co-morbidities.* [Online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf [Accessed 4 10 2018].

- Reported prevalence rates for anxiety and depression amongst people with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general population, and higher amongst people with Down's syndrome
- Challenging behaviours (aggression, destruction, self-injury and others) are shown by 10%-15% of people with learning disabilities, with age-specific prevalence peaking between ages 20 and 49

The prevalence of both learning disabilities and chronic physical disabilities in Worcestershire are described in Table 8.

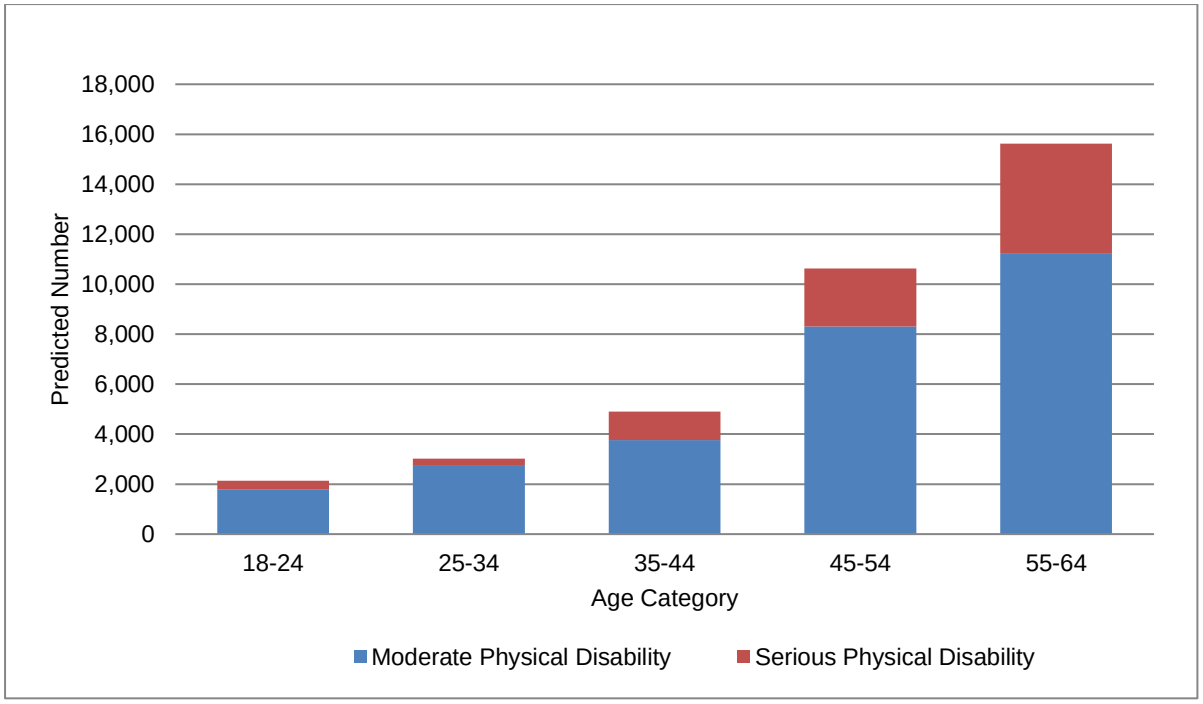
Table 8 Disability Prevalence in Worcestershire

Indicator	Source	Prevalence Worcestershire (number)	Prevalence England
Learning Disability (all ages)	Fingertips: QOF 2016/17	0.4% (2576)	0.5%
Long-term health problem or disability* (all ages)	Fingertips: Census 2011	17.9% (101,492)	17.6%

***** A "long-term health problem or disability" is defined as a problem or disability that limits a person's day-to-day activities, and has lasted, or is expected to last, at least 12 months.

Figure 39 below shows how the number of people living with a disability increases with age.

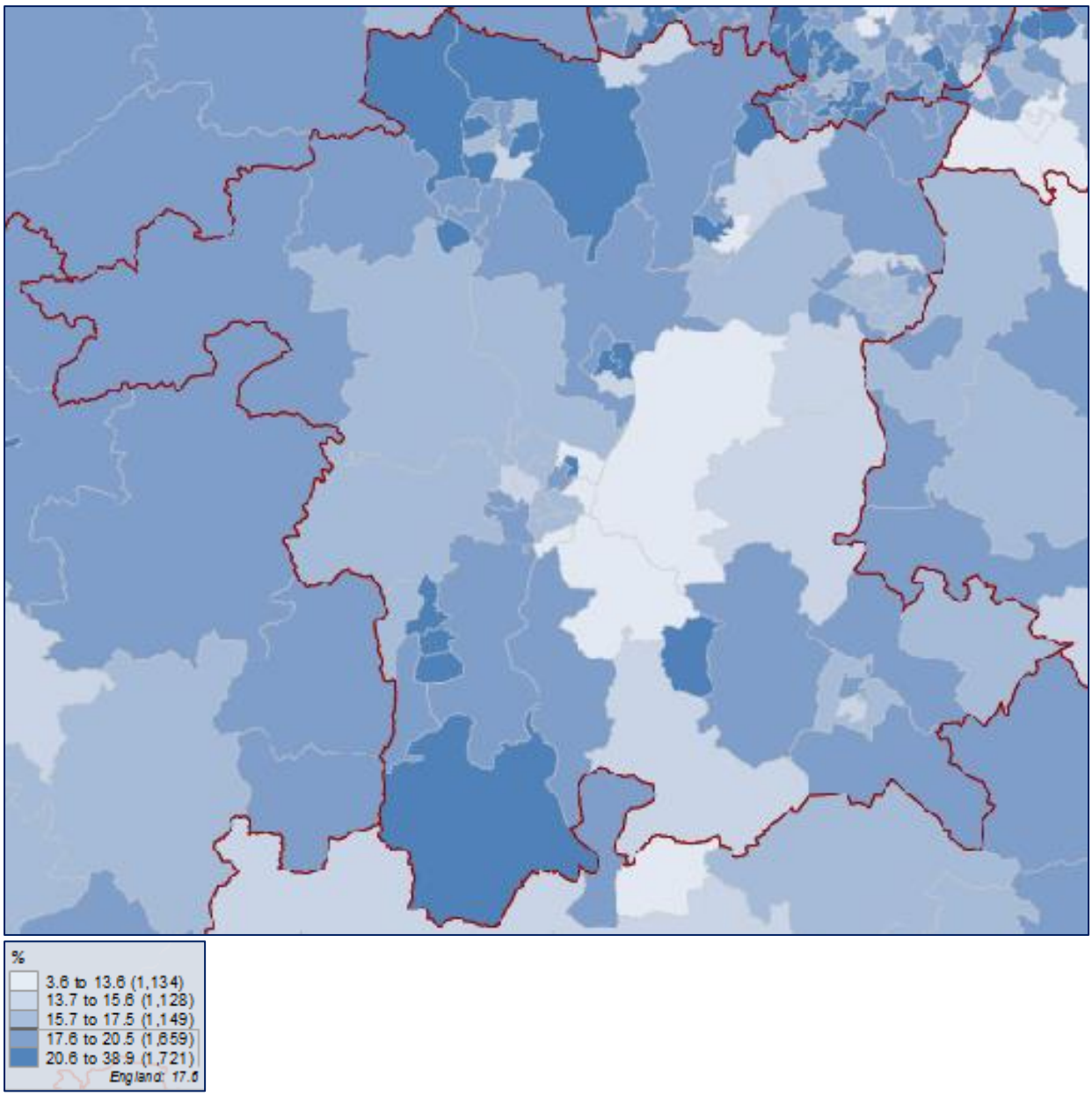
Figure 39 The Number of People Living with a Moderate or Severe Physical Disability as Predicted by Age and Gender Standardised Rates and Population Growth (2017)



Source: The Institute of Public Care

Figure **40** below shows the geographical distribution of people suffering with a limiting long-term illness or disability in Worcestershire. Northern Wyre Forest area, Worcester, Bromsgrove town centre, Pershore and the southern Malvern Hills area have the highest proportion.

Figure 40 Proportion of the Middle Super Output Area (MSOA) Suffering with a Limiting long-term illness or Disability (2011)



Source: PHE, Local Health.

Prison population and offenders

Studies have found that mental health problems are much more common in prisoners than in the general population. As many as 9 out of 10 prisoners report some kind of mental health problem. The most commonly reported symptoms in prisoners are sleep problems and worrying[63]

Prisons can promote poor mental health through: overcrowding, violence, enforced solitude and at the same time, lack of privacy, isolation from social networks, lack of meaningful activity and reduced access to mental health services[64]

The prevalence of severe chronic mental illnesses such as schizophrenia, bipolar disorder and autism disorders are more common in prisons suggesting that people with mental illness are more likely to go to prison in the first place[65]

The prisoner population in Worcestershire (September 2018) stands at 1,634[66]

For crime rates see Crime, Safety and Violence in the Understanding place chapter

Lesbian, gay, bisexual and/or transgender (LGBT) people

Lesbian, gay, bisexual and/or transgender (LGBT) people are more susceptible to mental health problems than heterosexual people due to a range of factors, including discrimination and inequalities. Members of the LGBT community are more likely to experience a range of mental health problems such as depression, suicidal thoughts, self-harm and alcohol and substance misuse[67].

Across all positive Office for National Statistics (ONS) metrics of quality of life (life satisfaction, happiness, and perception that things they do in life are worthwhile), people who were heterosexual gave a higher rating than their LGBT counterparts [68]. People who

[63] RCPSYCH, 2017. *Mental Illness, Offending and Substance Misuse[.* [Online] Available at: https://www.rcpsych.ac.uk/healthadvice/problemsdisorders/mentalillness,offending.aspx. [Accessed 4 10 2018]

[64] [6]4 Durcan, G. & Zwemstra, J., 2017. *Mental health in prison.* [Online] Available at: http://www.euro.who.int/__data/assets/pdf_file/0017/249200/Prisons-and-Health,-11-Mental-health-in-prison.pdf [Accessed 28 11 2018].

[66] UK Government, 2018. *Prison Population Figures.* [Online] Available at: https://www.gov.uk/government/statistics/prison-population-figures-2018 [Accessed 29 10 2018]

[67] Mental Health Foundation, 2018. *Mental health statistics: LGBT people.* [Online] Available at: https://www.mentalhealth.org.uk/statistics/mental-health-statistics-lgbt-people. [Accessed 4 10 18].

[68] ONS, 2017. *Lesbian, gay, and bisexual people say they experience a lower quality of life.* [Online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/articles/lesbiangayandbisexualpeople [Accessed 4 10 2018].
ONS, 2017. *Sexual identity, UK: 2016.* [Online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016 [Accessed 15 10 2018].

identified as bisexual reported significantly higher levels of anxiety than any other group, as well as reporting lower levels of life satisfaction and happiness[69].

30% of those who identified as bisexual reported high levels of anxiety, compared to 19% of heterosexuals[70].

According to the ONS survey of sexual identity (2017), within the West Midlands, 93.8% identify as heterosexual, 1.1% as Gay or Lesbian, 1.1% as bisexual, 0.8% as "other" and 3.2% don't know/refuse. Data is not available at county level.

Carers

Looking after a family member with a physical or mental health problem can have a significant impact on carers' own physical and mental health. An annual survey conducted by Carers UK in 2015 of over 5,000 carers across the UK revealed that 84% of carers feel more stressed (then they believe they would otherwise), 78% feel more anxious and 55% reported that they suffered from depression as a result of their caring role[71].

According to the 2011 census, 2.42% of the Worcestershire population (all ages) provide substantial unpaid care (50+ hours per week)[72]. The number and percentage of people providing care in the Worcestershire districts, Worcestershire, West Midlands and England can be found in Table 9

Table 9 Provision of Care by Area

Area	People Providing 50+ hours of Care Number providing care	% of total area population
Worcester	2075	2.10
Wychavon	2791	2.39
Wyre Forest	2677	2.73
Redditch	2154	2.56
Malvern Hills	1847	2.47
Bromsgrove	2174	2.32
Worcestershire	13718	2.42

[69] [1]4 ONS, 2017. *Sexual identity, UK: 2016.* [Online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016 [Accessed 15 10 2018].

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[71] Mental Health Foundation, 2016. *Mental health statistics: carers.* [Online] Available at: https://www.mentalhealth.org.uk/statistics/mental-health-statistics-carers. [Accessed 4 10 2018].

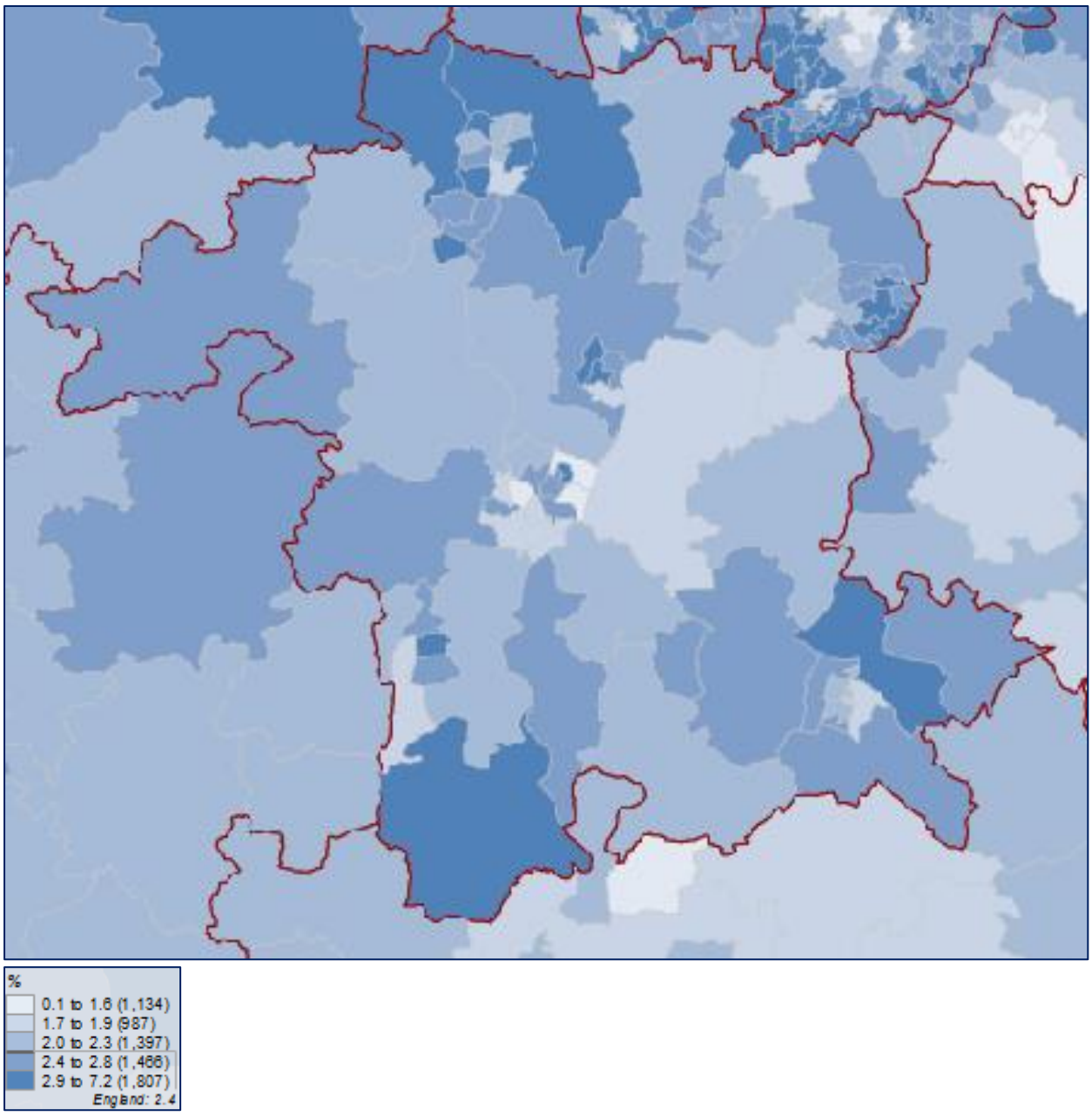
[72] ONS, 2011. *Census map analysis - Unpaid care.* [Online] Available at: http://webarchive.nationalarchives.gov.uk/20160107190833/http://www.ons.gov.uk/ons/interactive/census-map-analysis---unpaid-care/index.html [Accessed 30 10 2018]

West Midlands region	-	2.68
England	-	2.37

Source: 2011 Census

Figure 41 demonstrates the distribution of unpaid carers at the MSOA level.

Figure 41 The Proportion of Each Middle Super Output Area (MSOA) Providing Greater than 50 hours of Care per Week (based on 2011 census)



Source: Local Health

People with sensory impairment

Common genetic or neurological components may cause both sensory impairment and mental health problems. More often, sensory impairment affects communicative abilities, social interaction, and limits input from the surrounding environment, all of which may negatively impact a person's mental health[73].

A telephone survey of 1,200 bind or partially sighted people in the UK (2015)[74] found that:

• Only 17 per cent of people experiencing sight loss are offered emotional support in response to their deteriorating vision.

• Only 27 per cent of blind and partially sighted people of working age are in employment – a fall from 33 per cent in employment in 2006.

• 31 per cent of people are rarely or never optimistic about the future.

The prevalence of sensory impairment in Worcestershire and England as a whole is presented in Table 10 below. The prevalence of sensory impairment (sight and hearing) in Worcestershire is lower than that in England as a whole for all age groups shown in Table 10.

Table 10 Sensory Impairment by Age Group

Indicator	Period	Count	Worcs Per 100,000	England Per 100,000
People aged 18-64 registered deaf or hard of hearing	2009/10	355	105	173
People aged 65-74 registered deaf or hard of hearing	2009/10	205	370	620
People aged 75+ registered deaf or hard of hearing	2009/10	925	1,906	3,089
People aged 18-64 registered blind or partially sighted	2013/14	560	165	214
People aged 65-74 registered blind or partially sighted	2013/14	270	415	569
People aged 75+ registered blind or partially sighted	2013/14	1,225	2,299	4,255

[73] Dammeyer, J. & Hendar, O., 2013. Sensory impairment and mental health. In: *Mental Health and Psychiatry.* New York: Nova Science Publishers, pp. 29-52.

[74] Slade, J. & Edwards, R., 2015. *My Voice 2015: The views and experiences of blind and partially sighted people in the UK..* [Online] Available at: https://www.visionuk.org.uk/rnib-release-my-voice-2015-the-views-and-experiences-of-blind-and-partially-sighted-people-in-the-uk/ [Accessed 10 10 2018].

Source: NHS Digital

A slightly more recent estimate of hearing loss (all ages) within the Worcestershire districts has been published by NHS England as shown in Table 11 below.

Table 11 Hearing Loss Estimates (all ages) by Worcestershire District (2019 projected estimates)

District	Estimated number with hearing loss **(rounded to the nearest 500)**	Estimated prevalence per 100,000 population
Worcestershire (Total)	113500	197
Bromsgrove	19500	204
Malvern Hills	18000	237
Redditch	13500	160
Worcester	16000	159
Wychavon	25500	213
Wyre Forest	20500	207

Source: NHS England P20 estimated hearing loss : https://www.england.nhs.uk/publication/prevalence-of-hearing-loss-by-ccg-area-2019-ons-predictions/

Wychavon have the largest number of people suffering from hearing loss (n=25500) according to figures estimated for the 2019 population (Table 11). Malvern Hills have the highest rate at 237 per 100,000.

Homeless people

The homeless population covers a wide spectrum – well beyond the more obvious rough sleepers and hostel/shelter users. Homelessness can be viewed as a continuum, with sleeping rough at one extreme and living in insecure accommodation at the other. There are various ways of defining homeless people.

Crisis UK uses the terms 'core homelessness' and 'wider homelessness' which relate to the severity of the housing situation (Table 12)[75]

Core homelessness refers to households who are considered homeless at any point in time due to experiencing the most acute forms of homelessness or living in short-term or unsuitable accommodation. Wider homelessness refers to those at risk of homelessness or who have already experienced it and are in accommodation which is on a temporary basis.

Table 12 Types of Homelessness as Defined by Crisis UK

Core homelessness	Wider homelessness
Rough Sleeping	Staying with friends/relatives because unable to find own accommodation (longer term)
Sleeping in tents, cars, public transport*	Eviction/under notice to quit (and unable to afford rent/deposit)
Squatting (unlicensed, insecure) *	Asked to leave by parents/relatives
Unsuitable non-residential accommodation e.g. 'beds in sheds'*	Intermediate accommodation and receiving support
Hostel residents	In other temporary accommodation (e.g. conventional social housing, private sector leasing)
Users of night/winter shelters*	Discharge from prison, hospital and other state institution without permanent housing
DV victim in Refuge*	
Unsuitable temporary accommodation (which includes bed and breakfast accommodation, hotels etc	
'Sofa Surfing' – staying with others (not close family), on short term/insecure basis/wanting to move, in crowded	

[75]Bramley, G., 2017. *Homelessness Projections: Core Homelessness in Great Britain,* s.l.: Crisis UK.

conditions (this does not include students)

Source: Homelessness projections: Core homelessness in Great Britain (2017)

There are various causes of homelessness: structural (poverty/inequality/housing etc.) and individual factors (poor physical and mental health, alcohol/drugs etc.). The most common reasons for homelessness are the end of assured short hold tenancy and relationship breakdown, particularly if there is also domestic violence. Young people can become homeless when parents/relatives are no longer willing to accommodate them. It is estimated that approximately 50% of homeless people have four or more Adverse Childhood Experiences (ACEs).

The most recent estimate of the rate of statutory homelessness in Worcestershire is 2.7 per 1000 residents (Table 13). This is marginally above the rate in England (2.5/1000).

The rate of Family homelessness in Worcestershire is 1.9 per 1000 households as is the national rate. Homelessness in young adults (16-24 years) is higher in Worcestershire compared to England at 0.75 per 1000 and 0.56 per 1000 respectively.

Table 13 Homelessness in Worcestershire- rate per 1000 households

Indicator	Period	Worcestershire Count	Worcestershire	England
Statutory homelessness	2015/16	671	2.7	2.5
Family homelessness	2016/17	467	1.9	1.9
Homeless young people aged 16-24	2016/17	186	0.75	0.56

Source: Department for Communities and Local Government

A homeless health audit was carried out in each of the districts in Worcestershire in 2017/18; a total of 76 homeless individuals responded. The audit concentrated on those experiencing the most acute types of homelessness. Most participants in the audit were single.

Participants had an average (median) age of 44. Approximately three quarters of the sample (55 out of 76), were currently staying in Worcester. Survey participants came from a range of homelessness types (Table 14), the biggest groups being in a hostel or supported accommodation and sleeping rough (which together accounted for about 70%). The sample may under represent hidden homeless people, for example, just 6.6% were sleeping on somebody's sofa or floor. Note that this is a small sample and that there are significant gaps in our knowledge, for example amongst the hidden homeless and those living in temporary accommodation.

Table 14 Worcestershire homeless audit: where respondents are currently sleeping

Answer	Percentage (n=76)
In a hostel or supported accommodation	**48.7%**
Sleeping rough on streets/parks	**21.1%**
Sleeping on somebody's sofa/floor	**6.6%**
Housed - own tenancy in private rented sector	**6.6%**
In B&B or other temporary accommodation	**<6.6%**
In emergency accommodation, e.g. night shelter, refuge	**<6.6%**
Housed - in own tenancy in social housing	**<6.6%**
Other	7.9%

Source: Worcestershire Homeless Audit 2017/18.

NB: To effectively anonymise the information certain figures have been supressed.

Not only can homelessness increase the chances of developing a mental health problem, or exacerbate an existing condition, having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Psychological issues such as complex trauma, substance misuse and social exclusion are common amongst the homeless population. In 2015, 32% of single homeless people reported a mental health problem[76]. Rates of depression are over 10 times higher in the homeless population.

[76] Mental Health Foundation : https://www.mentalhealth.org.uk/statistics/mental-health-statistics-homelessness

The Worcestershire Homeless Audit 2017/18 asked the question: Has a doctor or health professional ever told you that you have any of the following mental health or behavioural conditions? The ten most prevalent responses to the question are presented in Table 15.

Table 15 Most Commonly Reported Mental Health Problems, n=76

Mental Health Problems	Percentage
Depression	75%
Anxiety Disorder or Phobia	55%
Dual Diagnosis with a drug or alcohol problem	30%
Psychosis (including Schizophrenia or Bipolar Disorder)	19%
Personality Disorder	17%
ADHD (Attention Deficit Hyperactivity Disorder)	12%
Eating Disorder	10%
Learning Disability or Difficulty	8%
Post-Traumatic Stress Disorder (PTSD)	7%
Other Mental Health or Developmental Condition	<6.6%
Autism/Asperger's	<6.6%

Source: Worcestershire Homeless Audit 2017/18.

NB: To effectively anonymise the information certain figures have been supressed.

Meeting the physical and mental health care needs of the homeless population poses significant challenges in comparison to the settled population, particularly with the clear evidence of the high rates of chronic disease and co-morbidity. The Worcestershire Homeless Audit 2017/18 evaluated how well the health needs of the homeless population were being met. In total, 22.8% of respondents with a physical health problem and 40.3% of respondents with a mental health problem reported that they were not receiving support/treatment for it (

Table 16 and Table 17).

Table 16 Proportion of Individuals with Physical Health Needs that are Receiving Care for this and the adequacy of this care?

Response	Count	Percentage
Yes, and it meets my needs	30	52.6%

Yes, but I'd still like more help	14	24.6%
No, but it would help me	7	12.3%
No, I do not need any	6	10.5%

Source: Worcestershire Homeless Audit 2017/18.

Table 17 Proportion of Individuals with Mental Health Needs that are Receiving Care for this and the adequacy of this care?

Response	Count	Percentage
Yes, and it meets my needs	21	33.9%
Yes, but I'd still like more help	16	25.8%
No, but it would help me	15	24.2%
No, I do not need any	10	16.1%

Source: Worcestershire Homeless Audit 2017/18.

Military Veterans[77]

When staff leave HM Forces, their healthcare transfers from the military to the NHS. The Government has limited data on the number of veterans with mental health conditions across the UK. NHS England only began to record widely the number of veterans accessing its mental health services from April 2017. Only around 0.1% of regular service personnel are discharged annually for mental health reasons. However, some veterans develop mental health problems after leaving service, many of whom will be experiencing Post Traumatic Stress Disorder (PTSD).

Veterans' mental health problems may be made worse or caused by post-service factors, such as the difficulty in making the transition to civilian life, marital problems, and loss of family and social support networks. Younger veterans are at high risk of suicide in the first two years after leaving service. Ex-service personnel are also vulnerable to social exclusion and homelessness, both of which are risk factors for mental ill health. Alcohol misuse is also high. Certain groups of veterans, regardless of deployment, are potentially more vulnerable to developing mental health conditions. These include female personnel and early Service leavers.

A recent study of 403 military veterans who had contacted Combat Stress, a veterans' mental health charity, found that 82% had PTSD, 74% had anger difficulties, 72% had anxiety and depression, and 43% misused alcohol. 32% of the veterans who had PTSD also had other over-lapping health problems, whereas only 5% had just PTSD on its own[78]

There are an estimated 5 million veterans in the UK. Table 18 contains estimates of working age veterans in Worcestershire.

Table 18 Estimates of the Number of Military Veterans Living in Worcestershire by District

Geographical level: National to Local authority	Estimated Number of working age veterans	All usual residents aged 16 to 64	Veterans as a percentage of all usual residents aged 16 to 64
Bromsgrove	935	57,972	1.6%
Malvern Hills	1,051	44,238	2.4%
Redditch	1,202	55,772	2.2%
Worcester	1,617	65,682	2.5%
Wychavon	1,611	72,024	2.2%

[77] Mental Health Foundation Armed, Forces and mental health: https://www.mentalhealth.org.uk/a-to-z/a/armed-forces-and-mental-health

[78] Murphy, D., Ashwick, R., Palmer, E. & Busuttil, W., 2017. Describing the profile of a population of UK veterans seeking support for mental health difficulties. *Journal of Mental Health,* pp. 1-8

Wyre Forest	1,360	60,727	2.2%

Source: UK Census 2011

Risk Factors and Protective Factors for Mental Health

Smoking

Smoking is linked with 1 in 6 deaths in England as is associated with a reduced healthy life expectancy (i.e. How long a person spends in good health)[79]. When compared to the general population, adults with a common mental health disorder (such as depression or anxiety) are twice as likely to smoke and adults with a serious mental illness (schizophrenia or bipolar disorder) are three times more likely to smoke[80]. High smoking rates among people with mental health problems are a large contributor to their 10 to 20-year reduced life expectancy[81]. In Worcestershire 37% of adults with serious mental illness (SMI) smoke whereas only 16.8% of the total Worcestershire adult population smoke[82]. These figures are lower than those for England with 40.1% of adults with a SMI smoking and 17.6% of the total adult population[83]. Table 19 gives smoking prevalence by CCG area in Worcestershire.

Table 19 QOF Based Smoking Prevalence Estimate by Area

Area	Smoking Prevalence (%)
England	17.6
West Midlands	18.0
NHS Redditch And Bromsgrove CCG	17.0
NHS South Worcestershire CCG	16.5

[79] ONS, 2018. *What affects an areas healthy life expectancy?.* [Online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/articles/whataffectsanareashealthylifeexpectancy/2018-01-18 [Accessed 6 12 2018].

[80],[15], [16], PHE, 2014. *Smoking prevalence in adults with serious mental illness.* [Online] Available at: https://fingertips.phe.org.uk/search/smoking [Accessed 4 10 2018].

[83]PHE, 2014. *Smoking prevalence in adults with serious mental illness.* [Online] Available at: https://fingertips.phe.org.uk/search/smoking [Accessed 4 10 2018].

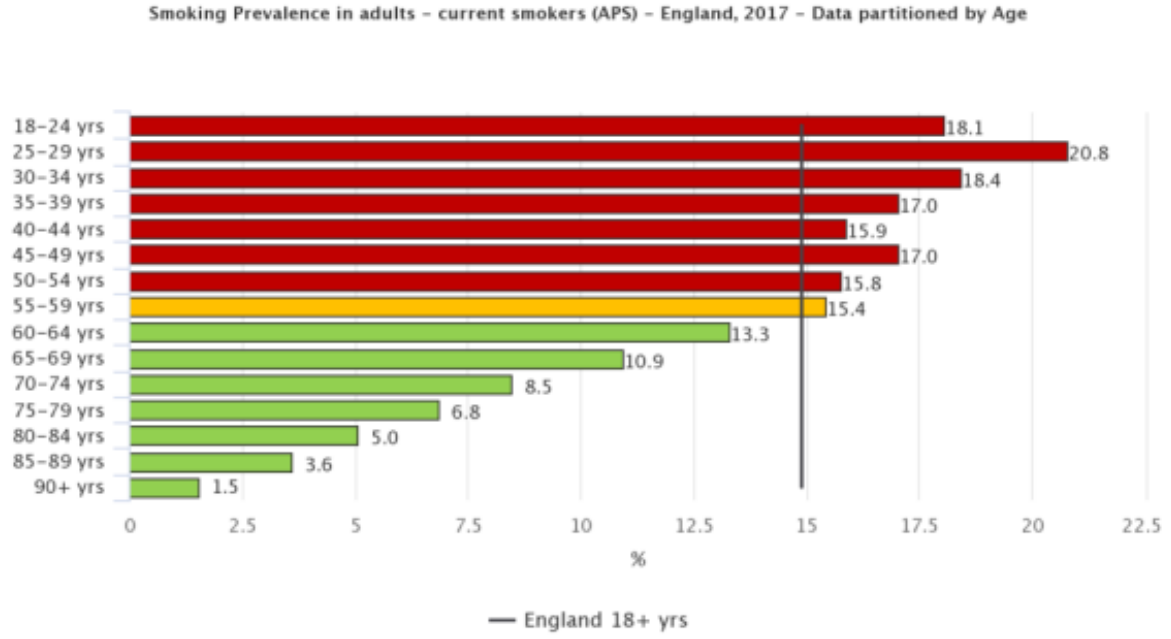
NHS Wyre Forest CCG	16.5

Source: PHE, Fingertips

Smoking is associated with many sociodemographic factors. Figure 42 **to** Figure 47 highlights the effect of age, gender, deprivation, ethnicity and sexuality on smoking prevalence. These factors are also associated with the prevalence of mental illness as described earlier.

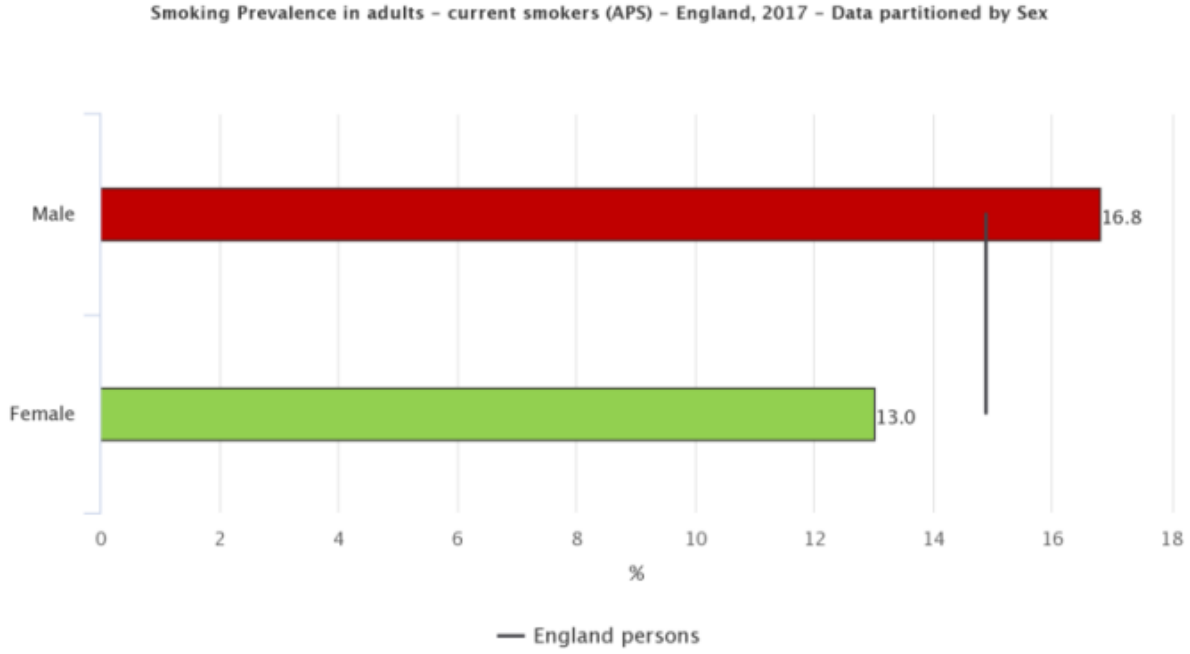
Age has a significant impact on smoking behaviour. Smoking is most common in the 25-29 age group and decreases with age after this point (Figure 42). Smoking is much more common in men (16.8%) compared to women (13.0%) (Figure 43)**.** Smoking prevalence in people with a serious mental illness and in the general population, increases with deprivation (Figure 44 and Figure 45). Prevalence is highest in mixed ethnic groups (20.5%) and lowest in Chinese and Asian groups (Figure 46). Sexuality has a strong effect on smoking prevalence. Bisexual people are most likely to smoke (26.6%) followed by gay or lesbian people (25.1%) (Figure 47).

Figure 42 The effect of Age on Smoking Prevalence in Adults (England)



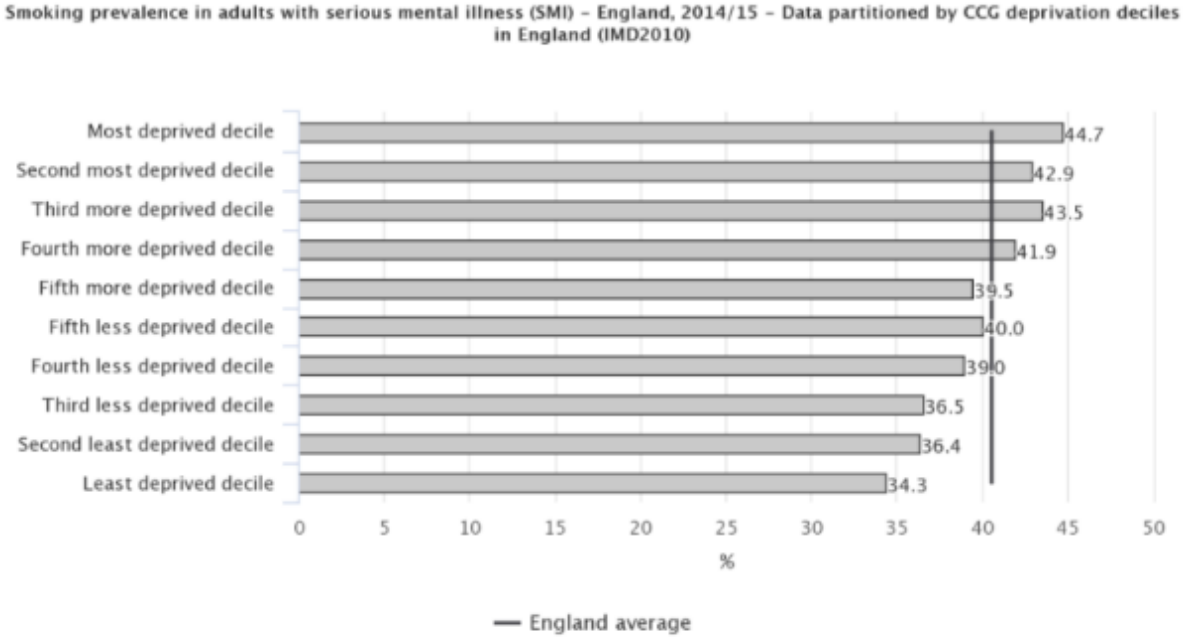
Source: PHE, Fingertips, based on APS (2017)

Figure 43 The Effect of Gender on Smoking Prevalence in Adults (England)



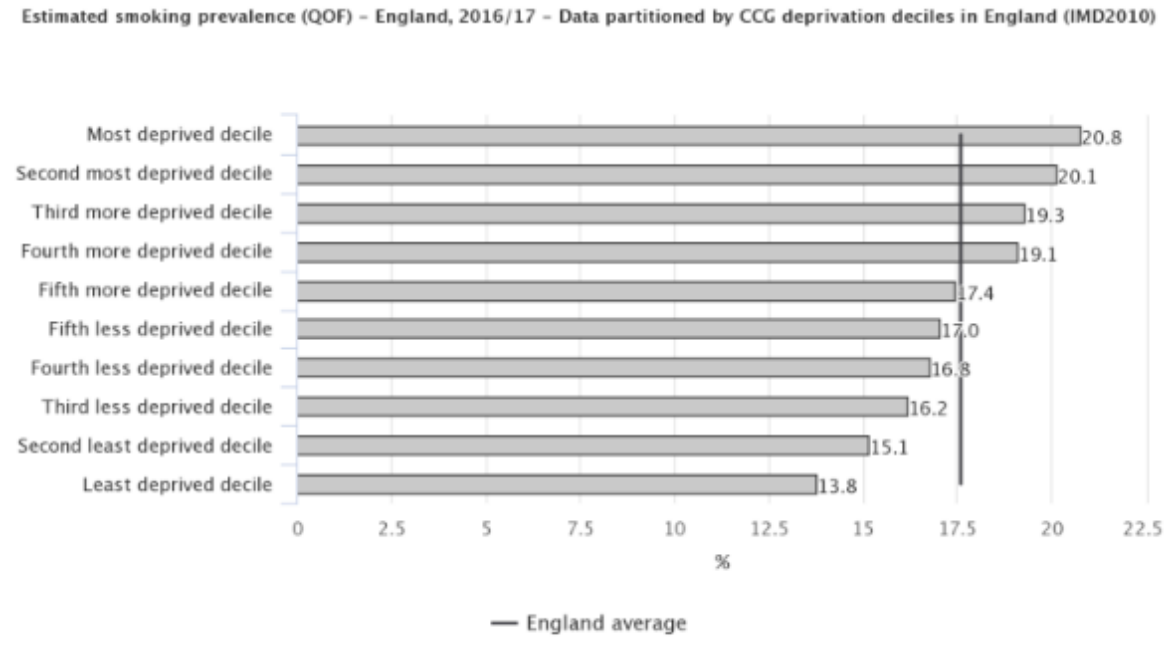
Source: PHE, Fingertips, based on APS (2017)

Figure 44 The Effect of Deprivation on Smoking Prevalence in Adults with a serious mental illness (England)



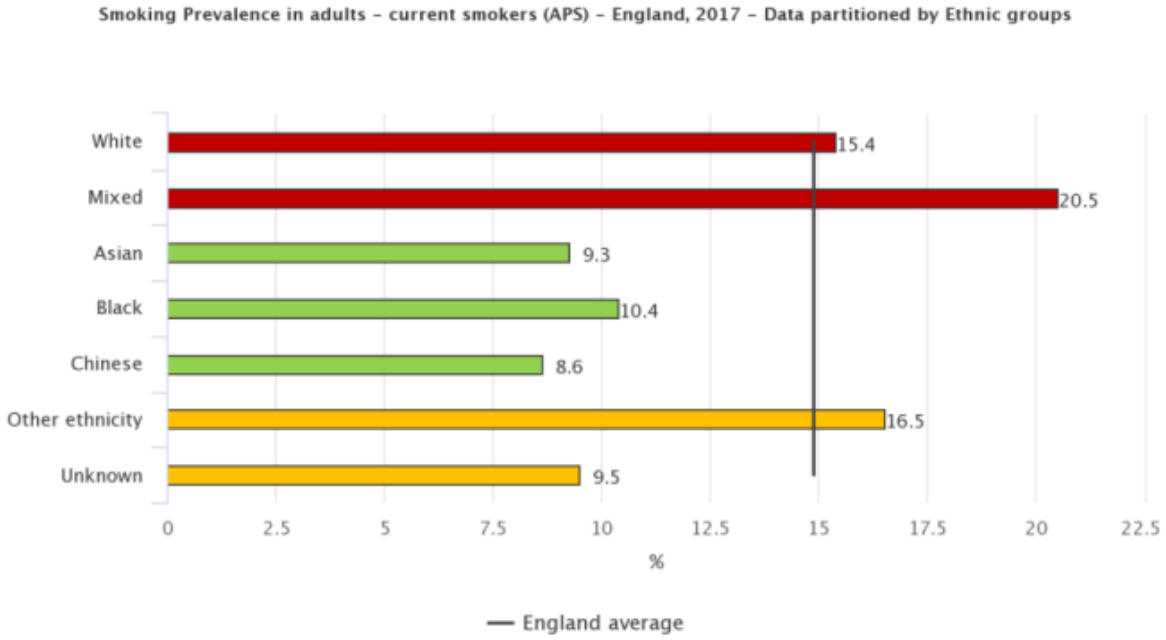
Source: PHE, Fingertips (2014/15)

Figure 45 The Effect of Deprivation on Smoking Prevalence in Adults (England)



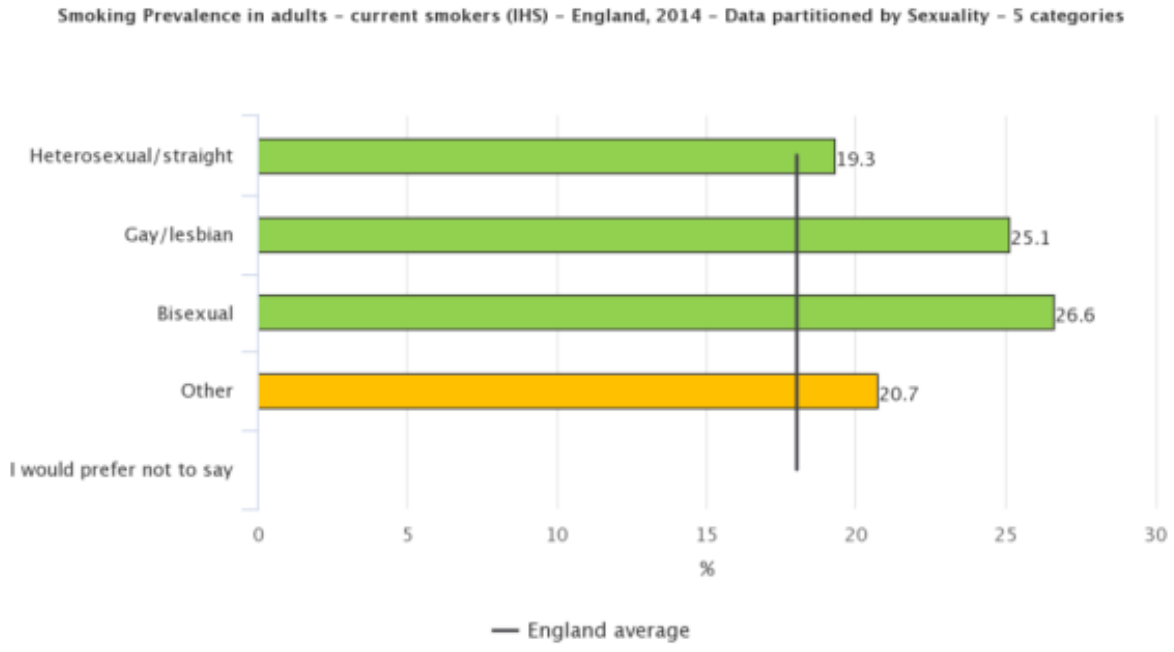
Source: PHE, Fingertips, QOF estimates (2016/17)

Figure 46 The Effect of Ethnicity on Smoking Prevalence in Adults (England)



Source: PHE, Fingertips, based on APS (2017)

Figure 47 The Effect of Sexuality on Smoking Prevalence in Adults (England)



Source: PHE, Fingertips, based on The Integrated Household Survey (2014)

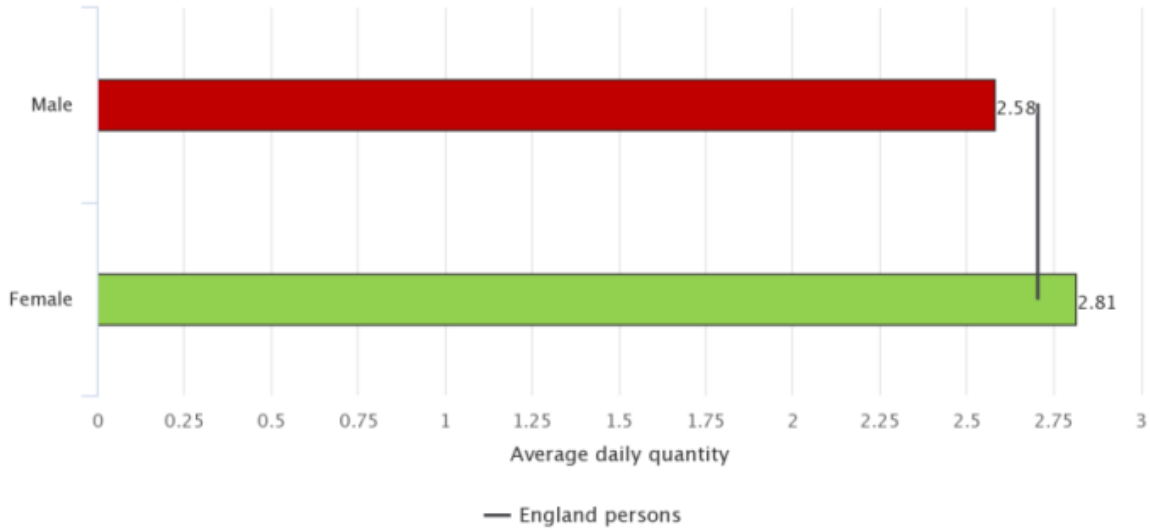
Diet

Eating healthy food, particularly fruit and vegetables, can positively affect mental as well as physical health. The importance of good nutritional intake at an early age has been well studied. A systematic review in 2014 found that a poor diet (with high levels of processed food products, saturated fat and refined carbohydrate) is linked to poorer mental health in children and adolescents[84]. Several studies in adults have linked a well-balanced diet, high in fruit and vegetables, to higher reported levels of wellbeing[85] and lower levels of depression[86].

According to the Active Lives Survey (2016/17), the average number of portions of fruit consumed daily by adults (16+) in Worcestershire is 2.68. This is similar to the average for England (2.65). The average number of portions of vegetables consumed daily was 2.76 for Worcestershire and 2.70 for England. A person's diet is influenced by a huge number of factors. The effect of gender, age and socioeconomic group on the number of portions of vegetables consumed daily are shown in Figure 48, Figure 49 and Figure 50**.**

Women, older adults and those with a managerial or professional occupation consume relatively more vegetables which may be used as an indicator of a healthy diet.

Figure 48 The Average Number of Portions of Vegetables Consumed daily by Adults in England by Gender



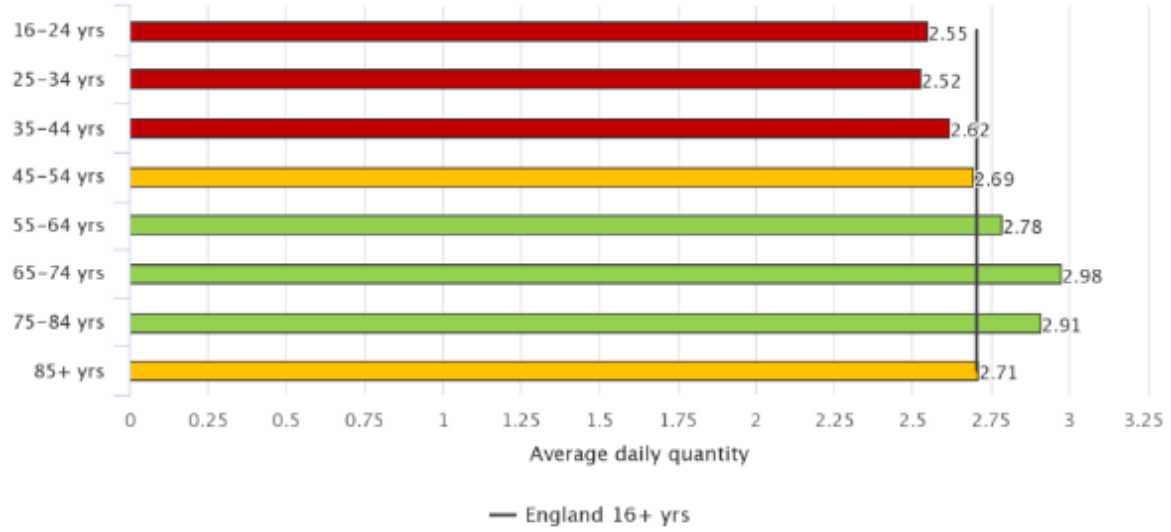
[84] O'Neil, A. 2014. Relationship between diet and mental health in children and adolescents: A systematic review. *American Journal of Public Health,* 104(10), p. 31–42.

[85] Samaraweera, P., Taggart, F., Kandala, N. & Stewart-Brown, S., 2014. Major health-related behaviours and mental well-being in the general population: The Health Survey for England. *British Medical Journal,* Volume 4, p. 9

[86] Parletta, N. et al., 2017. A Mediterranean-style dietary intervention supplemented with fish oil improves diet quality and mental health in people with depression: A randomized controlled trial (HELFIMED). *Nutritional Neuroscience,* pp. 1-14.

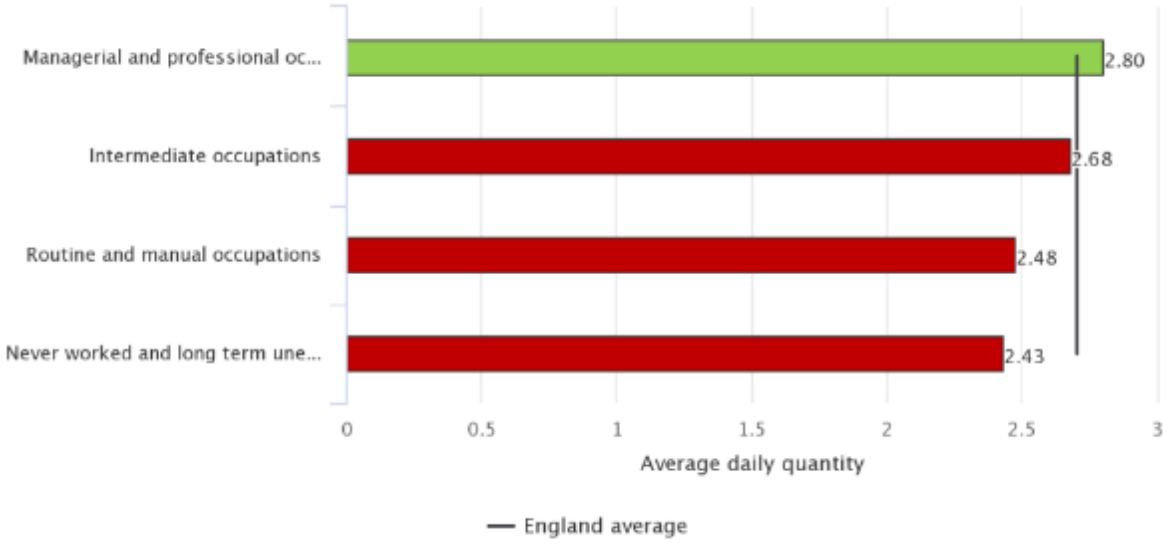
Source: PHE, Fingertips, based on Active Lives survey (2016/17)

Figure 49: The Average Number of Portions of Vegetables Consumed by Adults in England by Age Group



Source: PHE, Fingertips, based on Active Lives survey (2016/17)

Figure 50 The Average Number of Portions of Vegetables Consumed by Adults in England by Socioeconomic Class



Source: PHE, Fingertips, based on Active Lives survey (2016/17)

Physical Exercise

The relationship between physical activity and mental health works both ways. Physical activity can positively affect stress, self-esteem, anxiety, dementia and depression and is recommended in the treatment of depression[87]. However, those with severe mental health problems are less likely to engage in physical activity and are more likely to be physically unwell.

67.2% of Worcestershire adults undertake the recommended 150+ minutes of moderate intensity exercise per week. 21.1% undertake less than 30 minutes of moderate intensity exercise per week. These figures are similar to the national percentages of 66.0% and 22.0% (Table 20).

Table 20 : Physical Activity in Adults (19+) (2016/17)

Area	Percentage of adults that are physically inactive *	Percentage of adults that are physically active **
Worcestershire	21.1	67.2
West Midlands	25.0	62.6
England	22.2	66.0

*(<30 minutes of moderate intensity equivalent minutes per week)

**(150+ moderate intensity equivalent minutes per week)

Source: PHE, Fingertips, based on Active Lives survey, 2016/17

Overweight and Obesity

The relationship between mental illness and obesity is complex but it is generally acknowledged that rates of obesity are higher among people with a mental health condition[88]. The results from a 2010 systematic review found two-way associations between depression and obesity. People who were obese had a 55% increased risk of developing depression, whereas people experiencing depression had a 58% increased risk of becoming obese[89]

62% of Worcestershire adults are overweight, including obese (Table 21). There is some variation in the prevalence of excess weight between the different districts. Just over 65%

[87] Steinmo, S., Hagger-Johnson, G. & Shahab, L., 2014. Bidirectional association between mental health and physical activity in older adults: Whitehall II prospective cohort study.. *Preventive Medicine,* pp. 74-79
[88] Diet and Mental health: https://www.mentalhealth.org.uk/a-to-z/d/diet-and-mental-health
[89] Luppino, F., de Wit, L. & Bouvy, P., 2010. Overweight, Obesity, and Depression: A Systematic Review and Meta-analysis of Longitudinal Studies. *Arch Gen Psychiatry,* Issue 67, p. 220–229.

of adults in Wychavon and Redditch are overweight or obese compared to 57.5% in Worcester.

Table 21 The Proportion of Adults who are Overweight (including obese) by Worcestershire District (2016/17)

Area	% Of Adults (18+) Overweight including Obese
Worcester	57.5
Wychavon	65.3
Wyre Forest	60.3
Redditch	65.4
Malvern Hills	59.0
Worcestershire	62.0
England	61.3

Source: PHE, Fingertips, based on Active Lives survey, 2016/17

Alcohol misuse

Mental health issues not only result from drinking too much alcohol, they can also cause people to drink too much.

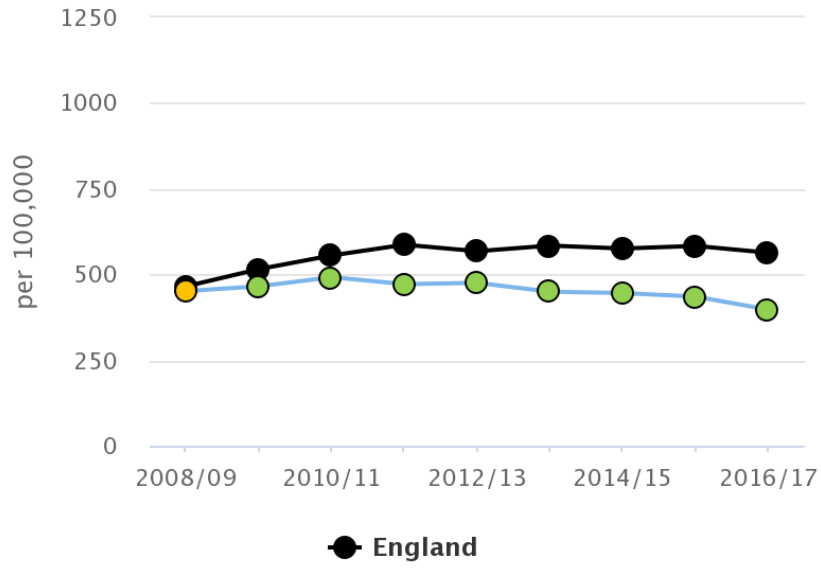
It is estimated, based on APMS 2014, that 1.17% of the Worcestershire population suffer from Alcohol Dependence (n=5,407). This is less than the national estimate of 1.39% for England [90].

There are several additional indicators which infer the burden of excessive alcohol intake in Worcestershire. These are described below.

[90]PHE, 2018. *Public Health Profiles.* [Online] Available at: https://fingertips.phe.org.uk [Accessed 13 12 2018].

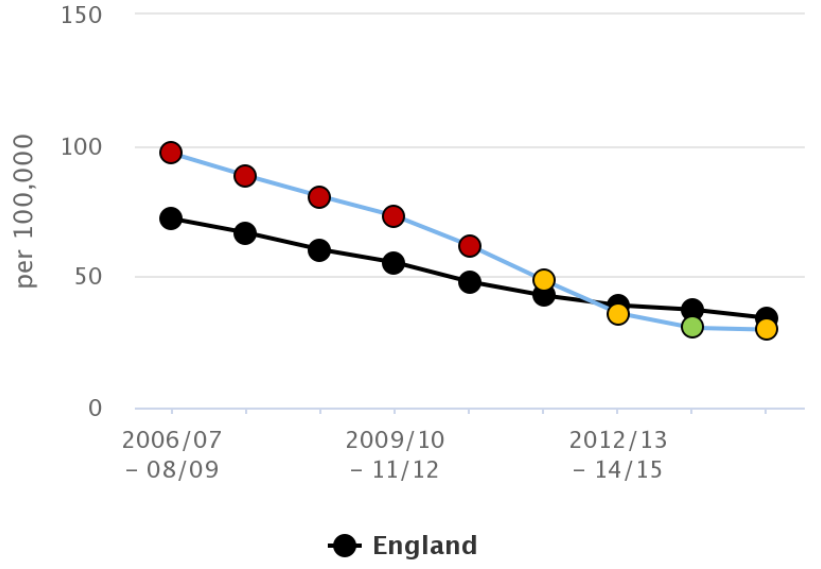
Figure 51 and Figure 52 demonstrate trends in hospital admissions for alcohol specific conditions, i.e. where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific (wholly attributable) condition.

Figure 51 Hospital Admissions for Alcohol Specific Conditions (persons, Worcestershire)



Source: Public Health England, Fingertips*

Figure 52 Hospital Admissions for Alcohol Specific Conditions (Under 18s, Worcestershire)

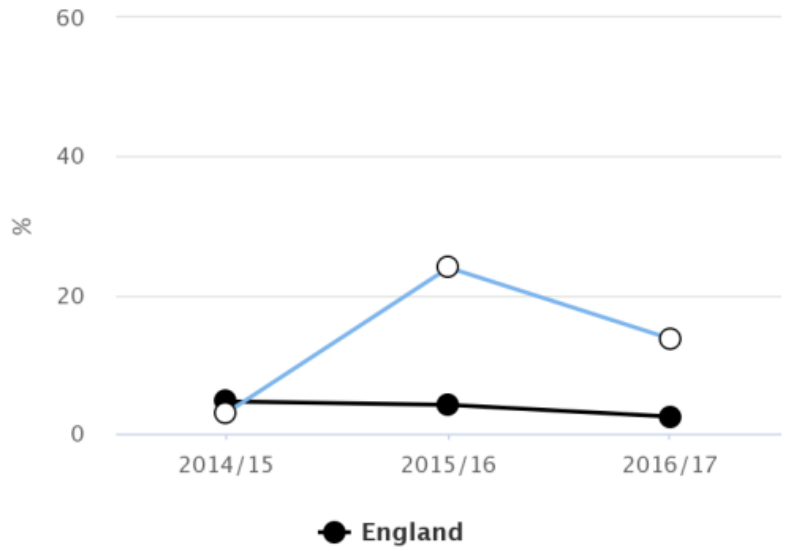


Source: Public Health England, Fingertips*

***Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates**

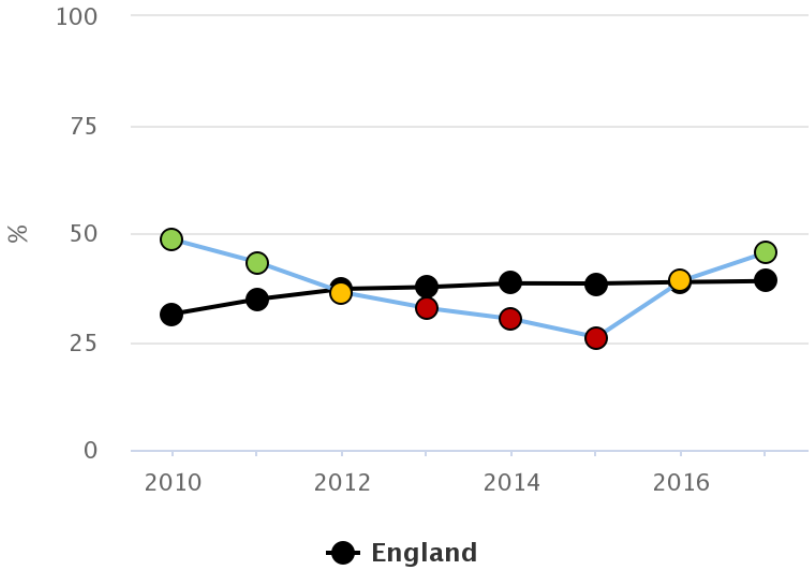
The National Drug Treatment Monitoring System (NDTMS) collect data on the number of individuals receiving treatment for alcohol dependence, waiting times for treatment and the percentage of adults that successfully complete treatment. Figure 53 shows the percentage of people who wish to access alcohol treatment services for the first time, that wait longer than 3 weeks be begin the programme. In Worcestershire in 2016/17 13.7% (n=82 people) had to wait more than 3 weeks for treatment to start, substantially higher than the 2.4% average for England (Figure 53). The percentage of adults who successfully complete alcohol treatment out of those who start treatment is presented in Figure 54**.** In Worcestershire in 2017, almost 50% of adults who entered the alcohol treatment programme successfully completed it (successful treatment defined as no re-present to treatment within 6 months).

Figure 53 Trends in the Proportion of Individuals Accessing Alcohol Treatment Services who had to Wait More Than 3 Weeks in Worcestershire



Source: PHE, Fingertips.

Figure 54 The Proportion of Adults who Accessed Alcohol Treatment Who Successfully Completed the Programme, Worcestershire



Source: Public Health England, Fingertips

Drug Misuse

Public Health England (PHE) have used various sources (drug treatment, probation, police and prison data) to derive drug use prevalence estimates. Estimated prevalence of opiate and/or crack cocaine use in Worcestershire is 7.7 per 1,000 population (2014/15 estimate) and the estimated prevalence in England is 8.6 per 1,000 population (2014/15)[91]

According to the National Drug Treatment Monitoring System (NDTMS) a total of 1,700 people received treatment at specialist drug misuse services in Worcestershire in 2016/17. In Worcestershire (2017) 8.0% of opioid users successfully completed treatment and 42.5% of non-opioid drug users successfully completed treatment (free of drugs of dependence and do not then re-present to treatment again within 6 months). In England 6.5% of opioid users and 36.9% of non-opioid drug user's successfully complete treatment.

Mental health problems are very common among those in treatment for drug use. The proportion of adults (>18 years) who, when assessed for drug treatment, were already receiving treatment from mental health services (for reasons other than substance misuse) was 24.3% (23.9% to 24.6%) in England and 8.4% (n=40, 95%CI 6.2% to 11.3%) in Worcestershire (2016/17).

The difference in the proportions above may be due to chance (small numbers of individuals receiving drug treatment in Worcestershire), error e.g. in coding or recording differences, or true. A true difference may be the result of poor access to mental health services in drug users in Worcestershire or a reduced prevalence on mental health issues in drug users in Worcestershire.

[91]PHE, 2018. *Public Health Profiles.* [Online] Available at: https://fingertips.phe.org.uk [Accessed 13 12 2018].

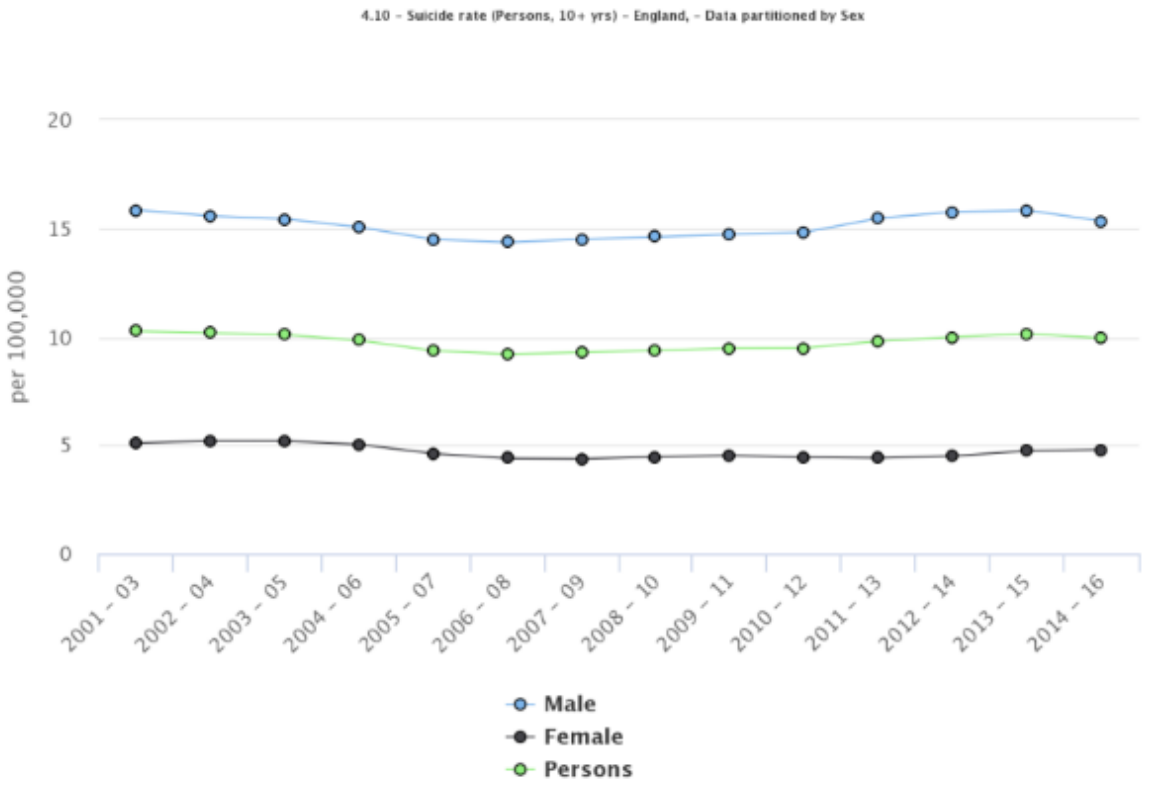
Suicide and Self-harm

Suicide rates in England have remained reasonably constant over the past decade (see Figure 55). There is a national ambition to reduce suicide rates by 10% by 2020/21[92] To help meet this the Worcestershire Health and Well-being Board has a suicide prevention strategy which it is currently working to.

There is a notable difference in suicide rate between men and women. In 2014/16 the rate in women was 4.8/100,000 and 15.3/100,000 in men. The national suicide rate along with rates in the West Midlands, Worcestershire and the Worcestershire districts are presented in Error! Reference source not found.. The suicide rate in Worcestershire (10.8/100,000, 95%CI 9.2 to 12.6/100,000) is above the West Midlands rate (9.5/100,000 95% CI 9.0 to 10.0/100,000) and England as a whole (9.6/100,000, 95%CI 9.4 to 9.7/100,000). Note however the overlapping confidence intervals suggesting no statistically significant difference. At the district level rates are highest in Redditch and Wychavon.

[92] NHS Seven Day Services Clinical Standards: https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

Figure 55 Suicide Rate Trends (Age 10+) in England 2001-2016 by Sex



Source: Public Health England, Fingertips

Table 22 Suicide rate (10+ years) (2015 /17)- Population>10yrs

Area	Count	Suicide Rate per 100,000
England	14,277	9.6 (9.4 to 9.7)
West Midlands region	1,494	9.5 (9.0 to 10.0)
Worcestershire	162	10.8 (9.2 to 12.6)
Bromsgrove	25	10.0 (6.4 to 14.8)
Malvern Hills	18	8.7 (5.0 to 14.0)
Redditch	26	11.6 (7.6 to 17.1)
Worcester	30	10.6 (7.1 to 15.2)
Wychavon	39	12.4 (8.7 to 17.1)
Wyre Forest	27	10.0 (6.5 to 14.6)

Source: Public Health England (based on ONS source data)

Table 23 describes the rate of self-harm events severe enough to warrant hospital admission.

describes the rate of self-harm by intentional self-poisoning with alcohol. These hospital admissions may be used as a proxy of the prevalence of severe self-harm although they likely underestimate the true burden of self-harm.

The rate of emergency admissions for self-harm in Worcestershire (159.7/100,000) is statistically significantly below the national rate (185.3/100,000), as indicated by the non-overlapping confidence intervals. The rates in all districts, with the exception of Redditch (196.9/100,000), are also below the national rate, Worcester, Wychavon and the Malvern Hills are statistically significantly below. The trends in hospital admissions for self-harm in Worcestershire and nationally are shown in Figure 56.

Table 23 Emergency Hospital Admissions for Intentional Self-Harm 2016/17

Area	Count	Rate per 100,000 (95% Confidence Intervals)
England	103,723	185.3 (184.1 to 186.4)
West Midlands	11,086	189.0 (185.5 to 192.6)
Worcestershire	890	159.7 (149.3 to 170.6)
Bromsgrove	146	161.2 (135.9 to 189.8)
Malvern Hills	98	136.5 (110.1 to 167.2)
Redditch	166	196.9 (168.0 to 229.4)
Worcester	154	140.3 (118.7 to 164.6)
Wychavon	173	153.7 (131.3 to 178.8)
Wyre Forest	153	167.3 (141.6 to 196.3)

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England.

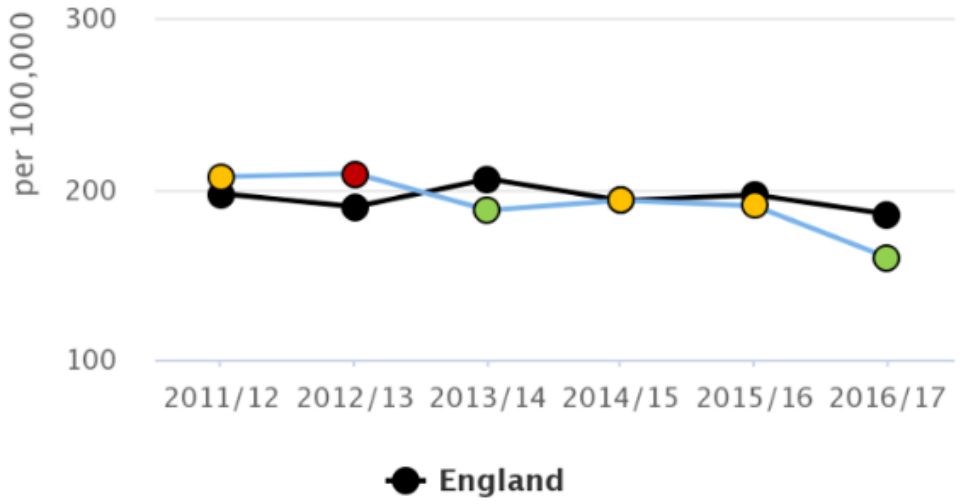
Table 24 Admission Episodes for Intentional Self-poisoning by Exposure to Alcohol (Persons) 2016/17

Area	Admission episodes for intentional self-poisoning with Alcohol*	
	Count	Rate per 100,000
England	25,851	46.7
Bromsgrove	24	*
Malvern Hills	21	*
Redditch	39	45.8
Worcester	46	43.1
Wychavon	40	36.6
Wyre Forest	42	46.8

Source: PHE, Fingertips

***Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates**

Figure 56 Trends in Emergency Hospital Admissions for Intentional Self-Harm, 2011/12-2016/17



Source: Public Health England, Fingertips

Acute and Community Mental Health Services in Worcestershire

Worcestershire Health and Care NHS Trust is the main provider of acute and community mental health services to the population of Worcestershire.

Mental health services for adults in Worcestershire include:

- Acute wards and psychiatric intensive care units
- Long stay/rehabilitation mental health wards
- Community-based mental health services
- Mental health crisis services and health-based places of safety
- Community mental health services for people with learning disabilities or autism

Acute wards and psychiatric intensive care units

The Trust's acute wards and psychiatric intensive care unit (ICU) care for adults (male or female) up to the age of 65. Two wards are based in Worcester at the Newtown Hospital site and one in Redditch.

• Hillcrest in Redditch is a 25-bed ward. Its focus is on treatment and recovery so that patients could be discharged back to their own home or longer-term care if this was required.

• Holt Ward in Worcester has 14 beds. Patients generally stay on this ward for up to two weeks before moving on to Hillcrest for treatment or back out to the community under the care of the community teams.

• Hadley psychiatric ICU is on the same site as Holt Ward and has 9 beds.

Long stay/rehabilitation mental health wards

Two high dependency wards care for patients aged between 18 and 65 years (male and female) with mental health conditions, who require a high dependency model of rehabilitation: Cromwell House, a 10-bed ward in Worcester, and Keith Winter Close, a 15-bed ward based in Bromsgrove. These wards provide a 24-hour service offering intensive input for patients who experience complex mental health difficulties, usually psychosis, and have persistent symptoms and severe levels of social and functional impairment.

Community-based mental health services

Community-based mental health services were reconfigured in October 2016 and renamed as the Community Assessment and Recovery Services (CARS), based at two centres, Studdert Kennedy in Worcester (south team) and New Brook at Princess of Wales Community Hospital in Bromsgrove (north team). In addition to these two main centres, the service also has 'touch point' centres in Malvern, Evesham, and Droitwich for the south team, and Kidderminster and Redditch for the north team. The service operates alongside other mental health services in Worcestershire to support adults of working age

(18-65) with mental health problems and help them on a recovery pathway.

Figures from the trust showed the service had 1,749 referrals in the twelve months to January 2018 and discharged 2,323 patients in the same period.

Mental health crisis services and health-based places of safety

Mental health crisis services and health-based places of safety provided by Worcestershire Health and Care NHS Trust are part of the trust's mental health and learning disability service delivery unit. Services are provided for people in mental health crisis aged 17 and above or those requiring assessment under Section 136 or 135 of the Mental Health Act 1983. Patients are usually seen at home and as an alternative to hospital admission.

There are three home treatment teams, South Worcestershire, Wyre Forest and the Bromsgrove and Redditch team, one crisis assessment team based in Worcester City and one health–based place of safety based at Newtown hospital, Worcester.

Community mental health services for people with learning disabilities or autism

Learning Disability Psychiatry - Assessment and treatment of psychiatric, behavioural and seizure disorders associated with learning disability in adults. The service is accessed through GP referral to a Psychiatrist or to the Community Learning Disability Team.

Community Learning Disability Teams - Two Community Learning Disability Teams operate in North (Bromsgrove, Redditch and Wyre Forest) and South (Malvern, Wychavon and Worcester) Worcestershire. These are integrated health and social care team providing a comprehensive community service to adults with a learning disability living within the Bromsgrove and Redditch areas of Worcestershire.

Church View Short Breaks- A specialist short breaks service providing short breaks to adults with various degrees of behaviours which challenge and complex health care needs.

Osborne Court is part of the provider arm within the Learning Disability integrated service. It operates four distinct services: Children's short break service, Children's emergency and assessment service, Adult's short break service and a Hydrotherapy Pool.

Specialist Services

Healthy Minds provide support to people, aged 16 and over, who are experiencing problems such as stress, anxiety, low mood and depression. The service aims to improve mental wellbeing through a range of interventions such as short courses, online therapies, and guided self- help. Part of Healthy Minds is the **Worcestershire Wellbeing Hub**; an information and signposting service for support from local community providers.

Now We're Talking Campaign –A campaign run by Worcestershire Health and Care NHS Trust in partnership with the Worcester Warriors (a local rugby team) which targets men in particular. As well as raising awareness of the local service available (namely, Healthy Minds), the campaign will encourage people to support their mental wellbeing, to talk and open up about mental health and will contribute to the aim of reducing the stigma around mental health.

The Mental Health Liaison Team respond to all mental health referrals from A&E and to referrals for patients admitted because of a suicide attempt or self-harm across the Acute hospitals (Worcestershire Royal Hospital and Alexandra Hospital).

New Opportunities Worcestershire offers patients in secondary mental health services, a specialised route to those needing greater support, assisting service users to improve skills (e.g. cooking, horticulture, art), gain confidence and increase concentration to enable them to move into mainstream activities or progress into other parts of the pathway.

Worcestershire Re-ablement Service is targeted at adults with severe and/or enduring mental illness. It aims to increase community-based roles and activities, including reducing social isolation by providing people with opportunities to extend their social networks and form relationships not only with other people with mental health difficulties and staff, but also with people outside the mental health system. All services users will already be in receipt of secondary mental health services. Referral to the service follows an initial discussion between the service user and their main mental health worker about which part of the Employment and Re-ablement pathway.

The Samaritans – A national charity with a branch in Worcester provide a platform for people suffering with suicidal thoughts or self-harm to talk to a trained volunteer about their issues either on the phone, by email or in person.

Equity of Access to Mental Health Services

Social characteristics (gender, disability, age, race and ethnicity), sexual orientation and cultural attitudes influence access to services and support. It is a legal requirement that access to mental health services should not be discriminatory on the basis of protected characteristics as defined by the Equality Act 2010. Protected characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage/civil partnership
- Pregnancy
- Race
- Religion or belief
- Sex
- Sexual orientation

Equity in Service Referral and Service Usage

There is limited data available regarding service referral and usage by the protected characteristics described above.

The age (grouped), gender and ethnicity of most referrals to Worcestershire Healthy Minds have been recorded over the past few years. Table 25 shows the demographics of the 11,366 individuals who were referred to this service between 1st of April 2017 and the 31st of March 2018.

Table 25 Demographics of Referrals to the Worcestershire Healthy Minds Service 2017/18

Demographic		Proportion of Referrals (%)
Gender	Male	37.9
	Female	62.1
	Unknown	0.04
Age Range	<16 years	0.02
	16-64 years	94.9
	≥65 years	5.09
Ethnicity	White	74.0
	Mixed	1.23
	Asian	1.1
	Black	0.39
	Chinese	0.10
	Other ethnic group	0.18
	Unknown	23.0

The gender of almost all individuals referred to the Worcestershire Healthy Minds service in 2017/18 was recorded. The majority of referrals were female (62.1%). Age was consistently recorded but detail was lacking with age groups set at less than 16 years, 16-64 years and more than 65 years. Over 96% of referrals were between 16 and 64 years. The service targets those over 16 years so it is not surprising that there are very few referrals for individuals less than 16 years. The majority (74.0%) of referrals are of white ethnicity. 23% of individuals referred did not have their ethnicity recorded. If these are excluded, 96.2% of the remainder are from a white ethnic group. This highlights the low proportion of the individuals referred who were from a BAME group.

Risk Factors and Protective Factors for Mental Health

Smoking

ASH: The Stolen Years: sets out recommendations for how smoking rates for people with a mental health condition could be dramatically reduced.

Mental Health Foundation: Physical health and mental health: includes summary of relationship between health behaviours and mental health.

NICE: Smoking: acute, maternity and mental health services: aims to support smoking cessation, temporary abstinence from smoking and smoke free policies in all secondary care settings, including mental health services. Includes interactive pathway, baseline assessment, implementation advice and self-assessment tool.

PHE: Smoking cessation in secondary care: mental health settings: guidance and self-assessment framework for NHS mental health trusts to develop local action to reduce smoking prevalence and the use of tobacco.

UK Faculty of Public Health: Better Mental Health for All – Relationship with physical health and healthy lifestyles: evidence and information about the links between physical and mental health.

Alcohol

Alcohol Concern: An Audit of the Focus on Alcohol-related Harm in Joint Strategic Needs Assessments, Joint Health and Well-Being Strategies and CCG Commissioning Plans: focusses on the priority given to tackling alcohol-related harm in Joint Strategic Needs Assessments (JSNAs), Joint Health and Wellbeing Strategies (JHWSs) and Clinical Commissioning Group (CCG) plans across England.

NICE: Coexisting severe mental illness and substance misuse: community health and social care services: covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse. The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.

PHE: Better care for people with co-occurring mental health, and alcohol and drug use conditions: guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions.

PHE: JSNA support packs for alcohol, drug and tobacco use 2017/18: JSNA support packs will help local areas to develop JSNAs and local joint health and wellbeing strategies, which effectively address public health issues relating to tobacco, drug & alcohol use.

Turning Point: Dual Diagnosis: Good Practice Guide - Helping practitioners to plan, organise and deliver services for people with co-existing mental health and substance use needs: written to support the development of services for people with co-existing mental health and substance use problems. At the heart of the handbook is a series of case studies showing how particular services have implemented good practice.

Suicide and Self Harm

Local Government Association Suicide Prevention a Guide for Local Authorities: guide for local councils on their role in suicide prevention, including a range of approaches and case studies to inform decision making.

Multicentre study of self-harm in England: collaborative research programme between the University of Oxford, University of Manchester and Derbyshire Healthcare NHS Foundation Trust.

National confidential inquiry into suicide and homicide by people with mental illness: provides the latest data and makes recommendations for improving clinical practice and service delivery to prevent suicide and reduce risk.

NICE: Self-harm pathway: quality statement around self-harm includes aspects of suicide prevention advice, particularly in the resource section (with particular reference to the use of risk assessments). Self-harm is a complicated issue which spans the life course and occurs in multiple conditions and care settings; the interactive pathway is a useful way to navigate through these.

PHE: Local suicide prevention planning – a practice resource: how local authorities can develop a multi-agency suicide prevention partnership, make sense of local and national data and develop a suicide prevention strategy and action plan.

Equity of Access to Mental Health Services

Race equality foundation and mental health providers forum: Better practice in mental health for black and minority ethnic communities: examples of best practice from organisations and projects promoting and tackling issues around mental health in BAME communities.

Ethnic inequalities in mental health: Promoting lasting positive change: summary of research and analysis in relation to people with a BAME background and mental health. Includes an overview of recent policy developments, headline statistics, and recommendations for action and investment.

Chief Medical Officer annual report: public mental health: includes chapters on parity of esteem and on ethnic inequalities and social inclusion.

IAPT positive practice guides: guides aiming to increase access across the age spectrum and to meet the needs of diverse and underrepresented groups.

Evidence and Further Information

The following documents and supporting materials are useful sources of further information:

Population Demographics and Vulnerable Groups

Mental Health Foundation: Fundamental Facts about Mental Health 2016: summary of mental health research including needs of particular groups.

Joint Commissioning Panel for Mental Health: Guidance for commissioners of mental health services for people with learning disabilities: provides guidance to support commissioners and providers including specific guidance on providing mental health services for BME communities and people with learning disabilities.

NICE: Health inequalities and population health 2012: summarises NICE recommendations for local authorities and partner organisations on population health and health inequalities.

Good Things Foundation: The Health and Wellbeing of Unpaid Carers 2015: report looking at how caring roles affect health and wellbeing, and how digital skills and community support could provide value to carer's lives.

Physical Disability

Academy of Royal Medical Colleges and others: Improving the physical health of adults with severe mental illness: essential actions: report from the Academy of Royal Medical Colleges and the Royal Colleges of General Practitioners, Nursing, Pathologists, Psychiatrists, Physicians, the Royal Pharmaceutical Society and Public Health England providing recommendations.

Improving the physical health of people with a serious mental illness: A practical toolkit: NHS toolkit including detailed case studies at pilot sites, short examples and supporting documents.

King's Fund: Bringing together physical and mental health: report advocating for integrated physical and mental health care. Provides examples of innovative service models and identifies areas where there is scope for improvement.

NHS England: Five Year Forward View for Mental Health: report from the independent Mental Health Taskforce setting out recommendations for the NHS and its arms-length bodies to achieve the ambition of parity of esteem between physical and mental health.

NHS health check best practice guidance: underlines the importance of physical health checks for people with severe mental illness.

PHE: Commissioning cost-effective services for promotion of mental health and wellbeing and prevention of mental ill health: includes information on interventions to protect the mental health of people with physical health problems.

PHE: Wellbeing in mental health: applying all our health: examples to help healthcare professionals make interventions to promote physical health and wellbeing in mental health.

Perinatal Mental Health

Introduction

The physical and mental health of the mother, and the family environment before, during and following pregnancy, infancy and childhood is of fundamental importance to mental health. A parent's ability to bond with and care for their baby, their parenting style and the development of a positive relationship can predict a number of physical, social, emotional and cognitive outcomes through to adulthood[93].

While the relationship between mother and child is particularly important, the mental health of fathers and other caregivers should also be considered. Paternal and maternal depression is shown to have a negative impact on how parents interact with children and can have long-term consequences if left untreated[94].

During pregnancy and the year after birth, many women experience common mild mood changes. Some women can be affected by common mental health problems, including anxiety disorders (13%) and depression (12%)[95]. The risk of developing a severe mental health condition such as postpartum psychosis (which affects between 1 and 2 in 1000 women who have recently given birth), severe depressive illness, schizophrenia and bipolar illness is low but increases after childbirth. The impact of poor mental health can be greater during this period, particularly if left untreated[96].

In addition to the direct impact on families, it is estimated that perinatal mental health problems cost the NHS and social services around £1.2 billion annually. A significant proportion of this cost relates to the impact on the child.

Birth Rate

In population terms, Worcestershire has a lower percentage of females aged 15-44 than England. This is the age group classed as the 'fertile' population. The General Fertility Rate (GFR) is the number of live births as a proportion of the female population aged 15-

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

[94] Centre for Mental Health, LSE Personal Social Services Research Unit. The costs of perinatal mental health problems (2015)

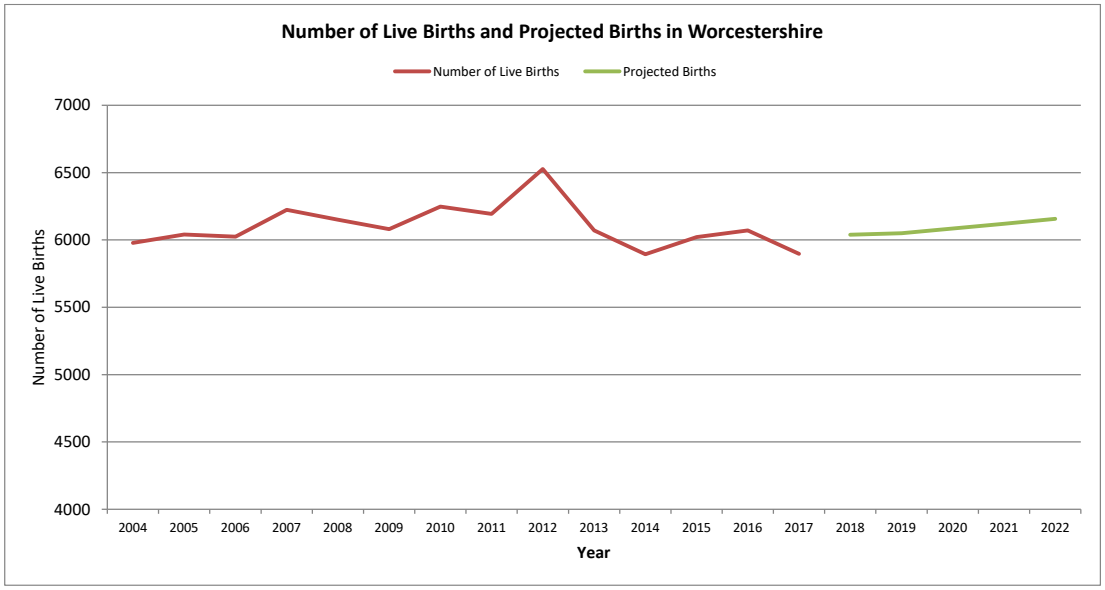
[95] NICE. Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline CG192 (2014)

[96] Royal College of GPs. Position statement about Perinatal Mental Health (2016)

44. This is the rate used to compare births across different geographical areas as it takes the population size into account.

Worcestershire has a lower General Fertility Rate than England - there are approximately 6,000 births every year in Worcestershire. The figure below shows the number of live births over the last 14 years and the predicted number for the next 5, based on the historical trend.

Figure 57 Number of Live Births and Projected Births in Worcestershire



Source: ONS Birth Registration data and projections

Table 26 Number of Live Births and Projected Births in Worcestershire

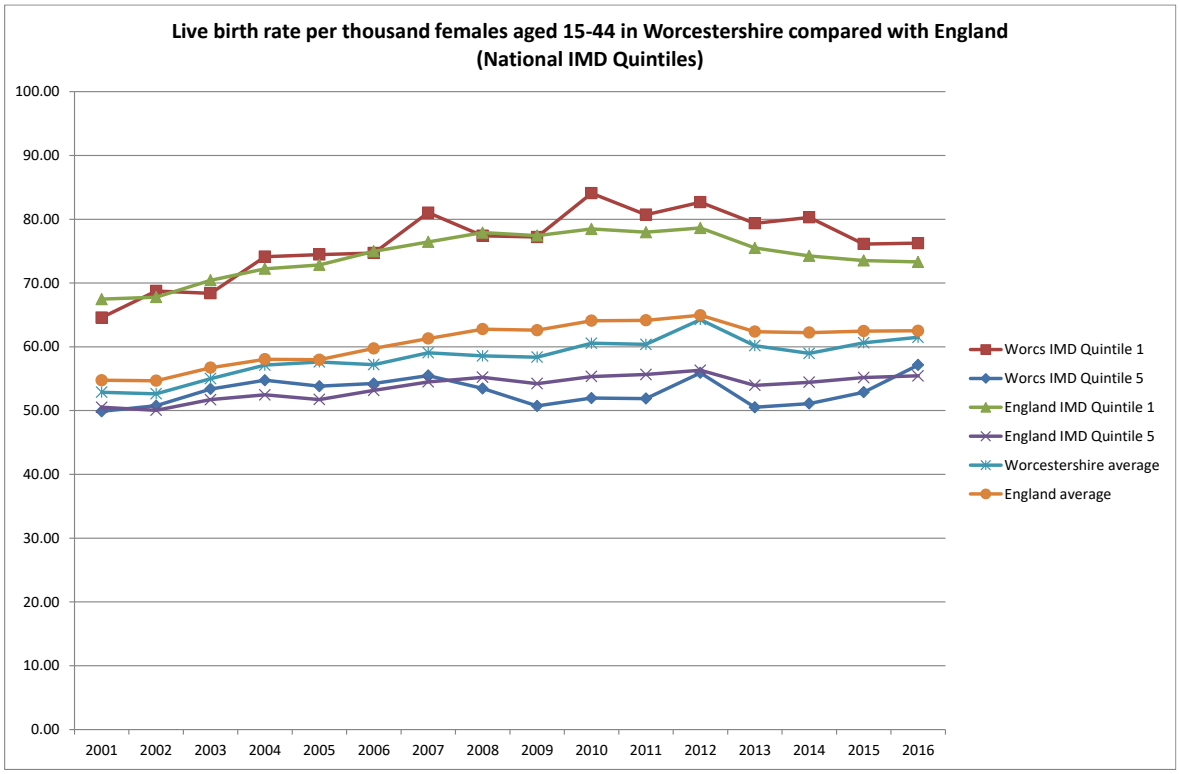
	Live Births	
	Actual	Projected
2004	5978	
2005	6041	
2006	6025	
2007	6223	
2008	6150	
2009	6080	
2010	6248	
2011	6193	
2012	6527	
2013	6070	

	Live Births	
	Actual	Projected
2014	5894	
2015	6021	
2016	6070	
2017	5897	
2018		6039
2019		6049
2020		6085
2021		6121
2022		6157

Source: ONS Birth Registration data and projections

It should be noted that we have a higher birth rate amongst the most deprived quintile of the population in Worcestershire as shown in Figure 58 below. Despite having a lower overall birth rate than England, in Worcestershire we have consistently had a higher birth rate in our most deprived areas. This trend indicates that although the overall population of children and young people are predicted to increase slightly, the numbers from the most deprived communities in the county are increasing more rapidly.

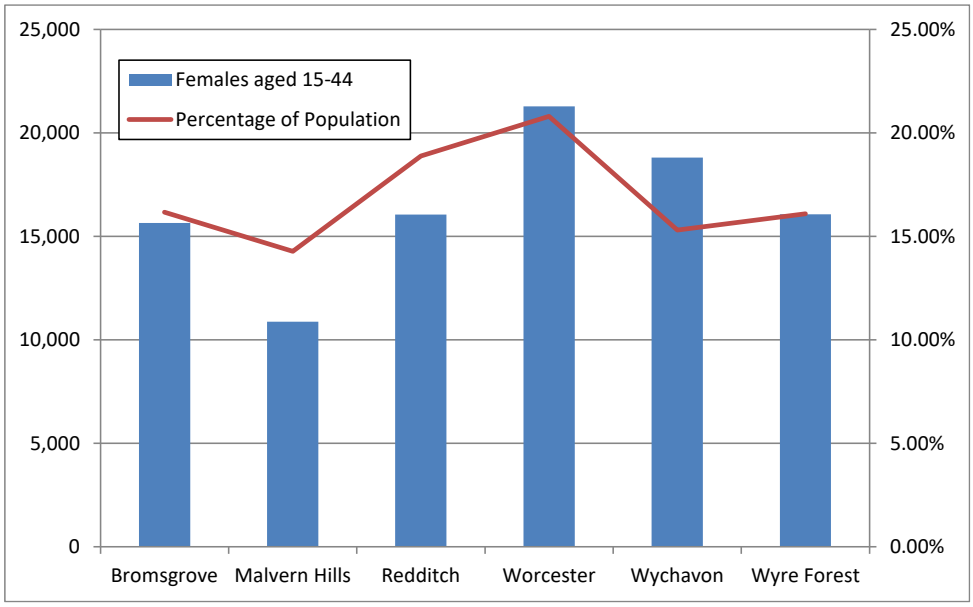
Figure 58 Live Birth Rate Comparison by IMD quintile: Worcestershire vs. England



Source: ONS Birth Registration (analysed by PHE/WCC Public Health)

At a sub-Worcestershire level, Worcester City and Redditch have higher percentages of females aged 15-44 than the average in Worcestershire, accounting for 21% and 19% respectively. Wychavon having the largest total population of all six Districts also has a considerable number of 15-44 year old females however, as a percentage of their total population this is lower than the average in Worcestershire.

Figure 59 Number of females aged 15-44 expressed as both Number and Percentage of the Council District population in 2016



Source: ONS Population Data

Prevalence

Perinatal mental health problems affect between 10 to 20% of women during pregnancy and the first year after having a baby[97]. The most common mental health problems that women in the perinatal period experience are depression and anxiety[98]. The table below gives an estimate of prevalence figures for perinatal mental health in Worcestershire based on national period prevalence estimates.

Figure 60 Annual Prevalence figures for the number of women who are estimated to be experiencing perinatal mental health problems

	Worcestershire	Notes* (Denominator is the number of women who are pregnant, which is approx. 6000 p.a.)
Postpartum psychosis	15	National prevalence estimate = 2 women in every 1000 2017/18 (actual data from Worcestershire Acute confirms this estimate)
Chronic SMI in perinatal period	15	National prevalence estimate = 2 women in every 1000
Severe depressive illness in perinatal period	175	National prevalence estimate = 30 women in every 1000

[97] Public Health England: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health

[98] Public Health England: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health

Mild-moderate depressive illness and anxiety in perinatal period	575 - 860	National prevalence estimate is between 100 and 150 women in every 1000
PTSD in perinatal period	175	National prevalence estimate = 30 women in every 1000
Adjustment disorders and distress in perinatal period	860 - 1715	National prevalence estimate is between 150 and 300 women in every 1000

Source: Perinatal Mental Health Dashboard (PHE) - Calculated for Worcestershire by applying national prevalence figures and rounding up to nearest 5

* Source of national prevalence estimates are the Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services. Volume two: practical mental health commissioning. London: Joint Commissioning Panel for Mental Health; 2012. Available from: www.jcpmh.info/resource/guidance-perinatal-mental-health-services

Risk Factors

Vulnerable populations that have been identified include mothers living in deprived areas or on low incomes, teenage mothers, maternal obesity, mothers who have had a traumatic birth, mothers with relationship difficulties, women who have been subjected to childhood/domestic abuse or neglect, women with a pre-existing psychiatric diagnosis and new mothers with an increased risk of depression.

Bereavement by miscarriage, stillbirth or neonatal death are also more likely to lead to mental health problems in both parents.

Below is a table showing the Worcestershire rates for some of these risk factors compared to the England average figures.

Table 27 Selected Risk Factor Indicators- Worcestershire compared to England

Indicator	Worcestershire	England	Comparison	Notes
Child poverty: % of children aged 0-15 (Income Deprivation Affecting Children Index)	15.7	19.9	Significantly below England	Percent of children living in child poverty lower than England
Births to mothers aged <20 as a percentage of live births	3.9	3.4	Not statistically significant	Despite a lower teenage conception rate than England, Worcestershire had a higher percentage of live births to mothers aged under 20 than in England in 2015
Percentage of births which are outside of marriage/civil partnership and sole registered (by one parent only)	4.2	5.4	Significantly below England	Lower percent of births registered by one parent in Worcestershire, so more likely to be registered by 2 parents
Lone parent households: % of households that have lone parents with dependent children	6.1	7.1	Significantly lower than England	In 2011 Worcestershire had a lower percentage of lone parent households than the England average

Infant mortality rate - Rate of deaths in infants aged under 1 year per 1,000 live births	4.1	3.9	Not statistically significant	Worcestershire had a slightly higher infant mortality rate than England for the 3 years 2015-2017 combined.
Stillbirth rate - Rate per 1,000 births	4.2	4.5	Not statistically significant	Worcestershire had a lower stillbirth rate than England for the 3 years 2014-2016 combined
Looked after children aged 0 to 4 years per 10,000 population	39.2	36.9	Not statistically significant	The looked after children rate for children aged under 5 is higher in Worcestershire than England
Looked After Children - Rate per 10,000 children under 18 years	66	60	Not statistically significant	The Looked after Children rate in Worcestershire was higher in 2017 than the England average
Children subject to a Child Protection Plan - rate per 10,000 children aged 0-17	44.5	43.3	Not statistically significant	The rate of children subject to a Child Protection Plan in Worcestershire was higher in 2017 than the England average
Percentage of children in need due to abuse or neglect	67.9	52.3	Significantly higher than England	Higher rate of children in need due to abuse or neglect than England in 2016/17
Rate of homelessness acceptances per 1,000 households	2.7	2.5	Significance is not calculated for this indicator	Slightly higher rate of homeless households than England
Depression prevalence (%) as recorded on practice disease registers (aged 18+)	12.0	9.9	Significantly higher than England	QOF shows higher rate of recorded depression than England
Severe mental illness (%) of people with on GP practice registers (all ages)	0.77	0.94	Significantly lower than England	QOF shows lower rate of severe MI than England
Percentage of women whose smoking status at time of delivery was current smoker	12.5	10.8	Significantly higher than England	Worcestershire has had a consistently higher percentage of current smokers than England for 7 out of the last 8 years.

Source: Public Health Outcomes Framework

Other Indicators

The indicators below are taken from maternity booking data for Worcestershire Acute, with comparisons for England. It should be noted, however, that there are large percentages of 'unknowns' when looking at the national data which may underestimate the true figure for England.

Table 28 Maternity Booking Data Indicators 2017/18

Indicator	Worcestershire	England	Comments
Complex Social Factors	8%	10%	England has large percentage of unknowns (23%)
Substance misuse at booking (current user)	1%	1%	England has large percentage of unknowns (31%)
Substance misuse at booking (previous user)	2%	2%	England has large percentage of unknowns (31%)
Alcohol Use - Units of alcohol consumed in previous week was <1 unit	99%	51%	99% of Mothers in Worcestershire had less than 1 unit in the week previous to the booking appointment. Nationally it was 51%, with another 48% unknown. There is general agreement that nationally women are underreporting their alcohol consumption.
Social support - Mother does not feel supported in pregnancy and in looking after her baby from partner, family or friends	7%	4%	Figure for England should be treated with caution as it has large percentage of unknowns (40%)
Physical disability - Mother indicates that she has a physical disability	1%	9%	England has large percentage of unknowns (19%)

Source: Maternity Booking Dataset

Evidence-based Guidelines

In addition, evidence-based guidelines recommend:

- All those involved in the care of pregnant or postpartum women should have training in the normal emotional changes associated with pregnancy and the postpartum period, the maternity context, psychological distress, perinatal disorders and early parent-child relationship issues.
- All women with serious psychiatric disorder should have access to specialist advice before becoming pregnant. This should cover the possible impact of pregnancy and childbirth on their condition, and of their condition and its treatment on the outcome of the pregnancy.
- All women should be asked about previous mental health problems at early pregnancy assessment. Those who have had a serious mental illness should be referred to a psychiatrist (preferably a perinatal psychiatrist) for proactive management during pregnancy.
- All women should be regularly asked about their current mental health during pregnancy and the postpartum period and if they have problems whether they would like help.
- All women requiring admission to a psychiatric unit in late pregnancy or the postpartum period should be admitted together with their infant to a specialised mother and baby unit unless there are specific reasons not to do so.
- Women with perinatal conditions who require the care of secondary mental health services should receive specialised perinatal community care.

- Women should have access to psychological and psychosocial treatments including prompt treatment by IAPT and other providers of psychosocial treatments such as listening visits and cognitive counselling by health visitors.
- Managed (strategic) clinical networks should be set up and commissioned covering populations of patient flow of approximately four to five million (delivered population 50,000) to advise commissioners, assist in the development of strategic plans and commissioning frameworks, advise provider organisations, assist with workforce development and training, develop integrated care pathways and develop and maintain a network of involved clinicians and other stakeholders including patient organisations .

The strength of evidence underpinning various treatments for harmful levels of drug and alcohol use during pregnancy is weak. Commonly used treatments found not to be effective in the general population include brief interventions providing advice to adults engaging in harmful drinking or drug use. However, the efficacy of these interventions during pregnancy has not been explicitly tested.

There is good evidence to suggest that methadone treatment programmes improve birth outcomes among children born to mothers with a heroin addiction. Recent studies have also found that buprenorphine is a safe alternative to methadone for managing opioid addictions during pregnancy.

Pregnancy is a period of particular risk for intimate partner violence (IPV), occurring in approximately one-sixth of all pregnancies. IPV substantially increases mothers' experiences of stress and trauma, resulting in increased levels of cortisol in the womb which may contribute to a variety of adverse childbirth outcomes, including maternal and infant death.

There is now good evidence to support the use of a variety of screening practices for the identification of IPV during the perinatal period. FNP remains an evidence-based option for reducing IPV among first-time teenage mothers. Psychosocial support integrated into routine antenatal care has evidence of reducing revictimisation rates among women reporting IPV during their pregnancies. This support provides mothers with information about partner behaviours considered to be abusive, as well as strategies for developing a safety plan.

Access to Services

Services need to recognise the importance of the mother-baby relationship and relationships with partners and the wider family. There should be a focus on:

- promoting healthy pregnancies
- promoting healthy lifestyles
- primary and secondary prevention
- early identification
- timely provision of quality specialist care.

These actions can reduce both the incidence and severity of related child development issues, and also the long-lasting effects on women and their families which result from untreated perinatal mental health problems[3].

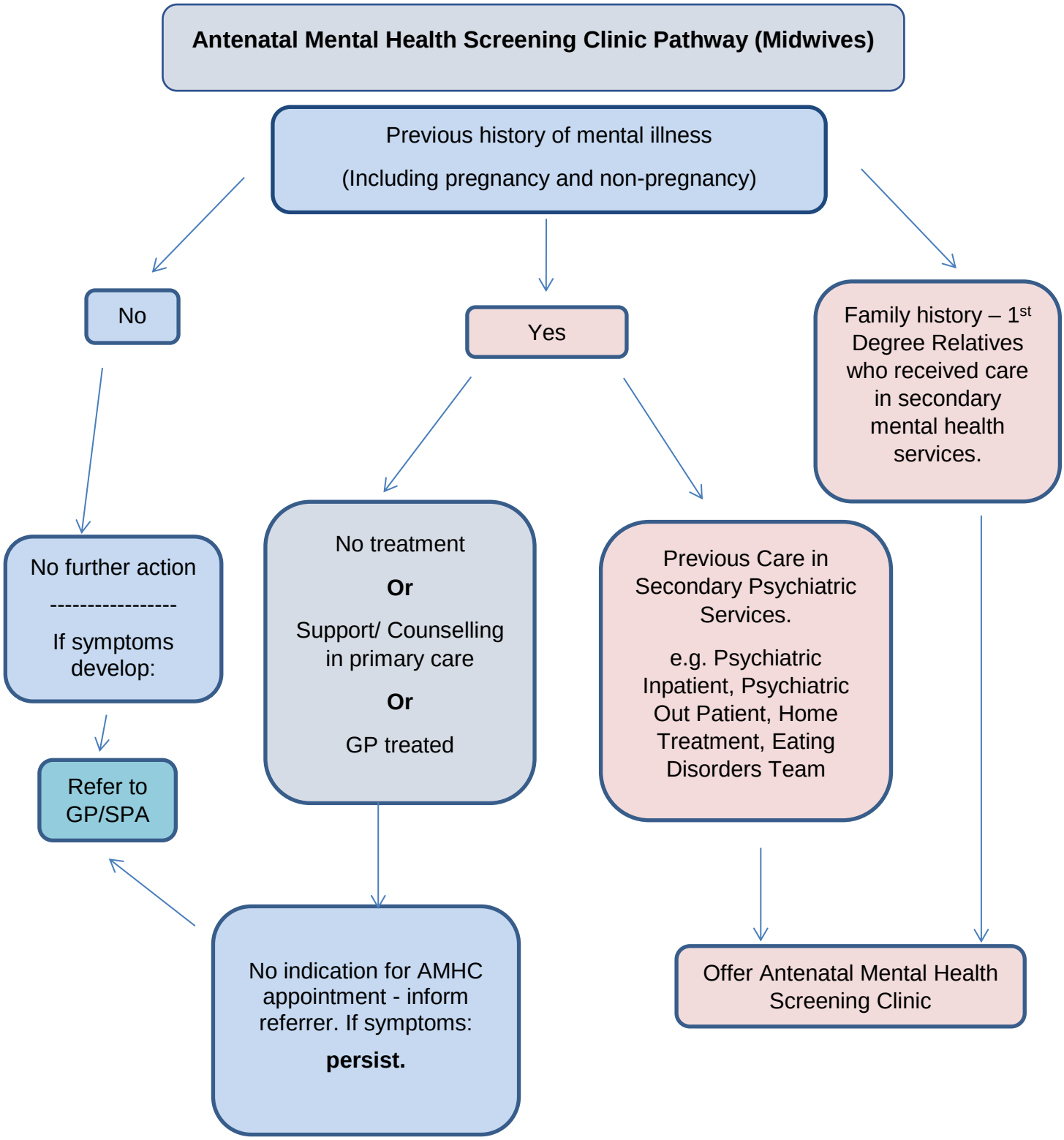
Locally in Worcestershire, all women are screened antenatally by both the Midwife and again by the Health Visitor at their antenatal visits. If issues are identified, then a referral pathway is followed. These are shown in more detail in the following pages. The Health Visitor will do another screen at the 6-8 week review postnatally and will screen again if there is felt the need to follow up.

Depending on the urgency of the referral women with low-level mental health issues will be referred to the Enhanced Primary Care Mental Health Service and any more concerning issues will be directly referred to either the PMHS antenatal clinic or the perinatal psychiatry service. This is delivered via outpatient clinics, Antenatal Mental Health Screening Clinics and home visits.

If admission is required to a specialist Mother and Baby Unit, this is funded by NHS England as a specialist service. This service provides inpatient care for women with complex or severe mental health problems during the last trimester of pregnancy and the first 12 months after childbirth. If this service is required referral is made to these specialist units which are located in Birmingham and Stafford.

Current Maternal Mental Health Pathways in Worcestershire

Figure 61 Universal antenatal mental health screening clinic pathway (Midwives)



Source: Worcestershire Health and Care Trust

Figure 62 Universal Antenatal Mental Health Screening Clinic Pathway (Health Visitors)

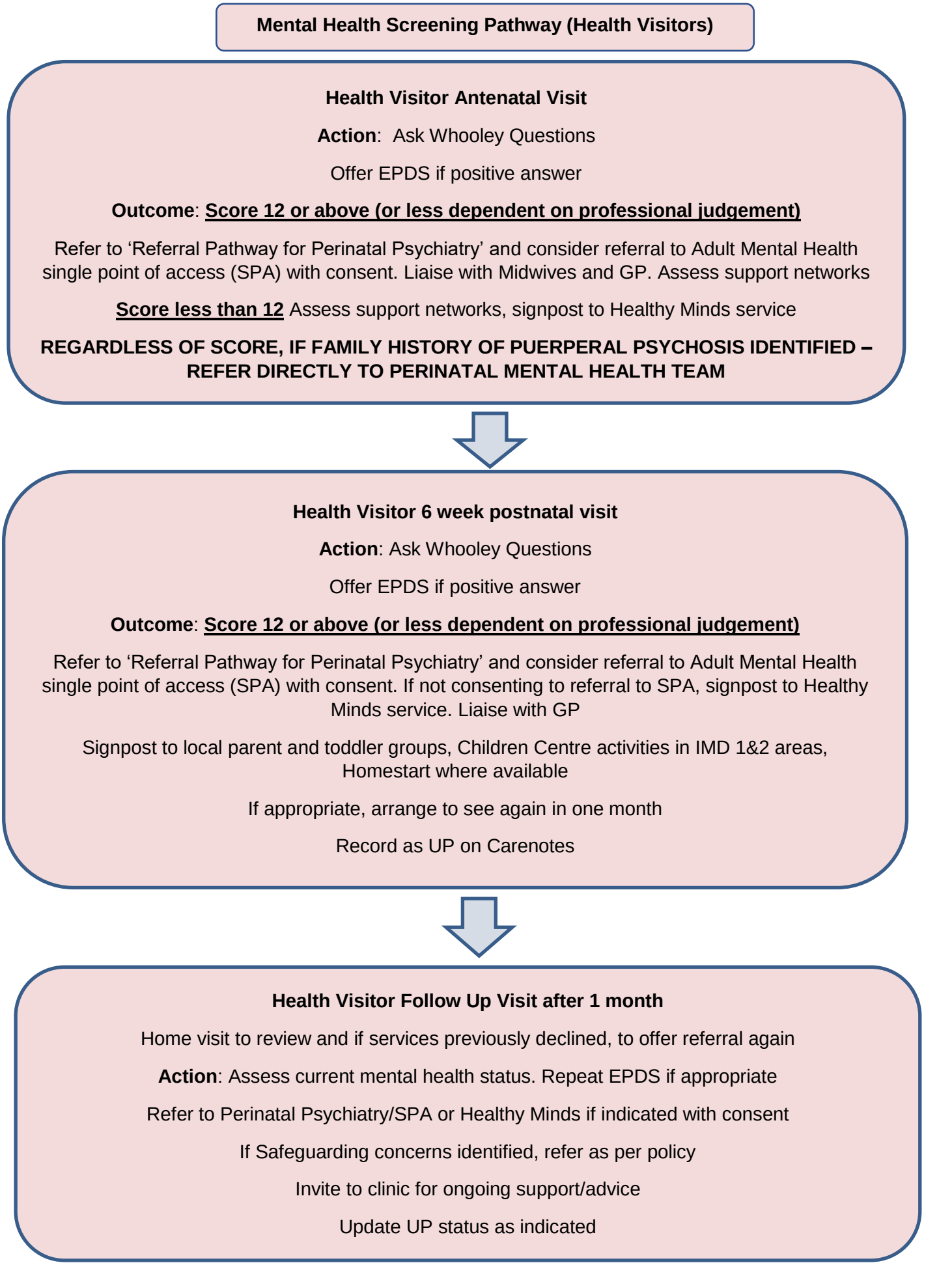
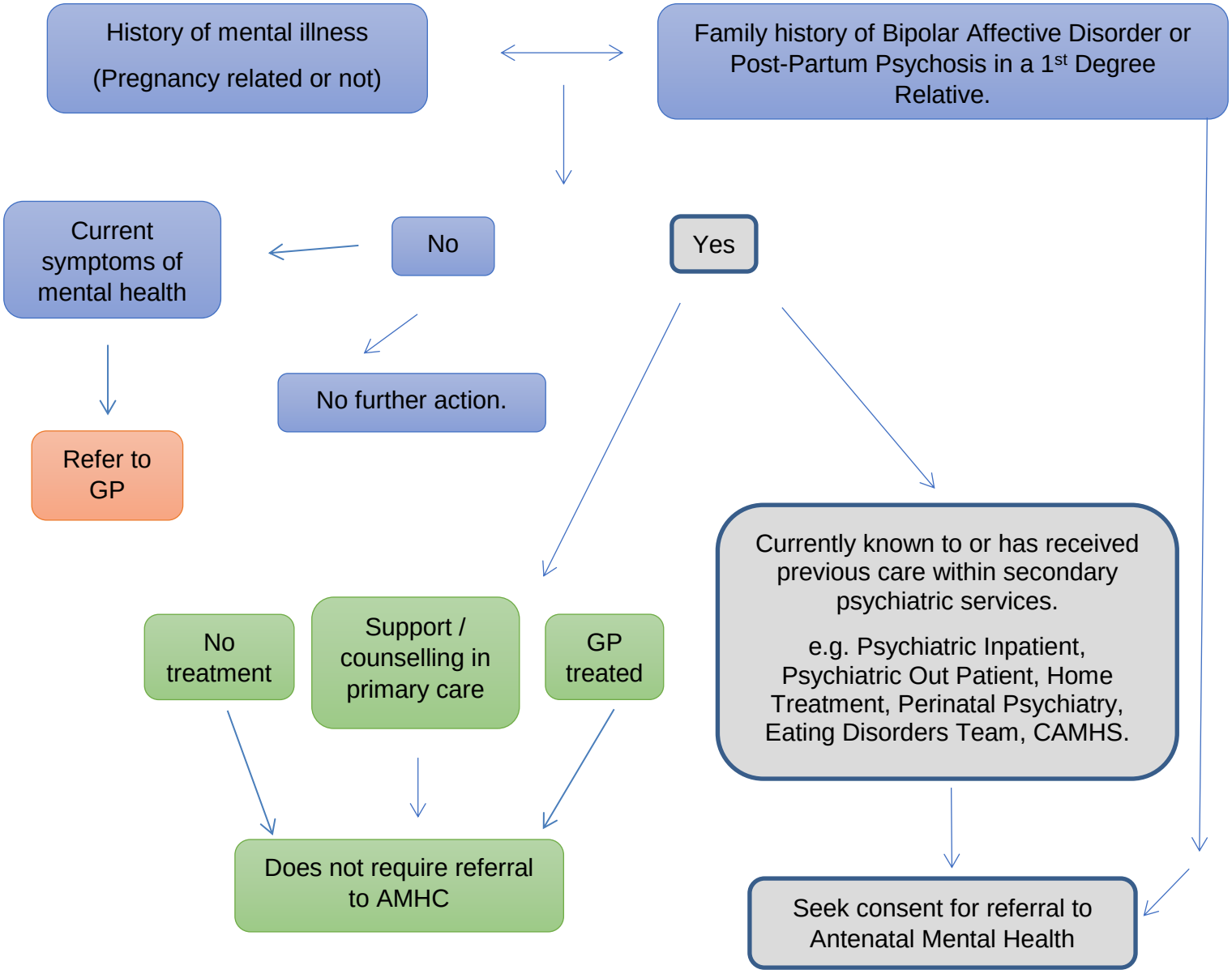


Figure 63 Antenatal Mental Health Screening Clinic Pathway (Midwives)

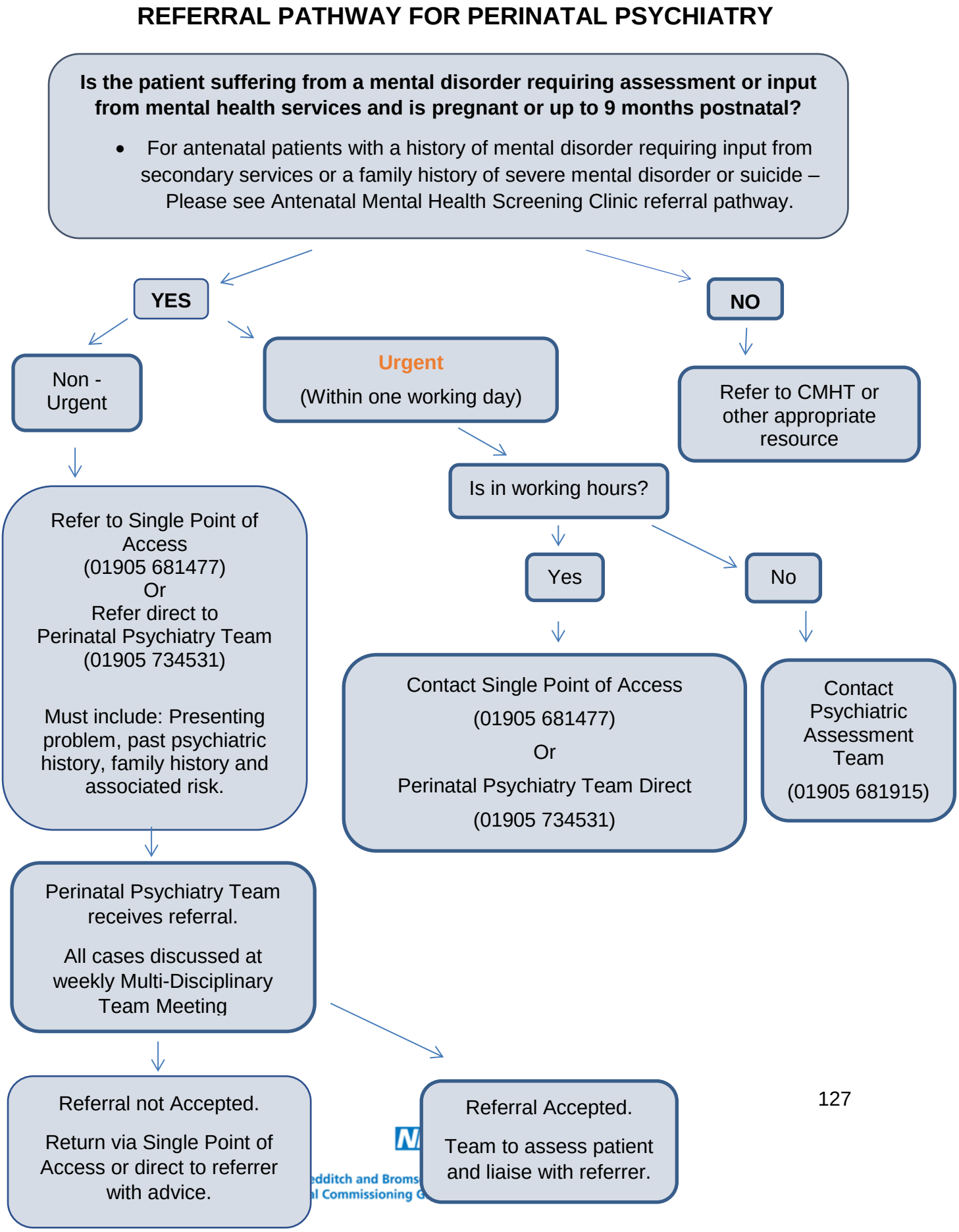
Antenatal Mental Health Screening Clinic Referral Pathway

(Midwife referral only, for women who are currently well)



Source: Worcestershire Health and Care Trust

Figure 64 Mental Health Referral Pathway for Perinatal Psychiatry



Perinatal Mental Health Service in Worcestershire

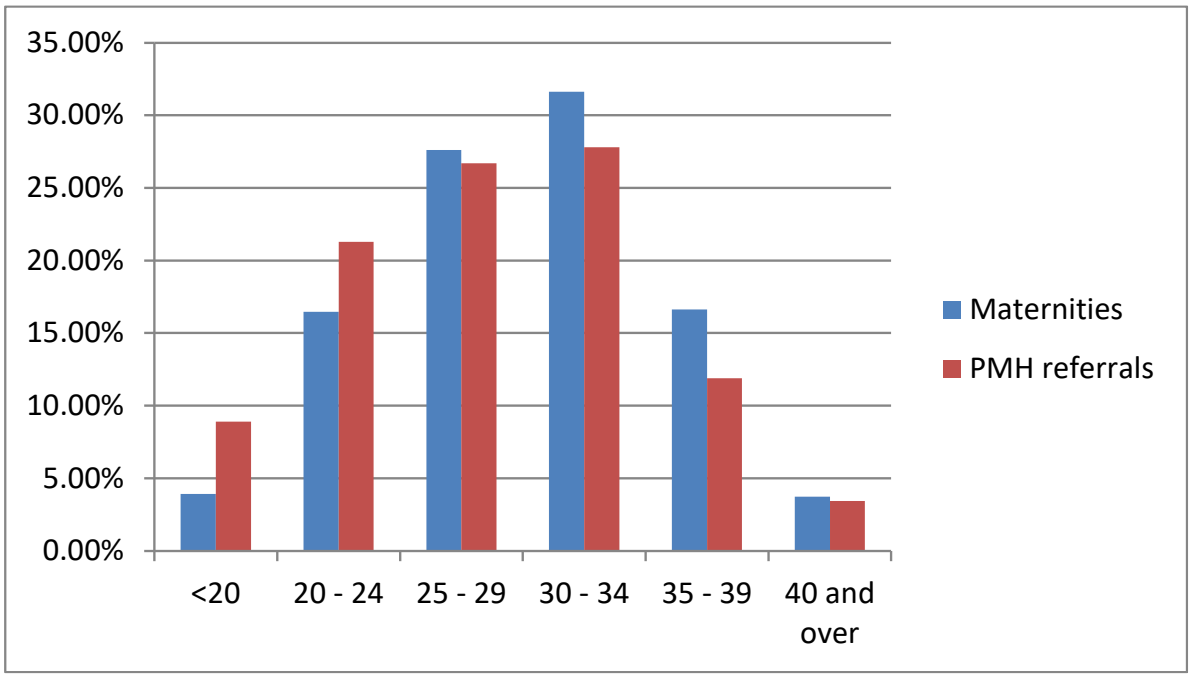
In Worcestershire, there is a well-established, multi-disciplinary, specialist Perinatal Mental Health Service (PMHS). Worcestershire Health & Care Trust has over 10 years of experience of running a specialist PMHS. The service supports women experiencing moderate to severe perinatal mental health difficulties. There is also an established perinatal mental health training programme developed for midwives and health visitors.

Specialist community perinatal mental health teams

There were 707 referrals to the team in 2016/17 and 623 in 2017/18. The trend in 2018/19 appears to be somewhere in between the past 2 years.

The age breakdown indicates that there are a higher percentage of referrals in younger mothers when compared with the proportion of maternities in these age groups (see Figure 65 below).

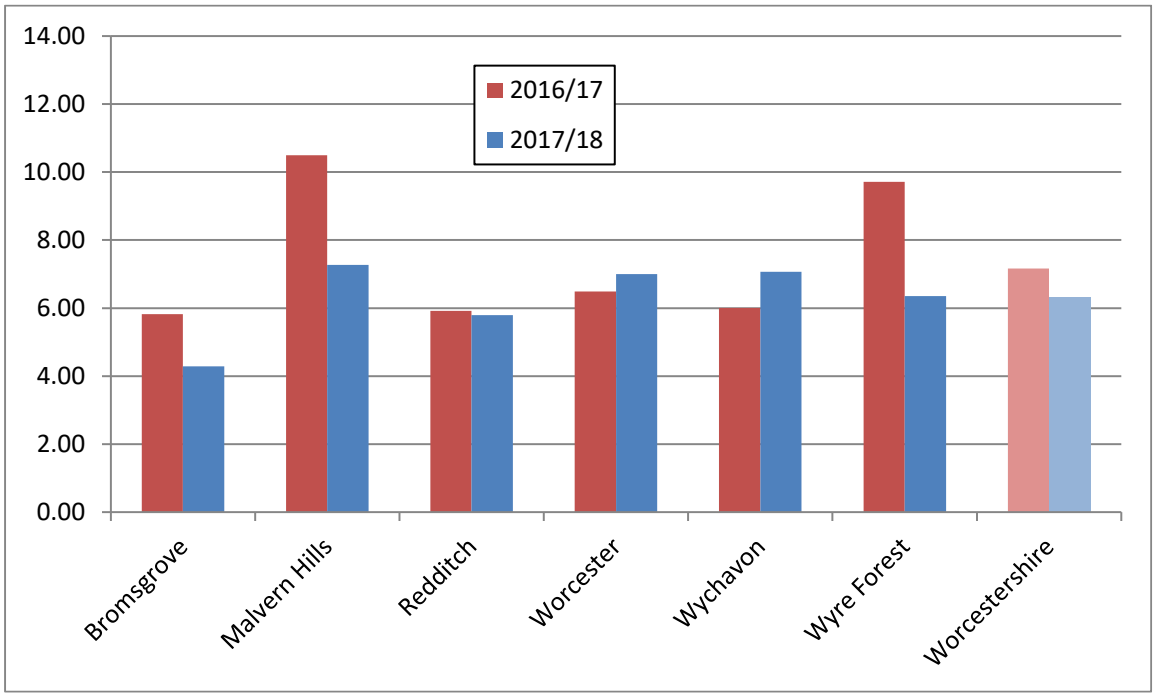
Figure 65 Comparison of percentage of maternities vs percentage of Perinatal Mental Health Referrals



Source: Perinatal Mental Health Service (PMHS) Referrals and ONS Vital Statistics

Figure 66 shows a referral rate by district of residence with higher referrals rates in Malvern and Wyre Forest in 2016/17 and the three districts in the South of the County in 2017/18.

Figure 66 Referral rate by Council District of Residence (Referrals per 1000 females aged 15-44)

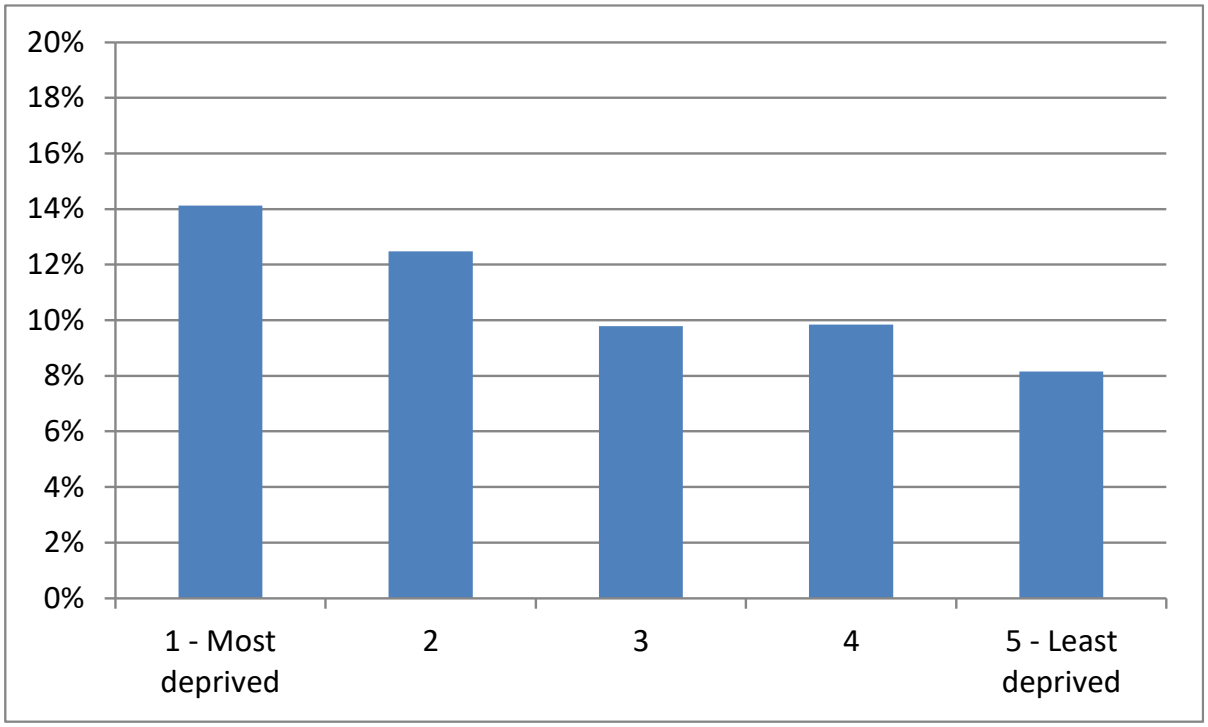


Source: Perinatal Mental Health Service (PMHS) Referrals

The main referrers into the service are the GP and the Midwife.

Each referral can be allocated to a deprivation quintile using the Lower Super Output Area (LSOA) of residence and then calculated as a percentage of the births in that quintile. In order to make the analysis more robust, we have combined the 2.75 years data we have. As expected there is a higher percentage of mothers who are referred who live in the more deprived quintiles than in the least.

Figure 67 Referrals by Deprivation quintile (calculated as a percentage of births in each quintile) – Pooled data for 2.75 years (1st January 2016 – 30th September 2018)



Source: Perinatal Mental Health Service (PMHS) Referrals

Service Improvements

Herefordshire and Worcestershire organisations successfully bid as a Sustainability Transformation Partnership for national community specialist perinatal funding to enhance local provision. This funding is being used to enhance the Perinatal Mental Health Service in Worcestershire ensuring that it is meeting national standards. Whilst Worcestershire had a well-established team, there were significant gaps, particularly specialist psychological interventions, CBT, occupational therapy, and nursery nursing interventions.

The service will prioritise mothers with serious and complex mental health needs including people who have experienced a serious mental health episode in the past but are currently well. Women with mild to moderate mental health difficulties will be triaged and signposted to other appropriate services in the perinatal pathway. It will ensure that the service meets the recommended national pathways.

Recommended Pathway

Good quality, evidence-based perinatal mental health care pathways are shown to:

- improve access to evidence-based treatment with greater detection and improved recovery rates, improving outcomes for women and their children
- reduce pre-term birth, infant death, special educational needs, and poor school attainment, and depression, anxiety or conduct problems in children
- reduce costs per birth to NHS caused by mental health problems during perinatal period
- reduce costs to society of failure to address perinatal mental health problems, which are estimated to be £8.1bn, three quarters of which relate to health and social outcomes of the child[99]

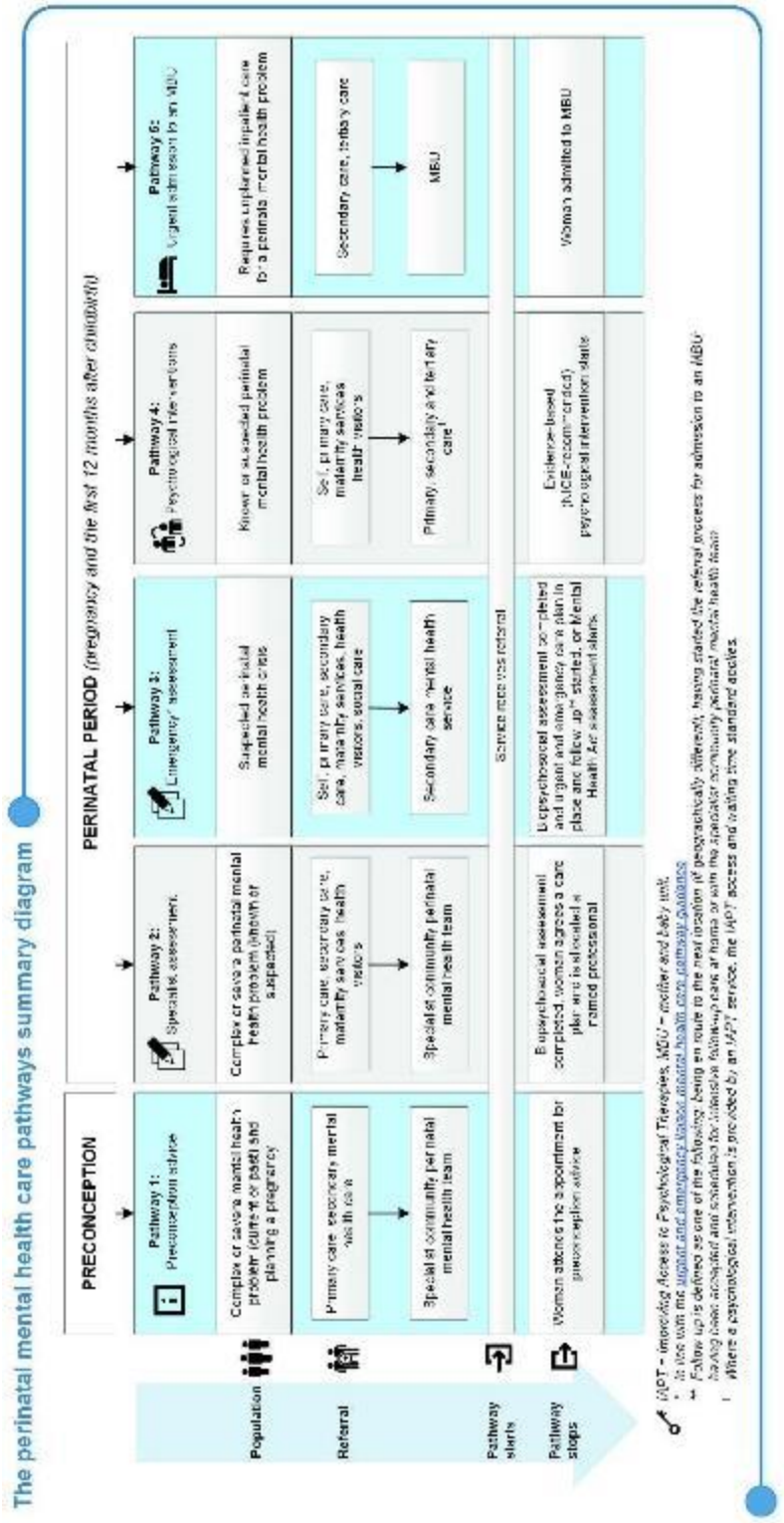
In May 2018 a document entitled "The Perinatal Mental Health Care Pathways" was published by the National Collaborating Centre for Mental Health. This guidance was produced following a process agreed with the National Institute for Health and Care Excellence (NICE) with involvement from an Expert Reference Group. This guidance sets out the policy and initiatives and strategic context for transforming perinatal mental health care in order to enable delivery of the key objectives set out by the Government in their Forward View documents produced in 2017.

The guidance provides services with evidence on what works in perinatal mental health care. The five year forward view for Mental Health set out the ambition to support at least 30,000 more women to access evidence-based specialist mental health care during the perinatal period. To meet this ambition, pathways are being introduced to help reduce unwarranted variation in quality in perinatal mental health care. The NHS has agreed to implement these recommendations supported by additional investment.

The national Expert Reference Group has developed a series of 5 pathways, shown in the figure below. These include NICE-recommended interventions to support the local delivery of perinatal mental health care.

[99] GOV.UK. (2019). Better Mental Health JSNA Toolkit - *4. Perinatal mental health*. [online]
Available at: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health

Figure 68 Recommended Perinatal Mental Health Care Pathways[100]



Evidence and Further Information

Key Data Sources

- Perinatal mental health profile: contains a range of available indicators, including risk factors, measures of prevalence and relevant maternity statistics
- Perinatal mental health data catalogue: gives detail on and provides links to metrics and data sets relating to perinatal mental health, describes metrics that will be available in the future and metrics that may be collected locally
- NMHIN and ChiMat needs assessment report: information on risk factors alongside detailed estimates of local numbers of perinatal mental health disorders. Prevalence estimates are based on applying national rates to local populations, they do not adjust for local demographic factors.
- NHS Benchmarking Network: has undertaken a detailed assessment of specialist inpatient and community perinatal mental health services covering 2015 to 2016. A national report is available to download and participating organisations can gain access to local data. Regional clinical networks have all been provided with a bespoke report covering their area.
- National inquiry into maternal deaths: shows that mental health problems are a leading cause of death in pregnancy and the 12 months after birth

Further Information

- Faculty of Public Health, Mental Health Foundation. Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016)
- Centre for Mental Health, LSE Personal Social Services Research Unit. The costs of perinatal mental health problems (2015)
- NICE. Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline CG192 (2014)
- Royal College of GPs. Position statement about Perinatal Mental Health (2016)
- GOV.UK. (2019). Better Mental Health JSNA Toolkit - *4. Perinatal mental health*.
- The Perinatal Mental Health Care Pathways. (2018). [online] NHS England, National Collaborating Centre for Mental Health.

[100] The Perinatal Mental Health Care Pathways. (2018). [online] NHS England, National Collaborating Centre for Mental Health. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/05/perinatal-mental-health-care-pathway.pdf

Children and Young People

Introduction

The last survey of the mental health of children and young people in England in 2017 found that one in eight (12.8%) of 5 to 19-year olds had at least one mental disorder when assessed in 2017. Prevalence rose as the child developed from 5.5% of 2 to 4-year olds, 9.5% of 5 to 10 year olds, 14.4% of 11 to 16 year olds and rising to 16.9% of 17 to 19 year olds had a clinically diagnosed mental health condition[101].

50% of those with a lifetime mental illness experienced symptoms before they were 14. Promoting emotional health and wellbeing and preventing poor mental health is high priority and cost saving.

Children Under Five

A child's attachment, security and positive stimulation from their main carers has a major impact on their social and emotional wellbeing. This provides the foundation for healthy behaviours and educational attainment. Children who have been neglected are more likely to experience mental health problems including depression, post-traumatic stress disorder, and attention deficit and hyperactivity disorder. In later life, they may also find it difficult to maintain healthy social relationships, including with their own children.

Parenting styles, interpersonal relationships and family functioning all have an influence on a child's mental wellbeing. Loving and trusting relationships, feeling supported and having a sense of connection are aspects which positively influence wellbeing. Factors which harm wellbeing include maternal mental health problems, family discord, hostility and breakup[102].

Health visitors and school nurses are well placed to play a key role in promoting emotional wellbeing and positive mental health of children, young people and their families. They have a specific contribution to make in identifying issues, using protective screening and providing effective support. The different levels of intervention across the 4 tiers of health visiting and school nursing service model are outlined in 'Promoting emotional wellbeing and positive mental health of children and young people'.[103]

The universal health visiting service, part of the Healthy Child Programme, is a home visiting service focused on assessing the needs of the family, and providing early

[101] NHS Digital (2018) Mental Health of Children and Young People in England 2017, Available from: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

[102] https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/5-children-and-young-people

[103] Public Health England (2015). *Promoting children and young people's emotional health and wellbeing - A Whole School and College Approach*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf

intervention where required. The universal health review at age 2 to 2.5 years uses the Ages and Stages Questionnaire to assess child development outcomes which include:

- Communication skills
- problem solving
- social-emotional development
- aspects of physical development.

Development delays identified at this stage are associated with poorer longer-term outcomes including mental health and general wellbeing. The new birth visits and 6 to 8-week review are also important components of this health visiting service.

All Age Children and Young People

Improving children and young peoples' mental wellbeing will positively impact on their cognitive development, learning, physical health, mental health and social and economic prospects in adulthood. Poor mental wellbeing increases the likelihood in later life of:

- poor educational attainment
- antisocial behaviour
- drug and alcohol misuse
- teenage pregnancy
- involvement in criminal activity
- mental health problems.

Those with better mental wellbeing are likely to deal better with stressful events, recover more quickly from illness, and be less likely to engage in behaviours which may put their health at risk.[2]

Transition to Adult Services

The point of transition from CYPMHS is a time of potential upheaval for young people. They may find it difficult to navigate new service settings or to manage their mental health and wellbeing following discharge from CYPMHS, especially as the availability and offer of support can change dramatically.

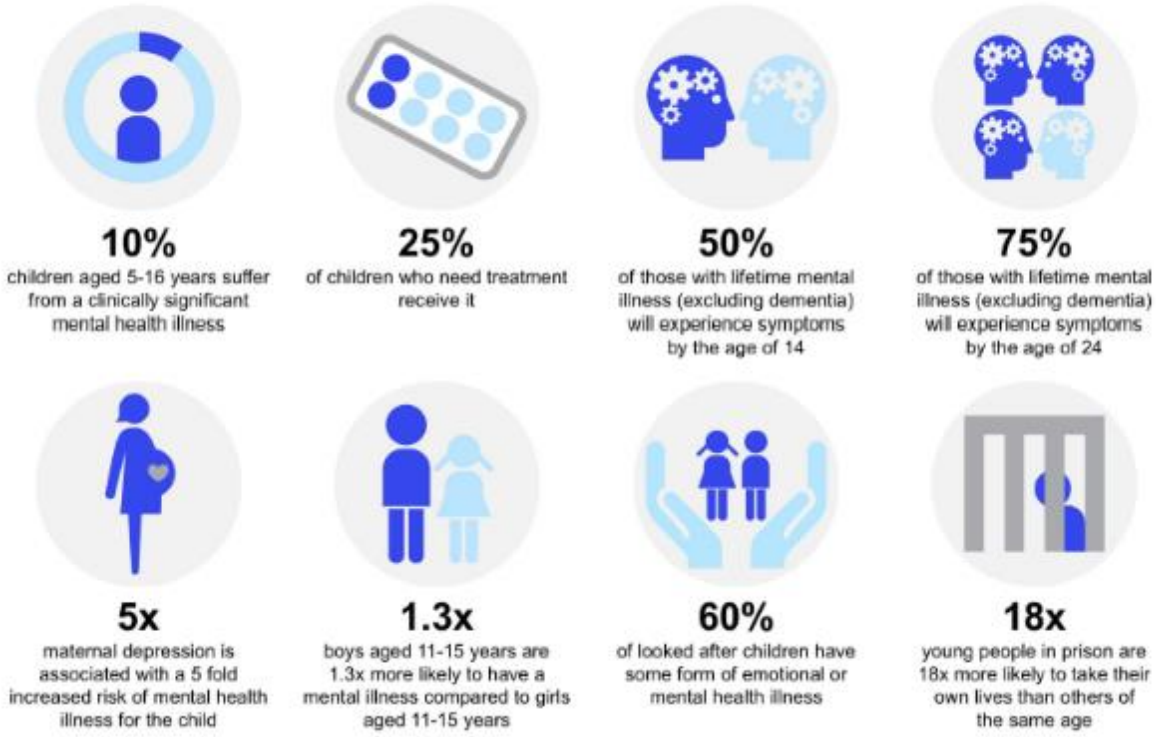
There are significant risks of young people disengaging or being lost in the transition process. This can result in young adults re-presenting in crisis or with a greater severity of need later in life. Transitions for vulnerable groups, such as those within the criminal justice system, can be particularly problematic. They require careful management and close engagement with the young person and, where appropriate, their families/carers.

Future in Mind recommends joint working and shared practice between services to promote continuity of care during transition. The transition out of CYPMHS must be supported by a robust and coordinated multi-agency approach to transition planning, with the full involvement of the young person throughout. [2]

65% of CYP MH Local Transformation Plans published in 2016 highlighted transition as a key area for development. NHS England has introduced a financial incentive to improve transition planning under the national mandatory Commissioning for Quality and Innovation (CQUIN) scheme 2017 to 2019.

The Transitions Out of CYPMH CQUIN sets out requirements for joint agency transition planning. It includes a survey to ask young people transitioning out of CYPMHS whether they feel ready for discharge, and whether they are meeting their personal transition goals following transition. [2]

Facts About Mental Health Illness in CYP



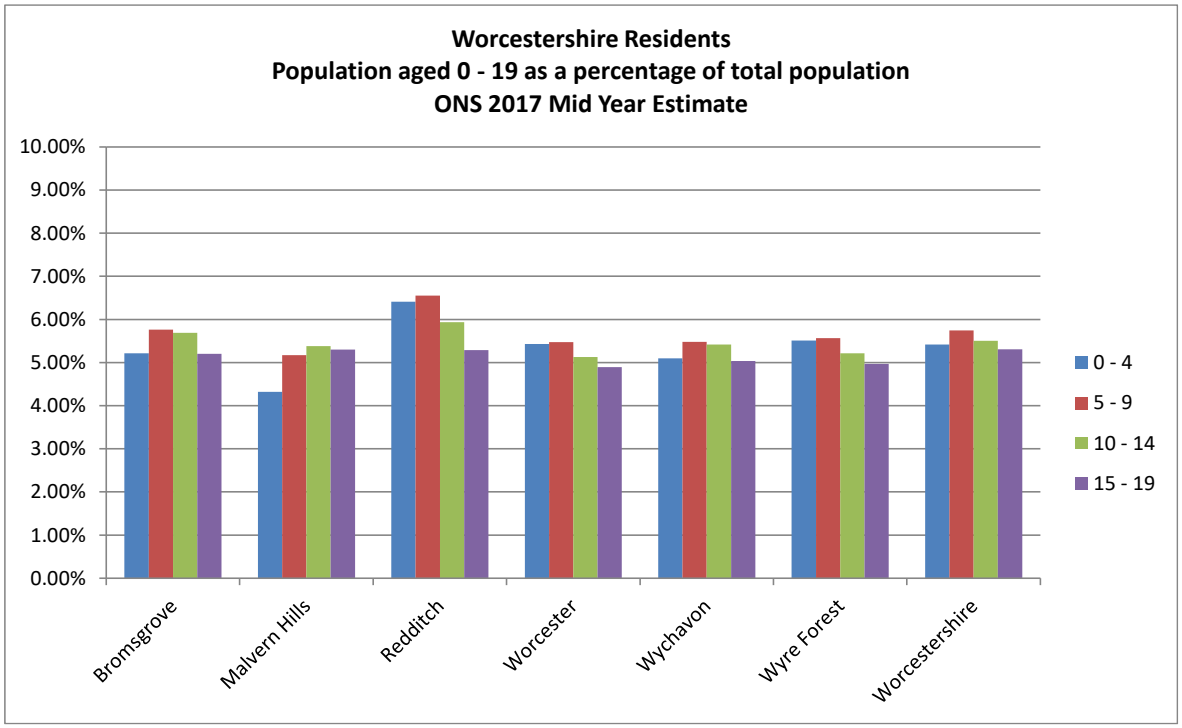
Source: The mental health of children and young people in England – December 2016

Demographics

At a county level the number of children and young people aged 0-19 years is estimated to be 129,300, which is 22% of the total population in Worcestershire. Within this the largest age group is the 5-9-year olds, representing nearly 6% of the total population and the smallest age group is the 15-19 year olds. This is a lower proportion than the England average of 24%.

There is variance by district - Redditch has the largest proportion of 0-19-year olds living within its boundaries, with them accounting for 24% of the population and Malvern having the smallest percentage (20%). Redditch has the highest proportion of 0-9-year olds who account for 13% of its population. However, in terms of numbers, Wychavon (as the largest district) has the highest number of 0-19 accounting for 20% of the CYP population in Worcestershire.

Figure 69 Population aged 0-19 by age groups and District



Source: ONS

Population estimate – the mid 2017 estimate was 129,289 population aged 0-19 living in Worcestershire. This is projected to increase to 134,300 by 2027, although as a percentage of the total population living in Worcestershire it is a slight decrease.

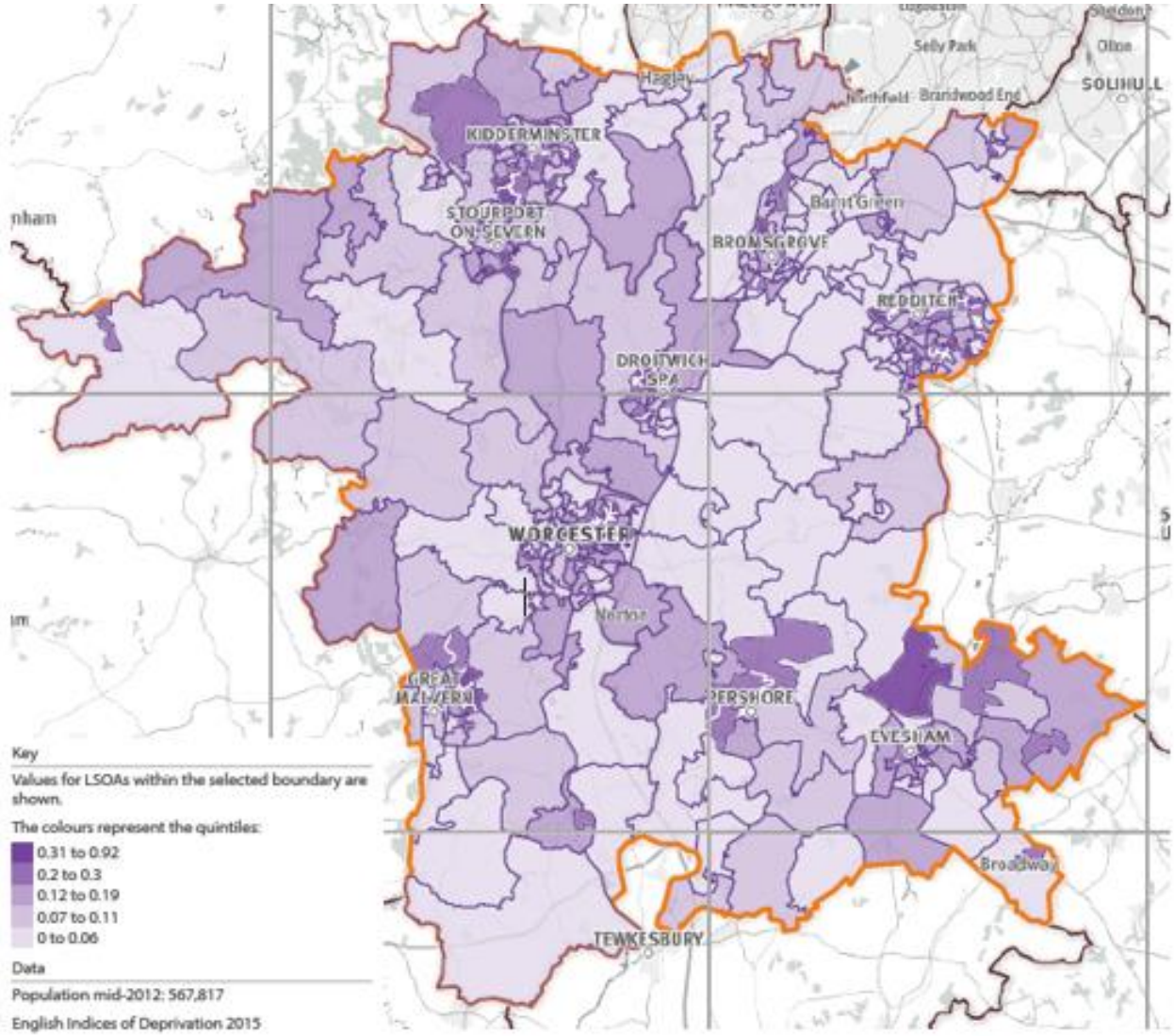
Deprivation

The **Income Deprivation Affecting Children Index** (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. It is a subset of the Income Deprivation Domain which measures the proportion of the population in an area experiencing deprivation relating to low income. The England-wide Income Deprivation Affecting Children Index, published using 2015 data, has an average value of 0.18 nationally. Locally the value for Worcestershire is 0.15, so compared to England Worcestershire has lower levels of child poverty. However, there are areas within Worcestershire that have higher levels of children living in income deprived families.

Only Wyre Forest CD has a higher rate than Worcestershire, and this is equal to the England average

There are 16 in decile 1 nationally (7 in Worcester City, 4 in Wyre Forest, 1 in Malvern, 2 in Redditch and 2 in Wychavon)

Figure 70 Income Deprivation Affecting Children Index (IDACI) by Lower Super Output Area (LSOA) in Worcestershire



Source: Public Health England SHAPE

Prevalence

The following table shows the estimated prevalence of children in Worcestershire with various mental health disorders in children and young people aged 5-16. These are estimates adjusted for age, sex and socio-economic classification based on national prevalence from the ONS survey carried out in 2004.

Table 29 Estimated Prevalence rates in Worcestershire 2015

Children aged 5 - 16	Year	Worcestershire	England

Estimated prevalence of mental health disorders in children and young people	2015	8.8%	9.2%
Estimated prevalence of emotional disorders in children and young people	2015	3.4%	3.6%
Estimated prevalence of conduct disorders in children and young people	2015	5.3%	5.6%
Estimated prevalence of hyperkinetic disorders	2015	1.4%	1.5%

Source: Public Health Outcome Framework – Children and Young People's Mental Health and Wellbeing

Mental Health of Children and Young People in England, 2017

Results are gradually being released for this recent survey carried out in 2017. Currently they are only available at a national level.

The main headline figures are as follows:

12.8% (one in eight) children aged 5 – 19 years had a clinically diagnosable mental health disorder;

Since 1999 there has been a slight increase in prevalence of mental health disorders in 5-15 year olds, rising from 9.7% in 1999 and 10.1% in 2004 to 11.2% in 2017.

Prevalence rises as the child develops from 5.5% of 2 to 4 year olds, 9.5% of 5 to 10 year olds, 14.4% of 11 to 16 year olds rising to 16.9% of 17 to 19 year olds had a clinically diagnosed mental health condition.

The increase is mainly in emotional disorders where the increase is seen in both sexes.

Mental disorders were found to be associated with low income, parental mental health, adverse life events, lower levels of social support and participation and less healthy family functioning.

Children with a disorder were more likely to have poor general health, a limiting long-term illness, a physical or developmental problem of a special educational need.

Two-thirds of 5-19 year olds with a disorder had contact with a professional service in the past year because of worries about mental health. Teachers were the most commonly cited source (48.5%). However, one in four children with a disorder had no contact with either professional services or informal support in relation to worries about their mental health.

Among children with a disorder, one in five reported waiting over six months for contact with a mental health specialist.

2-4 year olds

One in eighteen (5.5%) of preschool children were identified with at least one mental health disorder.

Boys were more likely than girls to have a disorder (6.8% as opposed to 4.2% of girls).

Behavioural disorders were evident in 2.5% of preschool children.

5-10 year olds

In 5-10 year olds, 9.5% of them had at least one disorder, with boys twice as likely as girls.

Behavioural disorders and emotional disorders were the most common types in this age group.

11–16 year olds

The move to secondary school coincides with the start of adolescence, at which point about one in seven (14.4%) of 11 to 16 year olds were identified with a mental health disorder. At this age boys and girls were equally likely to have a disorder.

Girls were more likely than boys to have an emotional disorder at this stage whereas boys were more likely to have a behavioural or hyperactivity disorder.

17-19 year olds

Young people aged 17 to 19 were three times more likely to have a mental health disorder (16.9%) than preschool children aged 2 to 4 (5.5%).

Nearly one in four (23.9%) of 17 to 19 year old girls had a mental health disorder. And 22.4% had an emotional disorder. Half of young women with a disorder at the time of the interview also reported having self-harmed or made a suicide attempt.

While most 17 to 19 year olds identified as heterosexual, one in ten identified themselves as not. Young people who identified themselves as non-heterosexual were more likely to have a mental health disorder (34.9%) than those who identified as heterosexual (13.2%).

11-19 year olds

11 to 19 year olds with a mental health disorder were more likely to use social media every day (87.3%) than those without a disorder (77.8%). Girls with a mental health disorder were more likely to feel that they compared themselves to others on social media. Both boys and girls with a disorder were more likely to feel that the number of 'likes' they got affected their mood than those without a disorder.

Those with a mental health disorder were nearly twice as likely to have been bullied in the past year than those without a disorder.

Alcohol use was more common in 11 to 16 year olds with a mental health disorder and they were three times more likely to have tried a cigarette.

Illicit drug use was three times more likely in 11 to 16 year olds with a mental disorder than those without one.

11 to 16 year olds with a mental health disorder with more likely to have self-harmed or attempted suicide at some point (25.5%) than those without a disorder (3.0%).

Using the revised national estimates of prevalence, we have applied these percentages to the ONS mid-year population estimates for 2017, to identify how many individuals may be living with a particular type of condition in Worcestershire. These figures are provided to give an indication of the numbers based on the latest available prevalence estimates.

In summary, there are estimated to be 13,547 children and young people aged between 2 and 19 who have a mental health disorder living in Worcestershire.

Table 30 Estimated Prevalence rates and Numbers in Worcestershire

	National Prevalence Estimate					Estimated Numbers of Children in Worcestershire				
Mental disorders	2 to 4 years	5 to 10 year olds	11 to 16 year olds	17 to 19 year olds	5 to 19 year olds	2 to 4 years	5 to 10 year olds	11 to 16 year olds	17 to 19 year olds	5 to 19 year olds
	Persons	Persons	Persons	Persons	Persons	Persons	Persons	Persons	Persons	Persons
	%	%	%	%	%	Number	Number	Number	Number	Number
Emotional disorders	1.0	4.1	9.0	14.9	8.1	189	1,666	3,407	2,811	7,852
Behavioural disorders	2.5	5.0	6.2	0.8	4.6	494	2,022	2,372	149	4,518
Hyperactivity disorders	0.5	1.7	2.0	0.8	1.6	96	696	758	150	1,598
Other less common disorders	2.8	2.2	2.2	1.8	2.1	542	889	833	336	2,058
Any disorder	**5.5**	**9.5**	**14.4**	**16.9**	**12.8**	**1,087**	**3,847**	**5,466**	**3,187**	**12,460**

Source: Estimates taken from the Mental Health of children and Young People Survey in England 2017 and applied to the ONS Population estimate for Worcestershire in 2017

Table 31 Other Prevalence Indicators available via PHOF

Other Age Groups	Year	Worcestershire	England
**Percentage of children aged 5-16 who have been in care for at least 12 months on 31st March whose score in the SDQ indicates cause for concern*	*2016/17*	*59.2%*	*38.1%*
Hospital admissions as a result of self-harm (10-14 years) – Rate per 100,000	2016/17	222.3	207.2
Hospital admissions as a result of self-harm (15-19 years) – Rate per 100,000	2016/17	601.4	617.1
Percentage of pupils with Special Education Needs (SEN) where primary need is social, emotional and mental health (primary school age)	2018	2.14%	2.19%
Percentage of pupils with Special Education Needs (SEN) where primary need is social, emotional and mental health (secondary school age)	2018	2.39%	2.31%
Percentage of pupils with Special Education Needs (SEN) where primary need is social, emotional and mental health (primary school)	2018	2.40%	2.39%

****Data issues with sample size being small for Worcestershire[104]***

Source: Public Health Outcomes Framework- Fingertips

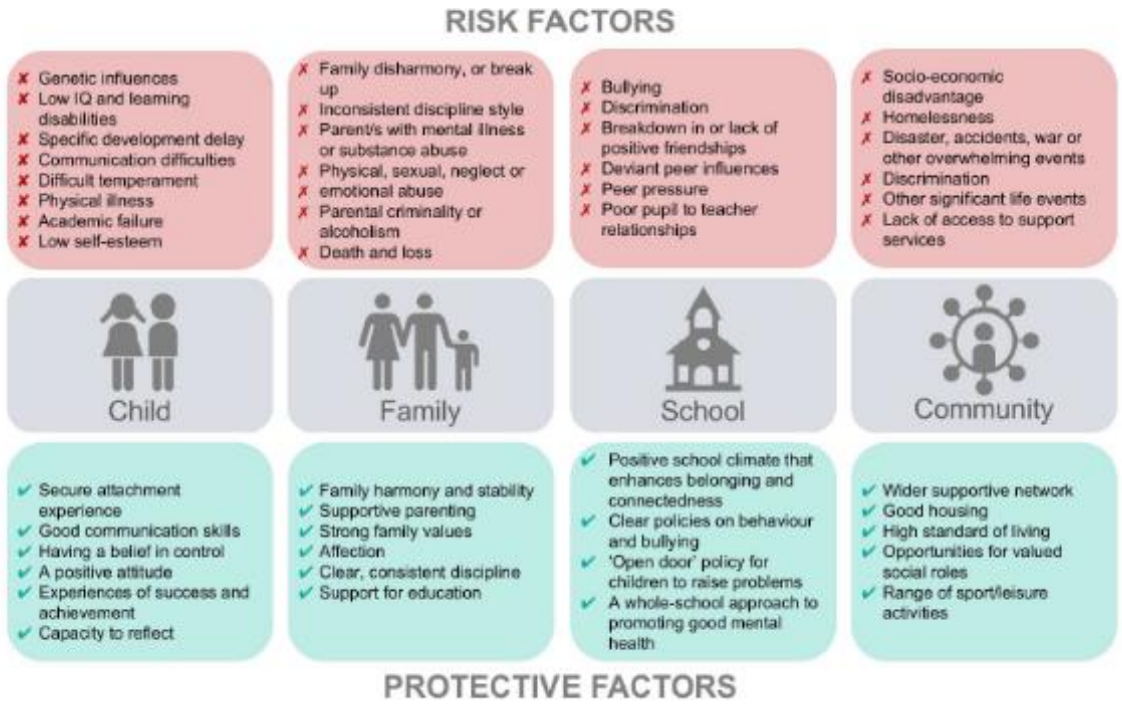
[104]Public Health Outcomes Framework- Fingertips
https://fingertips.phe.org.uk/search/sdq#page/6/gid/1/pat/6/par/E12000005/ati/102/are/E08000026/iid/92315/age/246/sex/4

Risk Factors

Particular groups of children have significantly worse outcomes. A child's gender, socioeconomic status, ethnicity, disability, sexual orientation and whether or not they are a child looked after or in the youth justice system all can have an impact on their development.

The following chart shows risk and protective factors for CYP's mental health

Figure 71 Risk and Protective Factors for CYP's Mental Health



Source: The mental health of children and young people in England, PHE (2016) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

Childhood experiences can have a lasting impact upon a child's mental health. Adverse childhood events (ACEs) have a strong influence on the chances of developing mental health problems, including being the victim of:

- physical abuse
- sexual abuse
- domestic violence
- parental separation
- emotional neglect
- emotional abuse
- living with an alcoholic or drug abuser
- having a parent in prison

There is an increased risk if a child experiences multiple cumulative events. Events associated with chronic adversity and deprivation carry the greatest risk. An increasing issue is that of cyberbullying with one survey reporting around 18% of 11 to 15 year olds experiencing some form of bullying via electronic communication over a two-month period[105]

A child's mental health is not the only aspect of their wellbeing which is influenced by adverse experiences. A strong relationship has been found between the experience of ACEs and risky behaviours during adulthood. Compared to experiencing no childhood ACEs, an adult who experienced four or more during childhood was:

4 times more likely to be a high-risk drinker

6 times more likely to be a current smoker

6 times more likely to have had sex under 16 years of age

11 times more likely to have smoked cannabis

16 times more likely to have used heroin or crack cocaine

Many of these behaviours can lead to physical ill health in adulthood and some of these behaviours have the potential to be repeated across generations. [2]

Adverse Childhood Experiences (ACEs) can significantly affect physical, mental and personal well-being throughout life. They can be categorised into three direct and six indirect experiences that have an impact on a child. The study by Bellis et al (2014[106]) identified that approximately 47% of individuals reported experiencing at least one ACE. 9% of individuals reported having 4 or more ACEs.

A U.K based study undertaken by Bellis et al in 2013 also identified that individuals with 4 or more ACEs were more likely to have a higher number of risky health behaviours and in turn have poorer health outcomes compared to those without ACEs.

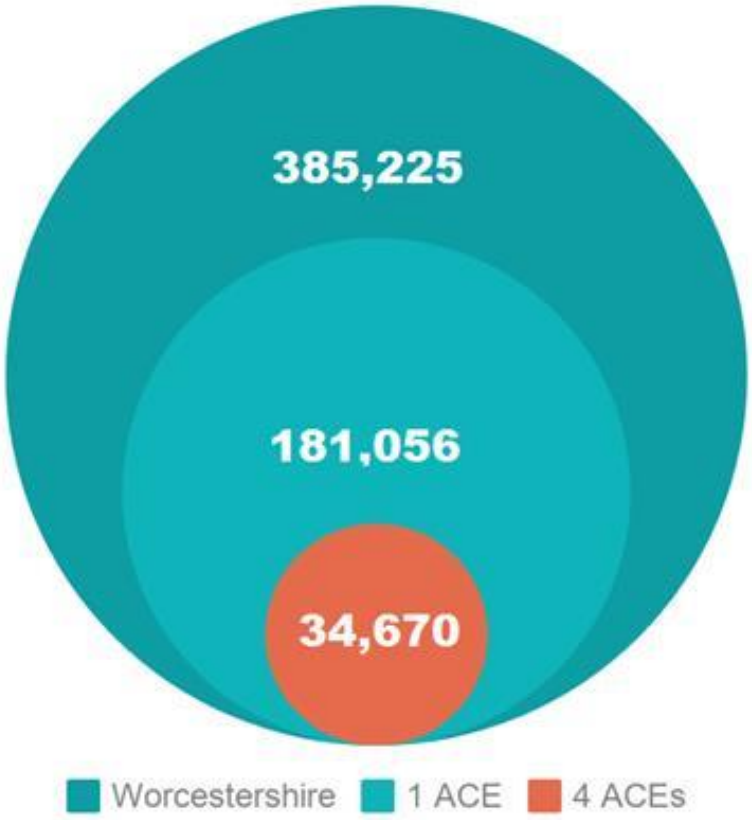
Hughes et al., 2017 identified that exposure to multiple ACEs can have an impact upon a wide range of health outcomes. The strongest correlation between multiple ACEs and onward transfer of ACEs to future generations were found in those who experienced violence, mental illness and problematic substance abuse in the family environment.

By applying these proportions to the 385,225 residents of Worcestershire who are aged between 18-70 it can be estimated there are around 181,056 adults who have experienced at least one ACE and 34,670 adults who have experienced four or more ACEs during their lifetime.

[105] Public Health England: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/5-children-and-young-people#fn:10

[106] WCC JSNA Briefing on Adverse Childhood Experiences, http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1473/jsna_publications_by_category/2

Figure 72 Estimates for individuals aged 18-70 years experiencing ACEs in Worcestershire

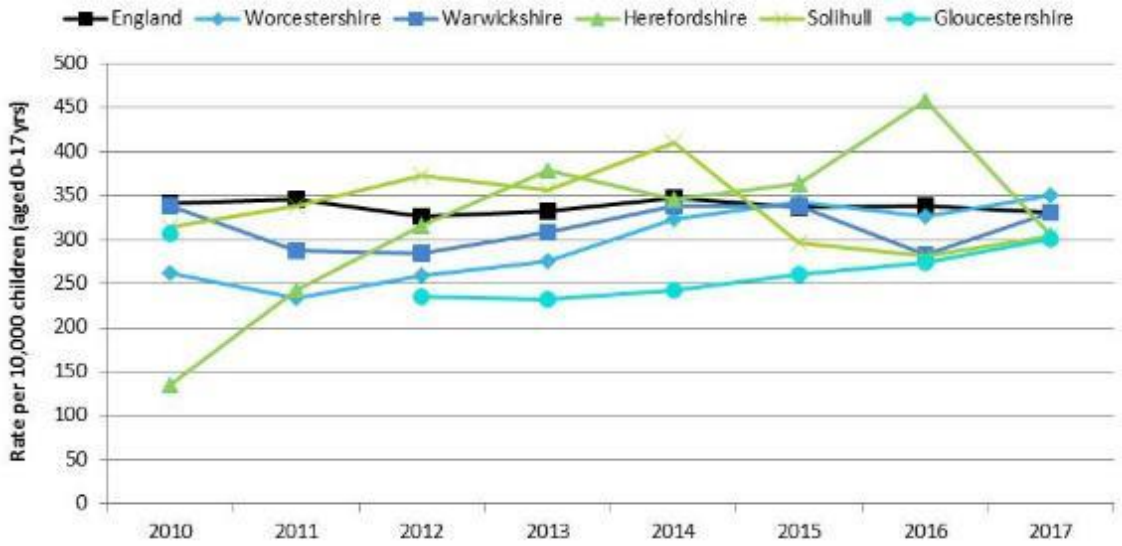


Source: Worcestershire JSNA Briefing -ACE's
http://www.worcestershire.gov.uk/homepage/301/jsna_briefings

Children in Need

Figure 73 shows the rate of Children in need (CIN) as at 31st March between 2010 and 2017 comparing Worcestershire to England and its statistical neighbours. Worcestershire has seen an increase over the last few years which has brought the rate of CIN to the highest of the areas compared.

Figure 73 Children in Need compared to England and Statistical Neighbours (2010-2017)



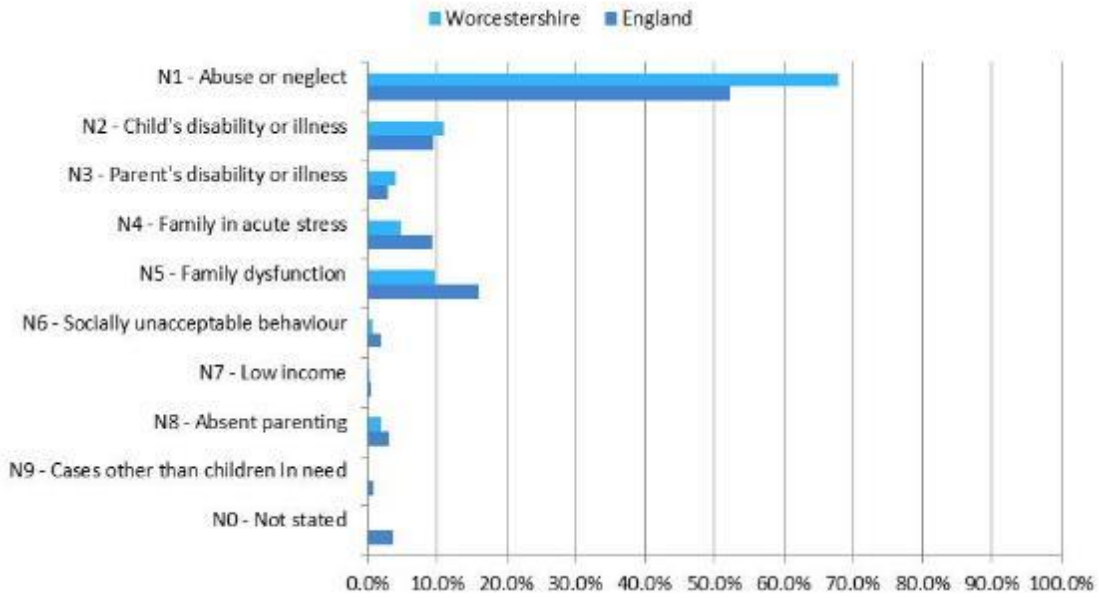
Source: Department for Education, Characteristics of Children in Need

The numbers of CIN have increased year on year over the last five years from 3000 (3% of the CYP population) to over 4000 (3.5%). If numbers of CIN continue to increase at the same rate over the next five years, they could rise up to nearly 5000 children (over 4%).

By far the largest majority of CIN are due to concerns that the child is subject to abuse or neglect and this majority is rising year on year. 70% of children in need have abuse or neglect as the primary need identified. This is followed by 11% whose need was due to a child's disability/illness and 10% due to family dysfunction.

Worcestershire has a significantly higher percentage of children whose primary need was abuse or neglect than England (68% compared to 52%). This accounts for over 2,750 of the 4,000 children flagged as CIN. The next largest category is child's disability or illness with 450 children identified in Worcestershire.

Figure 74 Primary Reason for Children in Need referral in Worcestershire compared to England (2017)



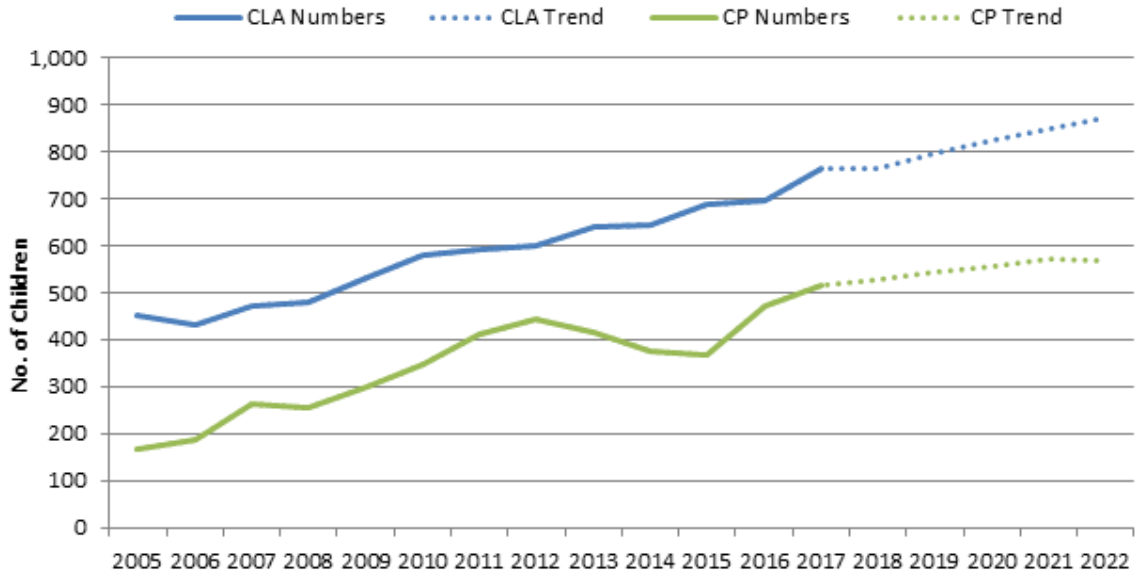
Source: Department for Education, Characteristics of Children in Need

Children Looked After (CLA)

Figure 75 shows the numbers of Children Looked After (CLA) and numbers of children who were the subject of a child protection plan (CP) for Worcestershire from 2005 to 2017. The data are based on a snapshot of numbers at the 31st March each year. The chart shows that the number of CLAs has increased steadily year on year, from less than 500, to almost 800 children. The numbers of CP increased from less than 200 to over 500 during the same period (with an increase up until 2012, a subsequent decline for three years, then a further increase over the last couple of years).

If numbers continue to increase at the same rate over the next five years, they could rise up to nearly 900 CLA and almost 600 CP by 2022.

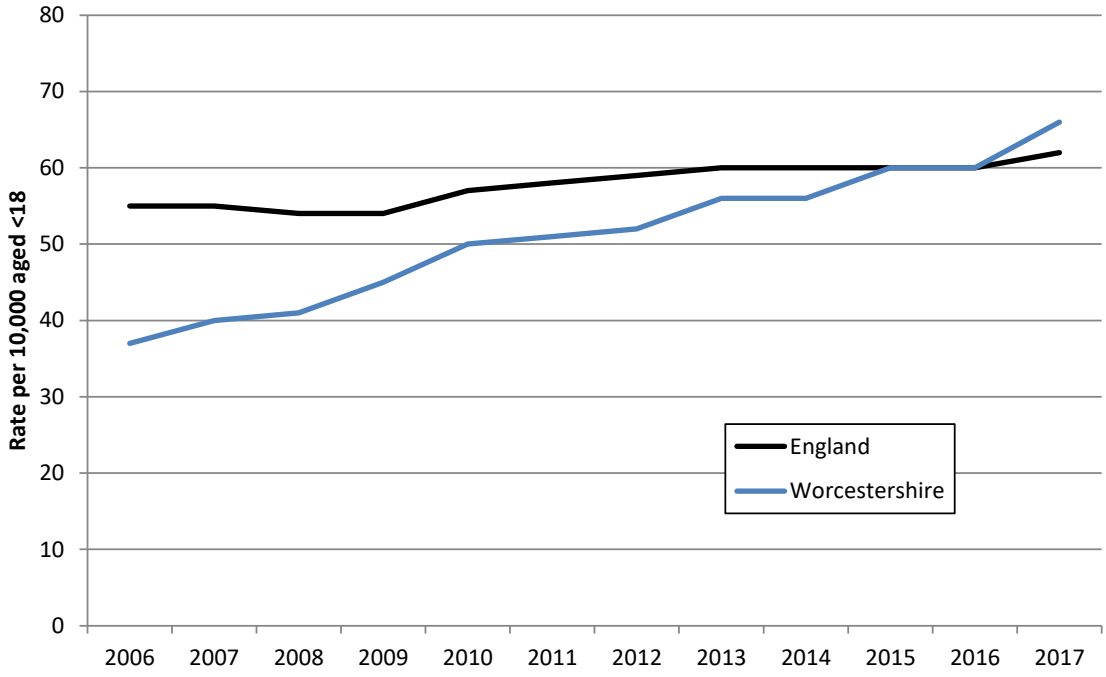
Figure 75 Trends over time for numbers of CLA and CP in Worcestershire



Source: Department for Education, Characteristics of Children Looked After

The CLA rate in Worcestershire has increased at a faster rate than the national average. The Worcestershire rate has increased over the past decade to reach and now overtake the England rate (Figure 76).

Figure 76 Children Looked After (CLA) rate per 10,000 persons aged <18



Source: Department for Education, Characteristics of Children Looked After

Pupils with Behavioural, Emotional and Social Support Needs

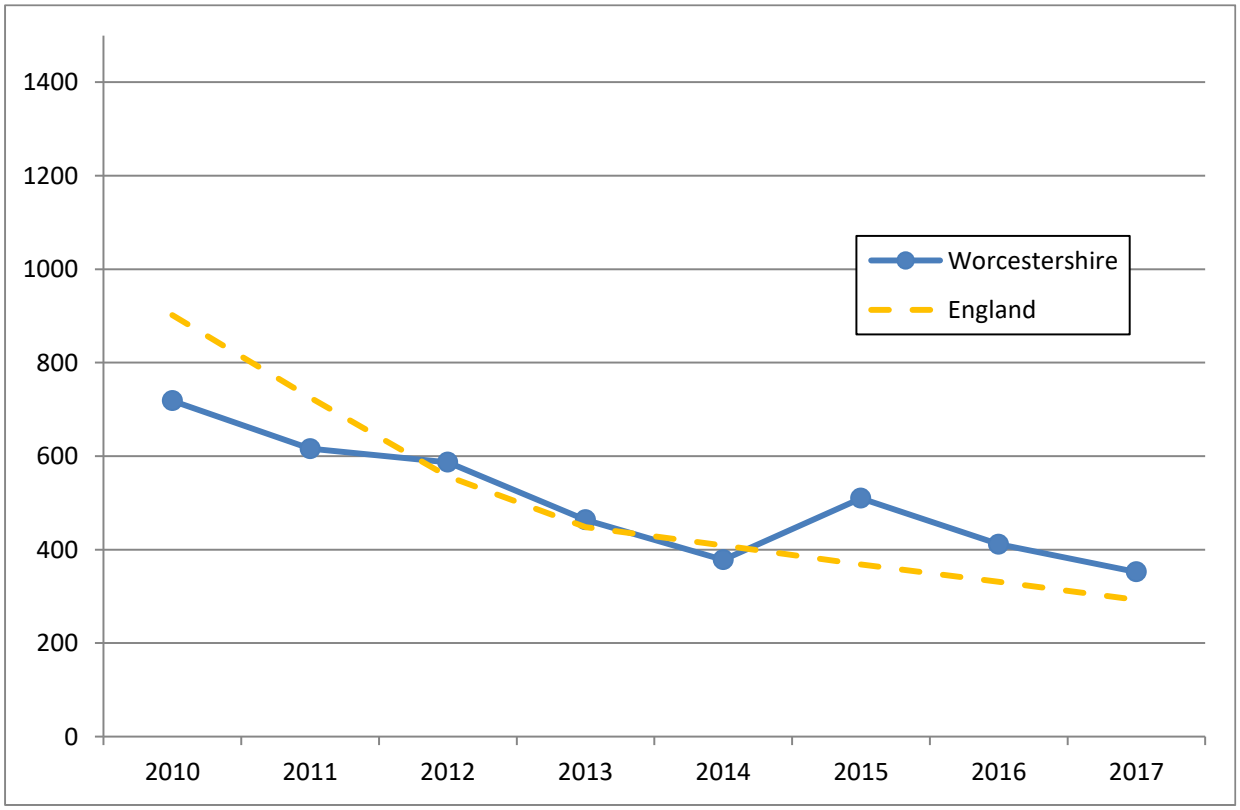
Compared to national figures, Worcestershire has a similar percentage of school children who have a SEN with social, emotional and mental health identified as their primary need (3.4% of school children).

Looking just at those children with SEND in Worcestershire, the proportion of children with a SEND need aged 4 to 19 years, who had Social, Emotional and Mental Health identified as their primary need was 16.8%. Interestingly, when considering all children who presented with Social, Emotional and Mental Health as their primary or secondary need, there were a much higher proportion of children who presented with this type of need 21.5% (n.2443).

First Time Entrants to the Youth Justice System

Over the last 3 years, the rate in Worcestershire has been statistically significantly higher than the national average.

Figure 77. First time entrants to youth justice (Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population)



Source: Public Health England, Public Health Outcomes Framework

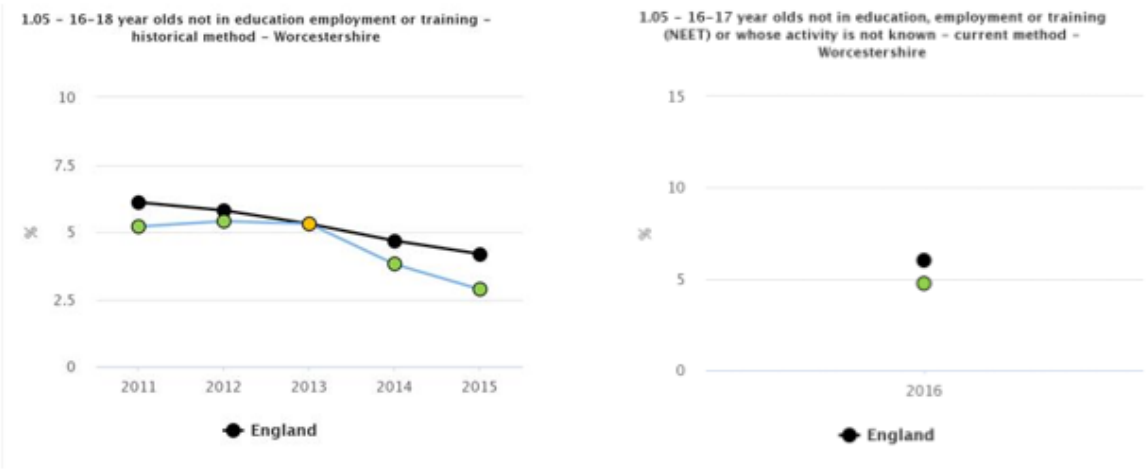
16 to 18 Year Olds Not in Education, Employment or Training (NEET)

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. The indicator is monitored to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work. Increasing the participation of young people in learning and employment not only makes a lasting difference to individual lives, but is also central to the Government's ambitions to improve social mobility and stimulate economic growth.

To support more young people to study and gain the skills and qualifications that lead to sustainable jobs and reduce the risk of young people becoming NEET, legislation was included in 2013 to raise the participation age as contained within the Education and Skills Act 2008. This required that from 2013 all young people remain in some form of education or training until the end of the academic year in which they turn 17[107].

Historically, Worcestershire has had a significantly lower proportion of 16-18 year olds who are not in education, employment or training (NEET) when compared to the England average, with the exception of 2013 where rates were similar to the England average. The way NEETS were calculated changed in 2016 and therefore data cannot be compared to previous years.

Figure 78: 16 to 18 year olds not in education, employment or training (NEET)



Source: Public Health England, Public Health Outcomes Framework

Other indicators show that compared to England Worcestershire has:

[107] Public Health England (2018) Indicator Definitions and Supporting Information, [Online], Accessed: 14/05/2018, Available from: https://fingertips.phe.org.uk/search/Not%20in%20Education#page/6/gid/1/pat/6/par/E12000005/ati/102/are/E10000034/iid/93203/age/174/sex/4

- A higher rate of children gaining 5 A*-C including English and Maths at GCSE
- A lower level of spending on children and young people's services

Promotion of Good Mental Health & Wellbeing and Mental Health Support

Rates of cyberbullying and self-harm in adolescents have increased. It is estimated that 10% of children aged 5 to 16 will suffer from a significant mental health illness and that 50% of those with a lifetime mental illness experienced symptoms before they were 14. Promoting emotional health & wellbeing and preventing poor mental health is high priority and cost saving.

Health visitors and school nurses are well placed to play a key role in promoting emotional wellbeing and positive mental health of children, young people and their families. They have a specific contribution to make in identifying issues, using protective screening and providing effective support. The different levels of intervention across the 4 tiers of health visiting and school nursing service model are outlined in 'Promoting emotional wellbeing and positive mental health of children and young people'[108]

The Children's Society and New Economics Foundation have adapted the Five Ways to Wellbeing to become more appropriate for use with children and young people[109]. The five steps provide the framework for Health Visitors and School Nurses working with children, young people and families, as well as an organisational tool to effect cultural change.

Connect… Enable young people to spend time with friends and family.

Be active… Urge young people to exercise regularly, either on their own or in a team.

Take notice… Encourage awareness of environment and feelings.

Keep learning… Keep young people's world as large as possible, encouraging their natural curiosity.

Creativity and play… Encourage children's imagination and creativity as they grow.

What works in schools to promote good mental health & wellbeing?

- Support from senior leadership team is essential
- Physical, social and emotional environment in which staff and students spend a high proportion of every week day has been shown to affect their health wellbeing as well as impacting on attainment
- School-based programmes of social and emotional learning have the potential to help young people acquire the skills they need to make good academic progress as well as benefit pupil health and wellbeing
- Involving students in decisions that impact on them can benefit by helping them to feel part of school and wider community and to have some control over their lives

[108] Department of Health and PHE (2014). Promoting emotional wellbeing and positive mental health of children and young people

[109] The Children's Society (2014). Ways to well-being Research report

- It is important for staff to access training to increase their knowledge and to equip them to be able to identify mental health difficulties in their students
- There are variety of tools that education settings can use as basis for understanding and planning a response to pupils' emotional health and wellbeing needs
- Schools have role in providing targeted support and specialist provision for pupils with particular needs

The Early Intervention Foundation has summarised the range of interventions that promote social and emotional skills in schools[110]. Promoting social and emotional development involves teaching and modelling social and emotional skills, providing opportunities for students to practice these skills and giving them the opportunity to apply these skills in various situations. The range of approaches for promoting social and emotional skills in schools can be divided into; Universal classroom-based interventions, Whole-school interventions and Targeted interventions. A further EIF review [111]systematically examined evidence on the effectiveness of school and out-of-school interventions implemented in the UK that are aimed at enhancing children and young people's social and emotional skills. The review identified the following approach:

1. Adopt whole school thinking
    - Use a 'whole school approach', which ensures that all parts of the school organisation work coherently together
    - Start with a positive and universal focus on well-being
    - Develop a supportive school and classroom climate and ethos
    - Identify and intervene early
    - Take a long-term approach
    - Promote the well-being of staff and tackle staff stress
2. Engage the whole community
    - Promote pupil voice and peer learning
    - Involve parents, carers and families
3. Prioritise professional learning and staff development
    - Understand risk and resilience to actively respond to problems and difficulties
    - Help all students with predictable change and transitions
4. Implement targeted programmes and interventions (including curriculum)
    - Use a range of leaders for specific programmes (such as psychologists)
    - Teach social and emotional skills (self-efficacy, emotional literacy, motivation and problem solving, social skills)
5. Develop supportive policy
    - Provide clear boundaries and robust policies
6. Connect appropriately with approaches to behaviour management
    - Understand the causes of behaviour
7. Implement targeted responses and identify specialist pathways

[110] Introduction to social and emotional learning in schools [Internet]. Early Intervention Foundation. Early Intervention Foundation; 2018

[111] Clarke AM, Morreale S, Field C-A, Hussein Y, Barry MM. What works in enhancing social and emotional skills development during childhood and adolescence? A review of the evidence on the effectiveness of school-based and out-of-school programmes in the UK

- Provide clear pathways of help and referral
- Provide more intense work on skills work for those with difficulties

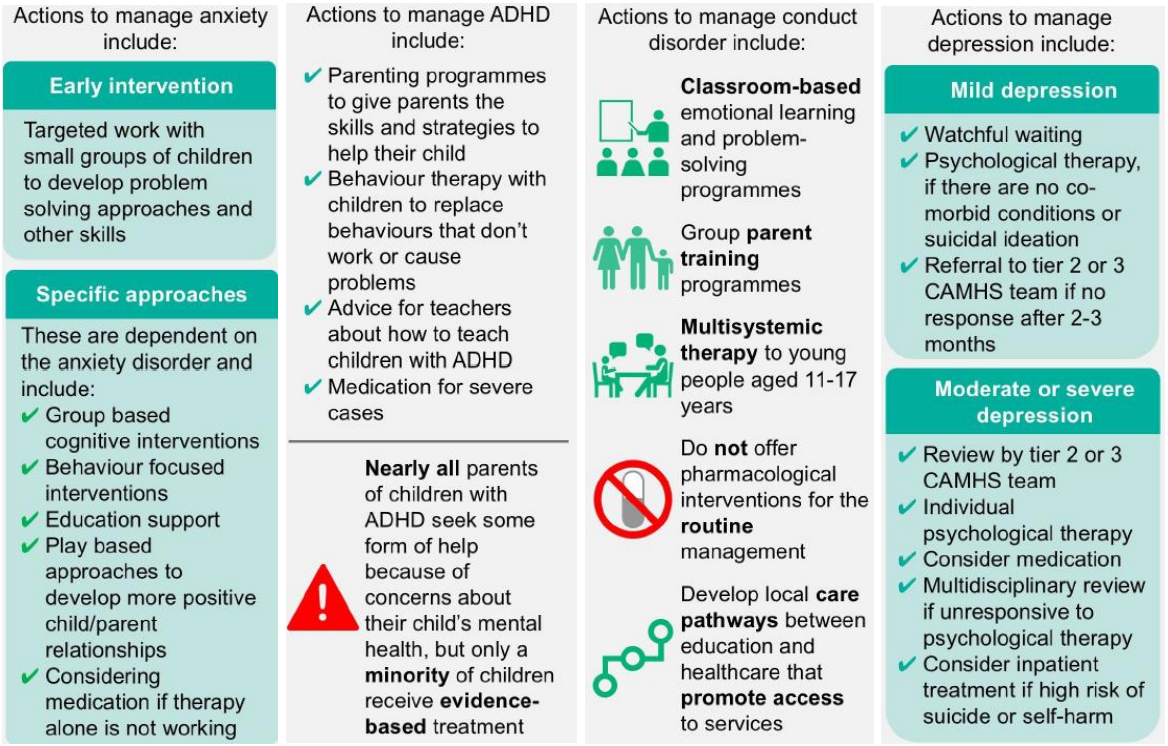
A report by the Mental Health Policy Commission[112] sets out the evidence base around the factors that can impact on young people's mental health. It identified a need to achieve "mentally friendly

Education" and recommended the implementation of whole-school Social and Emotional Learning programmes that are universal but can offer additional support for more vulnerable children and whole-school approaches for addressing harmful behaviour, particularly bullying, substance abuse, and reducing exclusions.

There are a variety of risk factors and protective factors that can negatively or positively impact on a child or young person's mental health.[113]

There is good evidence that investing in prevention and early intervention in CYP mental health avoids young people falling into crisis and avoids expensive and longer-term interventions into adulthood.[114]

Figure 79 Summary of What Works to Improve Mental Health in CYP by Condition



[112] Mental Health Policy Commission. INVESTING IN A RESILIENT GENERATION Keys to a Mentally Prosperous Nation Executive Summary and Call to Action. 2018.

[113] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

[114] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

Source: The mental health of children and young people in England, PHE (2016) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

More specifically in respect of conduct disorders a clinical knowledge summary by NICE in 2018 summarised the management of suspected conduct disorders in children aged from 36 months to 18 years of age[115]. This recommends a referral to Child and Adolescent Mental Health Services (CAMHS) for a CYP with suspected conduct disorder if they have a coexisting mental health problem (for example depression, or post-traumatic stress disorder), a neurodevelopmental condition (in particular ADHD or autism), a learning disability or difficulty or substance misuse in young people.

For children who do not have a complicating factor refer directly for a psychosocial intervention depending on the age of the CYP:

- Parent training programmes — usually offered where the child is aged 3 to 11 years (Incredible Years).
- Foster carer or guardian training — usually offered where the child is aged between 3 and 11 years.
- Child focused programmes — usually offered where the child is aged between 9 and 14 years (CBT based).
- Multimodal interventions — usually offered to young people aged between 11 and 17 years (MST).

[115] https://cks.nice.org.uk/conduct-disorders-in-children-and-young-people#!scenario

Access to Services

Around 25% to 35% of young people who need support are not accessing services[13] and around 60%-70% of children have not had appropriate interventions at a sufficiently early age. When children and young people do access services, the average wait for the first routine appointment was 9 weeks in 2015/16.

CCGs, working with local partners across the NHS, public health, children's social care, youth justice and education sectors; are working together to lead and manage change in line with the key principles outlined in Future in Mind. This is being done through the development of Local Transformation Plans.

The plans cover prevention and support and care for existing or emerging mental health problems, as well as transitions between services and addressing the needs of the most vulnerable. Key elements of the plan should include commitments to transparency, service transformation and monitoring improvement.

The 'You're Welcome - Quality criteria for young people friendly health services sets out principles to help commissioners and service providers to improve the suitability of services for young people. The quality criteria are based on examples of effective local practice working with young people aged under 20 years. An updated version of 'You're welcome' is planned for 2017 to 2018.

Implementing the Five Year Forward View for Mental Health, makes the delivery commitment that by 2020 to 2021, mental health services will provide timely access to evidence-based, person-centred and outcome focused care.

This is backed by a commitment that 70,000 more children and young people will have access to timely and appropriate care each year by 2020 to 2021. Widened access is to be supported by a workforce ambition to train 3,400 existing staff members in evidence-based treatment and recruit a further 1,700 staff in children and young people's mental health services (CYPMHS).

There is a commitment that, by 2020, 95% of CYP with an eating disorder will receive treatment within 1 week if the need is urgent and 4 weeks if the need is non-urgent. There is also a commitment to improve crisis care for all ages, including investing in places of safety, and improved access to and use of inpatient care closer to the young person's home, driving towards better integration with local community services to reduce the length of stay and bed usage.

NHS England will ensure that, by 2020 to 2021, the access and waiting time standard for early intervention in psychosis (EIP) services is being met. This standard requires that at least 60% of people experiencing first episode psychosis (aged 16 to 45) will start treatment with a NICE-recommended package of care with a specialist EIP service within two weeks of referral.

Commissioners and providers should ensure that children and young people benefit from the standard and put in place robust local arrangements between children and young people's mental health services and EIP services so that specialist expertise in working with children and young people with psychosis is available.[2]

Worcestershire Emotional Health and Wellbeing and Mental Health Services

A universal online counselling and emotional well-being platform is available for all children and young people, called Kooth which is accessible through mobile, tablet and desktop and free at the point of use[116]. The service is free, anonymous and provided by qualified counsellors.

The Reach4Wellbeing Service, promotes and supports emotional wellbeing for children and young people aged 5-19 years old. The service offers short-term group support programmes for those experiencing emotional difficulties, specifically anxiety, low mood and self-harm. The service is provided by WHCT. The group programmes are based on the evidence-based programme Coping Cat. The Coping Cat program is a CBT manual-based and comprehensive treatment program for children from 7 to 13 years old with separation anxiety disorder, social anxiety disorder, generalized anxiety disorder, and/or related anxiety disorders[117].

The Consultation, Advice, Support and Training Service (CAST) provided by WHCT, works directly with professionals who are working with young people experiencing or at risk of experiencing mental health difficulties including; School Nurses, Teachers, GPs, Health Visitors, Social workers and Family support workers. The service offers consultation, advice, support and training which can be specifically tailored to suit the professional seeking the service[118].

The Children's and Adolescent Mental Health Service (CAMHS) is a multi-agency specialist team including psychiatrists, psychologists, psychotherapists, nurses and social workers providing county wide services. The service specialises in delivering assessment, support, therapeutic intervention and treatment for children and young people with both emerging and complex and enduring mental health difficulties.

The Community Eating Disorder Service for Children and Young People is a newly developing service, specialising in the treatment of eating disorders in children and young people aged 8 to 17 ½. The service works across the CAMHS Worcestershire bases, with an eating disorder lead clinician in the CAMHS teams in Worcester, Redditch and Wyre Forest.

[116] https://kooth.com/

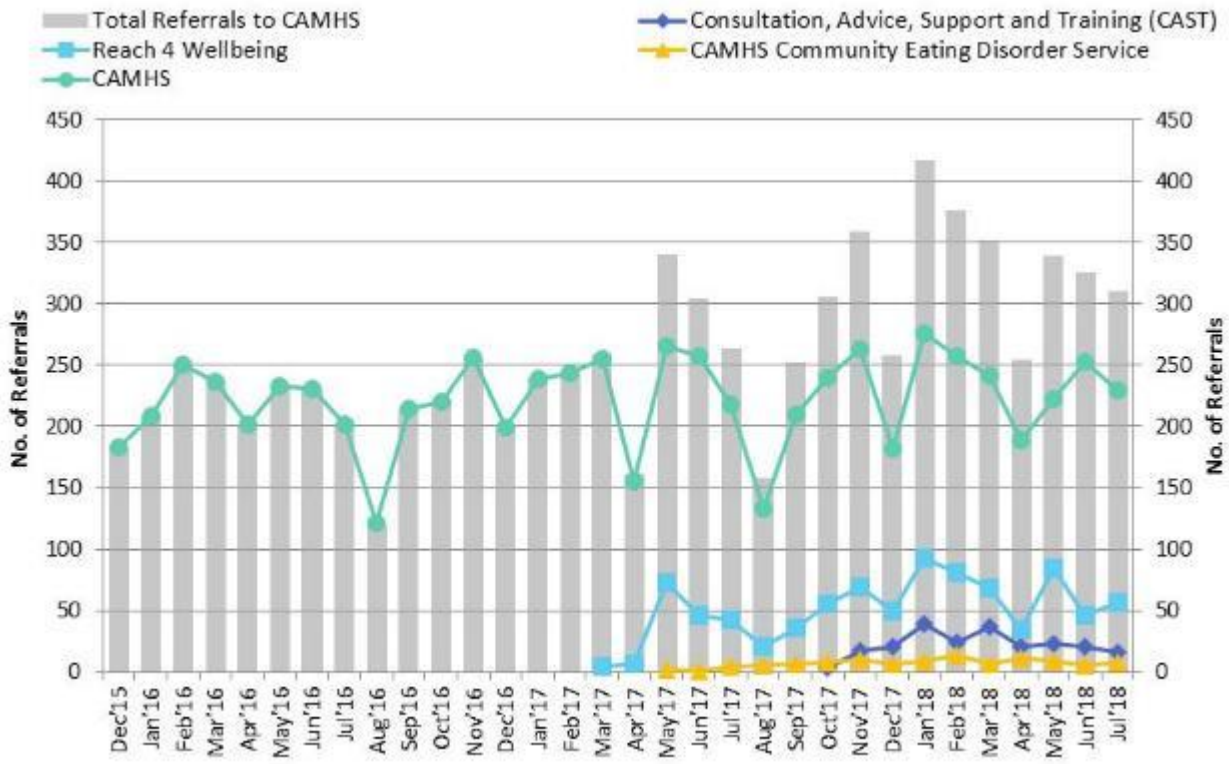
[117] Kendall, P.C. and Hedtke, K.A. (2006) Cognitive-Behavioural Therapy for Anxious Children: Therapist Manual (Third Edition). Ardmore: Workbook Publishing

[118] NHS Worcestershire Health and Care NHS Trust (2018) CAST, [Online], Available from: https://www.hacw.nhs.uk/our-services/childrens-community-health-services/camhs/cast/ , Accessed: 21st December 2018.

The Kooth on-line counselling, Reach4Wellbeing, CAST and Community eating Disorder services have all been developed since the 2015 EHNA as part of the CYP Mental Health and Emotional Wellbeing Transformation Plan. The data presented below relates to the period 1st December 2015 to 31st July 2018 unless otherwise stated and includes analyses referred to as pre and post implementation of the new service elements.

Between December 2015 and July 2018 there were a total of 8275 referrals to all WHCT Child and Adolescent Mental Health and Emotional Wellbeing Services overall. 7088 (85.7%) referrals were made to CAMHS, 862 (10.4%) to Reach 4 Wellbeing, 220 (2.7%) for Consultation, Advice, Support and Training (CAST) and a further 105 (1.3%) referrals were made to the Community Eating Disorder Service. 5.7% (n.470) referrals were for children who were known to be Looked After Children (LAC). Figure 94 highlights the total of all referrals and referrals for each service element by month.

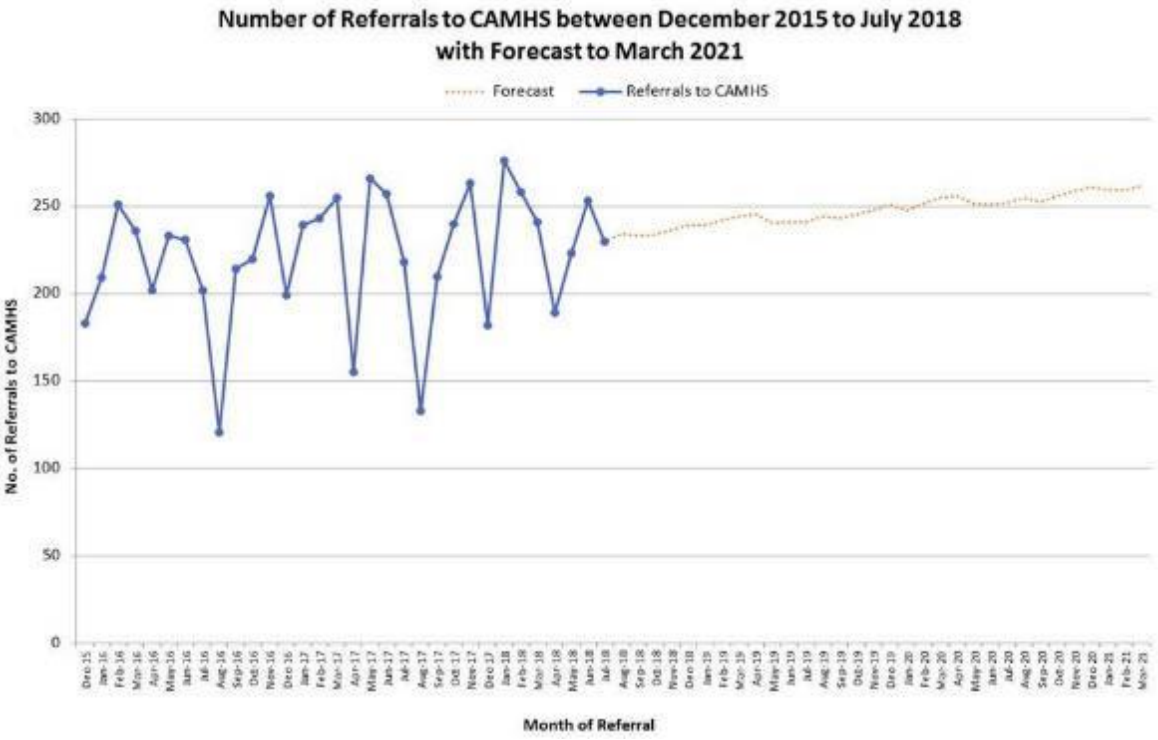
Figure 80 Referrals to all Mental Health and Emotional Wellbeing Services in Worcestershire by Month (Dec 15-Jul 18)



Source: Child & Adolescent Mental Health & Emotional Wellbeing Services Referrals - WHCT

Although it is early days, **Figure 80** suggests that referrals to CAMHs service remains at similar levels as prior to the introduction of the new lower level of need services. This may reflect increasing need or previously unmet need. The historical trend for referrals to specialist CAMHs below suggests referrals are continuing to increase.

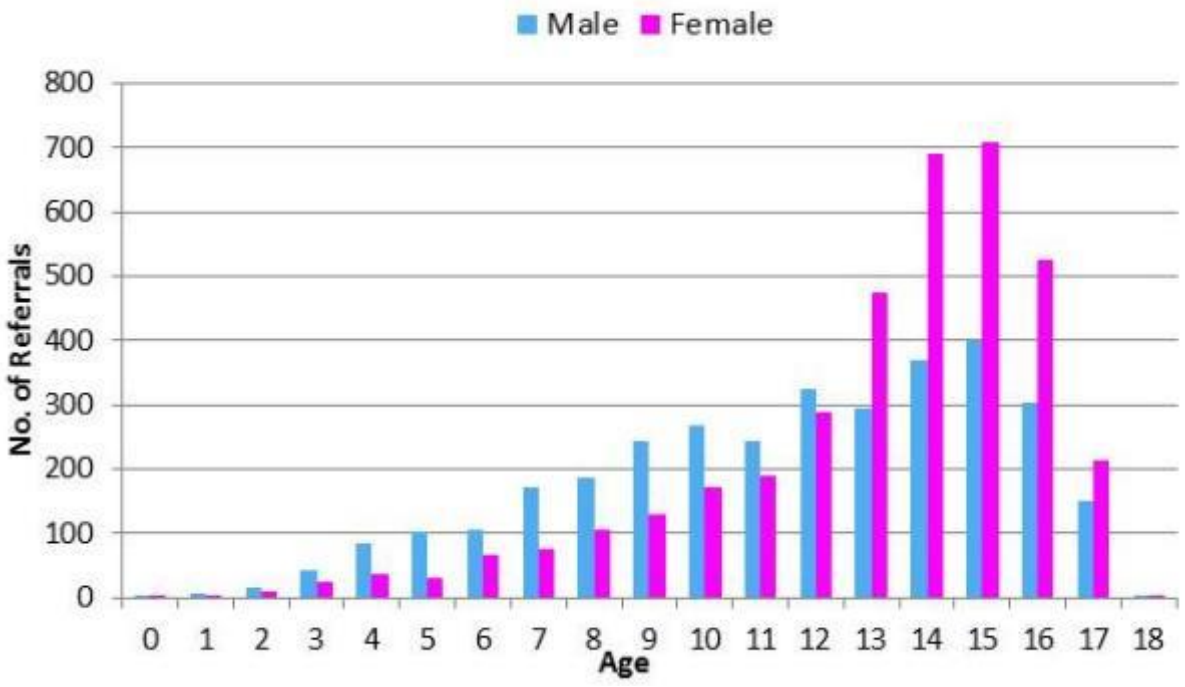
Figure 81 Forecast trend for CAMHs referrals 2015 to 2021



Source: Child & Adolescent Mental Health & Emotional Wellbeing Services Referrals - WHCT

Between December 2015 and July 2018 there were 7,088 referrals to CAMHS, which accounted for the largest proportion of referrals to all services overall (85.7%). There are a slightly higher proportion of girls referred to CAMHS at 53.0% (n.3759) when compared with boys 47.0% (n.3328). There is a marked distribution in age, Figure 82 shows that boys are referred to CAMHS at an earlier age in comparison to girls. Of all CAMHS referrals, around three quarters of boys are referred to CAMHS between the ages of 0-14 (74.1%) compared to girls (61.4%). Whereas more girls aged 15 to 18 (38.6%) are referred than boys (25.9%).

Figure 82 Referrals to CAMHS by age and gender Worcestershire (Dec'15-Jul'18)



Source: Child & Adolescent Mental Health & Emotional Wellbeing Services Referrals - WHCT

Around two-thirds of referrals to CAMHS were from General Practitioners (66.4% pre, 63.3% post). There were notable differences in the proportion of referrals from different agencies in the pre-post service changes. There was an increase in referrals to CAMHS from education (6.5% to 8.7%), Community Paediatrics (4.3% to 8.0%), Social Services (4.9%, 5.6%) and school nurses. However, should be noted that categorisation of referral source appears to have improved during same period which may be masking these differences - pre-changes 9.1% of referrals were from "Any other service or agency" compared to 4.5% post-service changes.

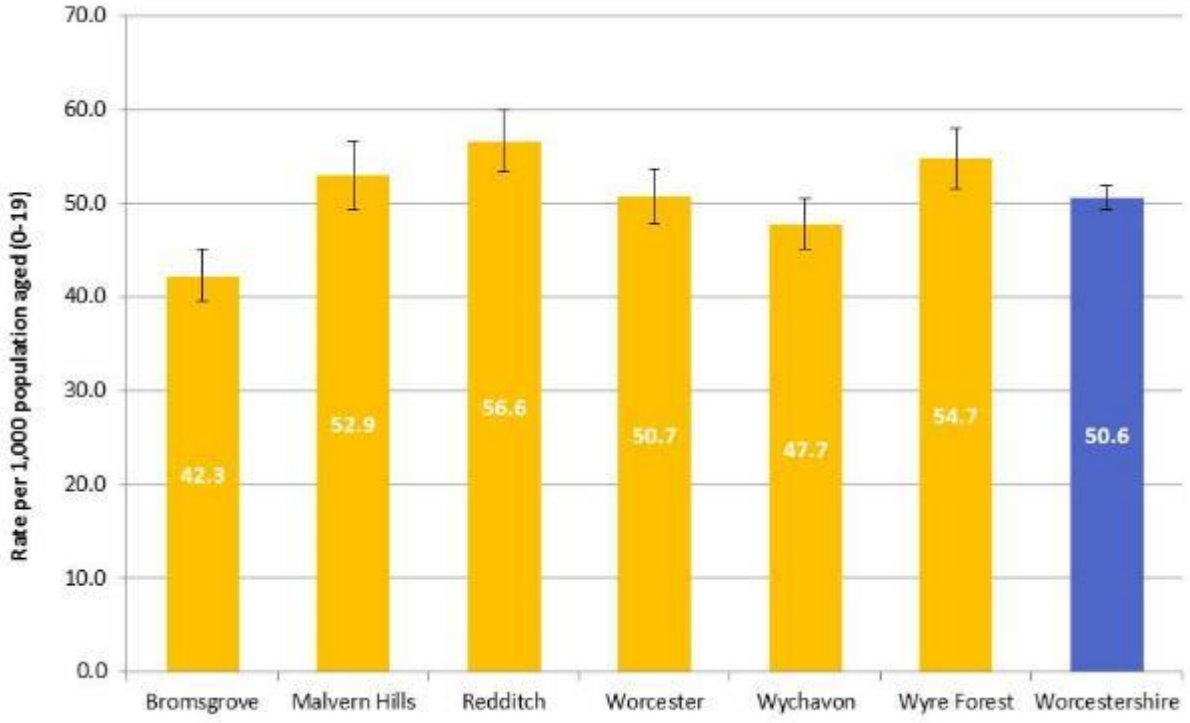
Table 32 Referrals to CAMHS by Referrer for Pre and Post service change period (Dec'15 to Jul'18)

Referrer	Pre	Post	Total	Pre (%)	Post (%)
General Practitioner	2319	2276	4595	66.4%	63.3%
Education Service	227	311	538	6.5%	8.7%
Any Other Service or Agency	319	162	481	9.1%	4.5%
Community Paediatrics	151	287	438	4.3%	8.0%
Social Services	172	200	372	4.9%	5.6%
Accident And Emergency Department	150	157	307	4.3%	4.4%
School Nurse	47	80	127	1.3%	2.2%
Hospital Based Paediatrics	46	58	104	1.3%	1.6%
Internal Community Mental Health Team	34	35	69	1.0%	1.0%
Health Visitor	15	23	38	0.4%	0.6%
Internal Community Health Service	9	2	11	0.3%	0.1%
Permanent transfer from NHS Trust	1	1	2	0.03%	0.03%
Police	1	0	1	0.03%	0.00%
Carer	1	0	1	0.03%	0.00%
Midwife	1	0	1	0.03%	0.00%
Internal Inpatient Mental Health Service	1	0	1	0.03%	0.00%
Independent - Low Secure Inpatients	0	1	1	0.00%	0.03%
Total	**3494**	**3593**	**7087**		

Source: Child & Adolescent Mental Health & Emotional Wellbeing Services Referrals - WHCT

There were 7,088 referrals received by the CAMHS service for children resident in Worcestershire, 198 children were referred from neighbouring counties and there were a further 349 records where area of residence could not be identified. There was a similar rate of referrals to CAMHS across most district areas in Worcestershire when compared to the Worcestershire rate (50.6 per 1,000 population). Rates of referrals to CAMHS were significantly lower for Bromsgrove at 42.3 per 1,000 population aged 0-19 when compared to the Worcestershire rate.

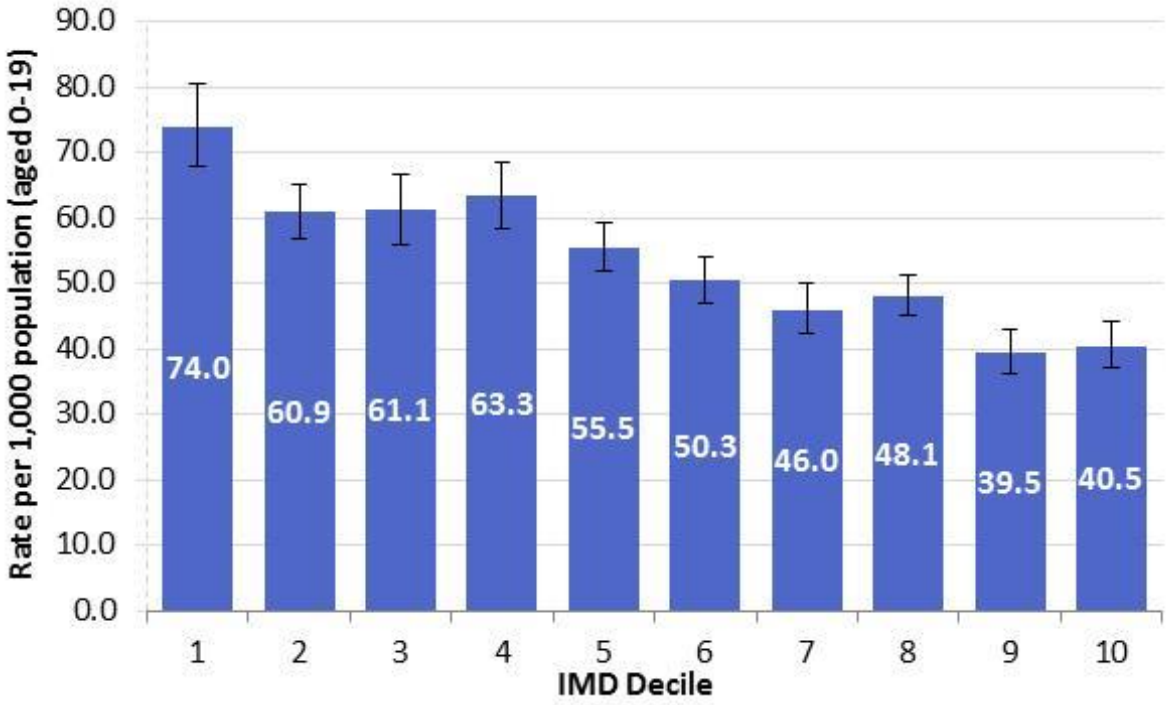
Figure 83 Rate of referrals to CAMHS by District per 1,000 population aged 0-18



Source: Child & Adolescent Mental Health & Emotional Wellbeing Services Referrals - WHCT

There is a clear difference between the rate of referrals from children and young people in the most deprived (Decile 1) to the least deprived (Decile 10). There were a significantly higher rate of referrals for children and young people living in the most deprived areas (74.0 per 1,000 population aged 0-19 years) compared to the least deprived areas (40.5 per 1,000 population aged 0-19 years).

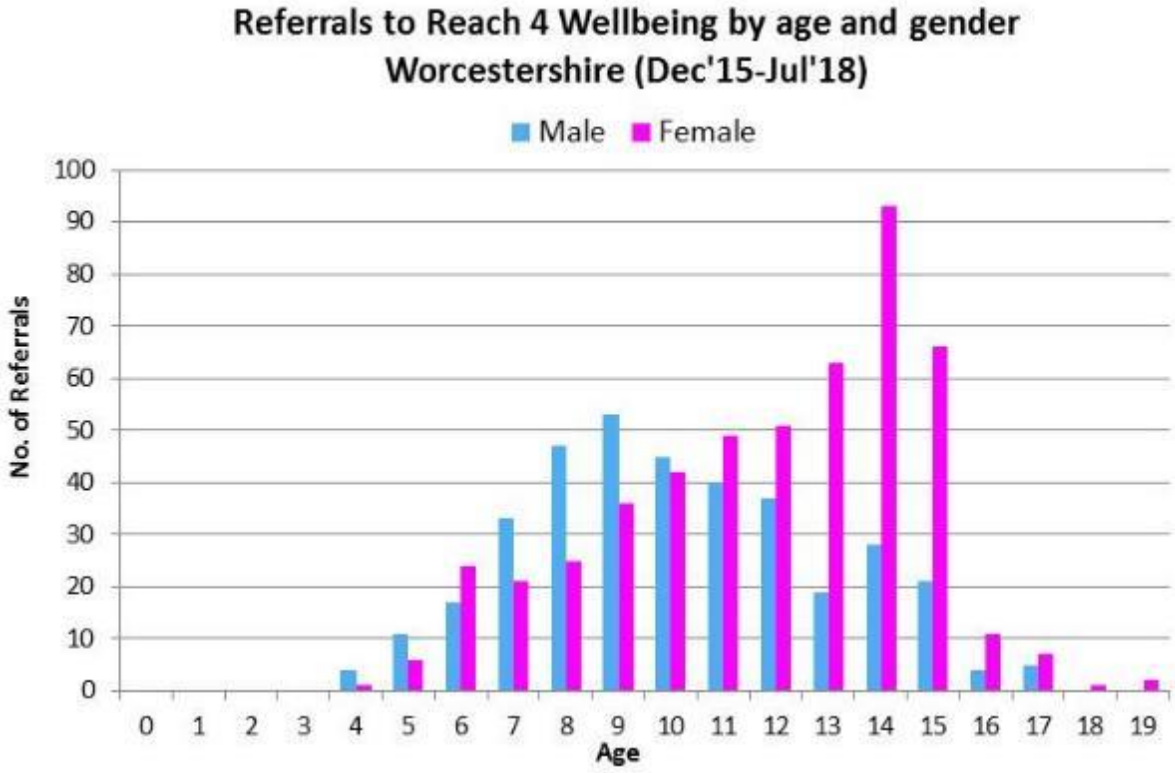
Figure 84 Rate of CAMHS Referrals by Deprivation Decile per 1,000 population aged 0-18 years resident in Worcestershire



Source: Child & Adolescent Mental Health & Emotional Wellbeing Services Referrals - WHCT

There were 862 referrals to the Reach4Wellbeing service in Worcestershire between March 2017 and July 2018. More girls were referred to the service (n.498), compared to boys (n.364). There is a difference between the ages at which boys and girls are referred to Reach 4 Wellbeing. Figure 99 shows that boys are referred at a younger age in comparison to girls. Between the ages of 0-9, just under half of all boys are referred into the service (45.3%) compared to just over a fifth of girls (22.7%). At ages 10-19, 54.7% of boys were referred to the service, compared to 77.3% of girls.

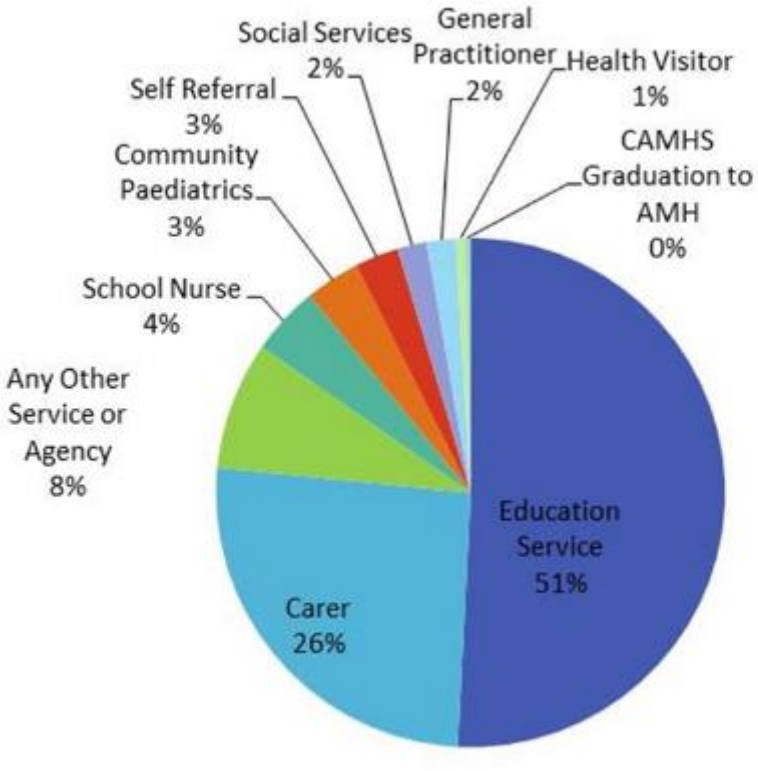
Figure 85 Referrals to Reach 4 Wellbeing by age and gender Worcestershire (Mar'17-Jul'18)



Source: Referrals to Reach 4 Wellbeing Referrals- WHCT

Approximately half of all referrals to Reach4Wellbeing were from schools/education (51%, n.438) with a further 26% (n.222) of referrals from Carers. A smaller proportion of referrals came from other agencies such as school nursing (4%, n.38), Community paediatrics (3%, n.30), Social Services (2%, n.16), GP (2%, n.16) and Health Visitor (1%, n.5). A small number of individuals self-referred (3%, n.24).

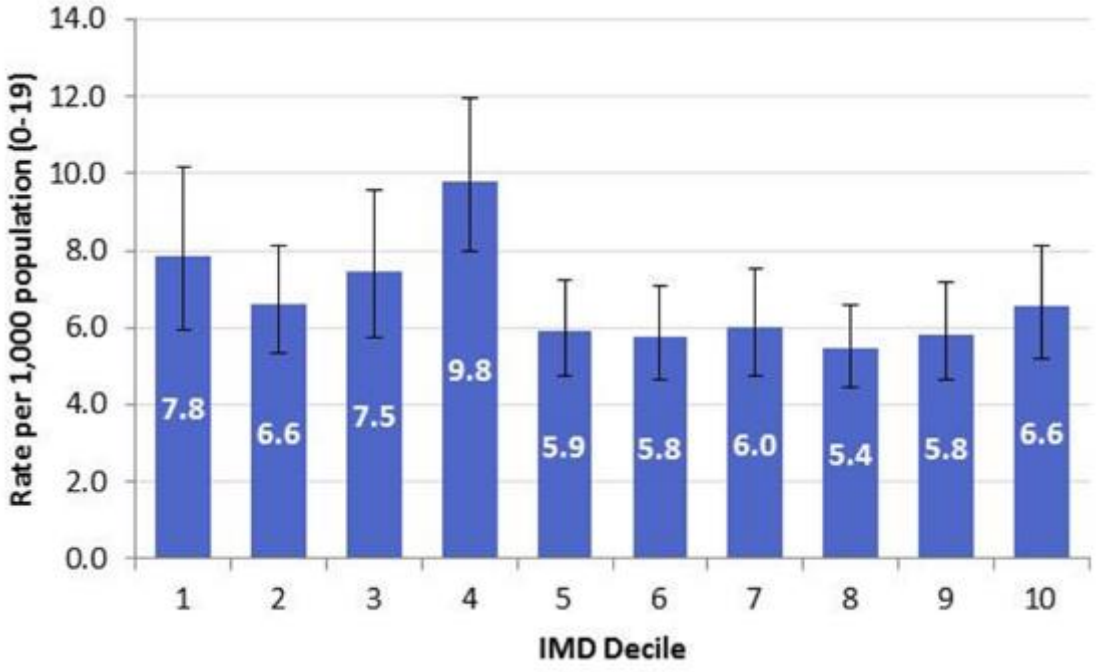
Figure 86 Referrals to Reach4Wellbeing by Referrer (Mar 17 to Jul 18)



Source: Referrals to Reach 4 Wellbeing Referrals- WHCT

Interestingly Figure 86 shows, there was no significant difference between referrals from the most deprived and least deprived deprivation decile.

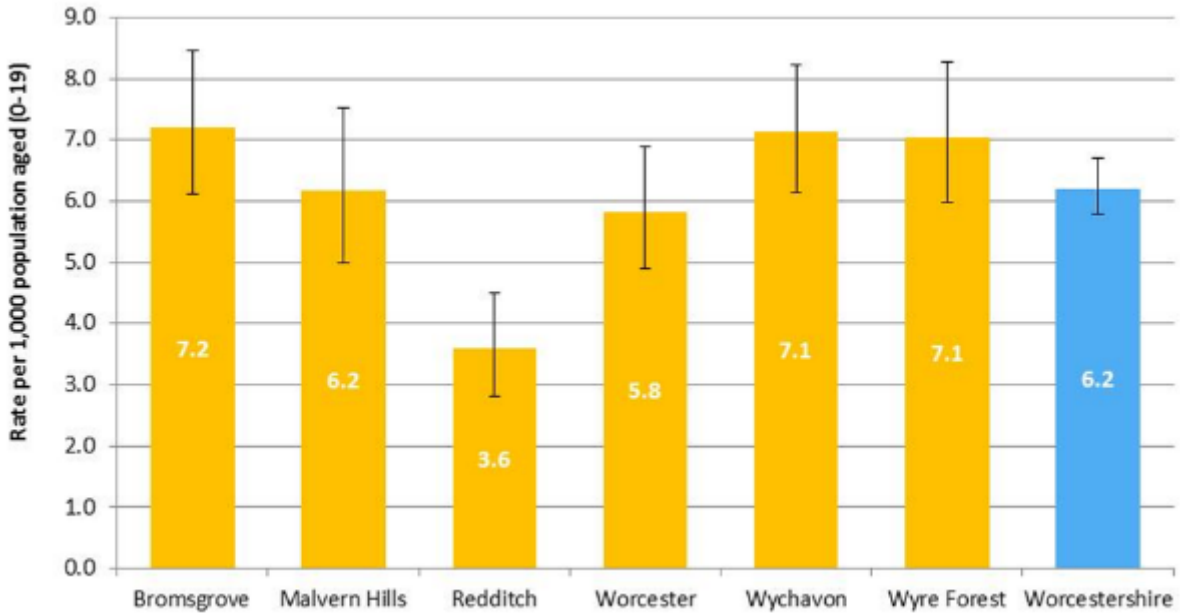
Figure 87 Reach4Wellbeing Referral rates by Deprivation Decile (Mar 17 to Jul 18)



Source: Referrals to Reach 4 Wellbeing Referrals- WHCT

There was a significantly lower rate of referrals from Redditch to the Reach4Wellbeing service**.** However, the service works closely with and through schools and this may indicate that the service had not yet worked with some of the schools in Redditch by July 2018.

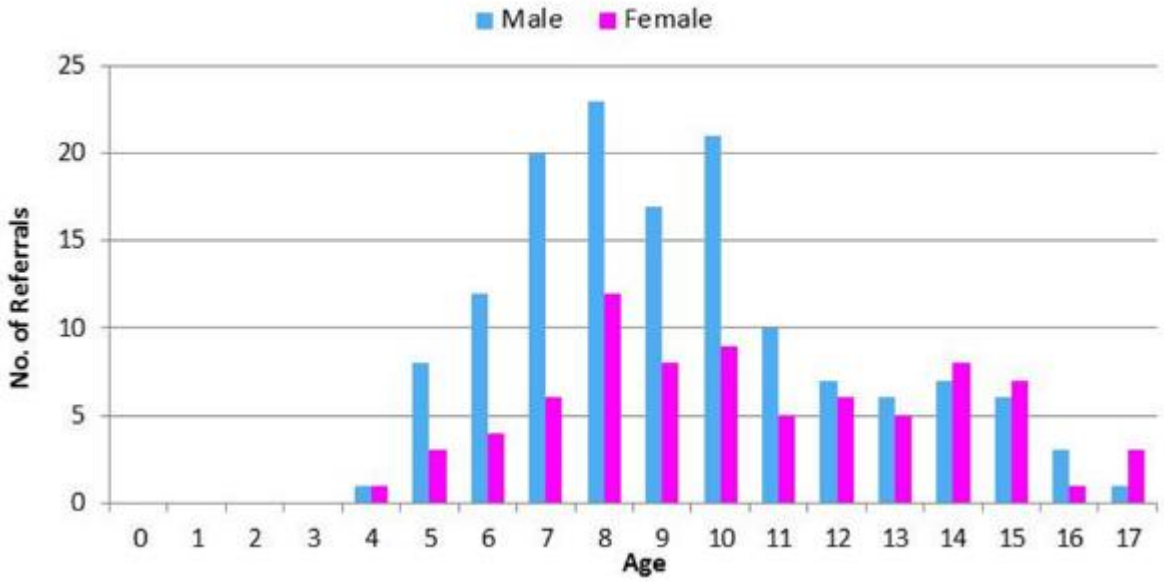
Figure 88 Referral rates to Reach4Wellbeing by District (Mar 17 to July 18)



Source: Referrals to Reach 4 Wellbeing Referrals- WHCT

There were a total of 220 referrals to the Consultation, Advice, Support and Training (CAST) service between October 2017 and July 2018. Around two-thirds of referrals to CAST were regarding boys (64.5%, n.142) compared to girls (35.5%, n.78). Similar to other mental health services for children and young people, activity for boys were at a younger age, in comparison to girls. At ages 15-19, a higher proportion of girls were referred to the service compared to boys.

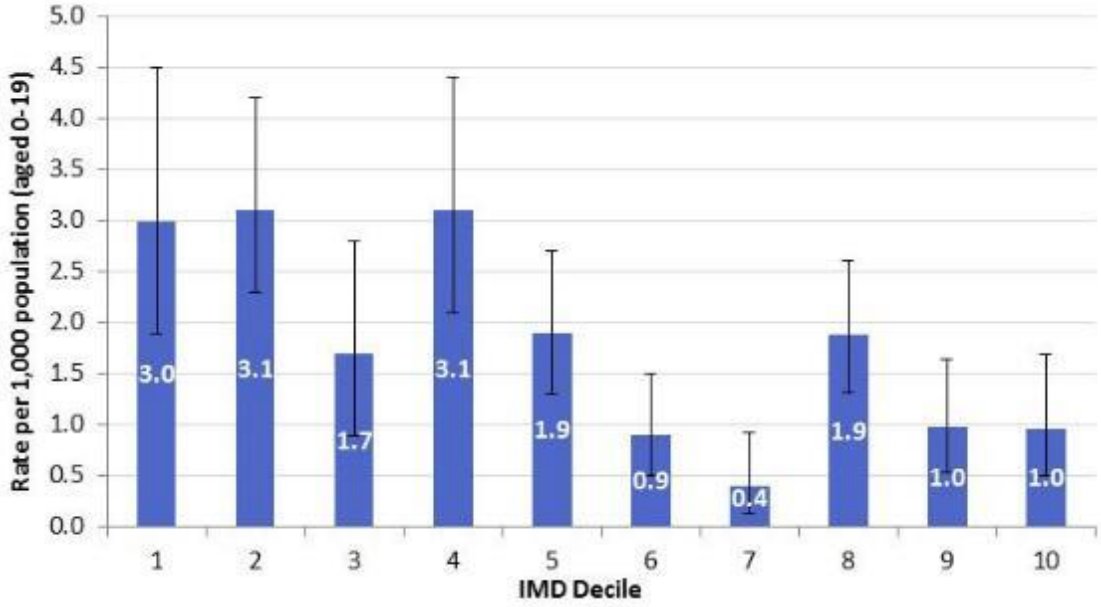
Figure 89 Referrals to CAST by age and gender Worcestershire (Oct 17-Jul 18)



Source: CAST Referrals- WHCT

Figure 90 shows, there was a significantly higher rate of referrals to CAST service relating to CYP from the most deprived (3.0 per 1,000 aged 0-19) and least deprived (1.0 per 1,000 population aged 0-19) deprivation decile. There was no significant difference between the rate of referrals across district areas, when compared to Worcestershire overall.

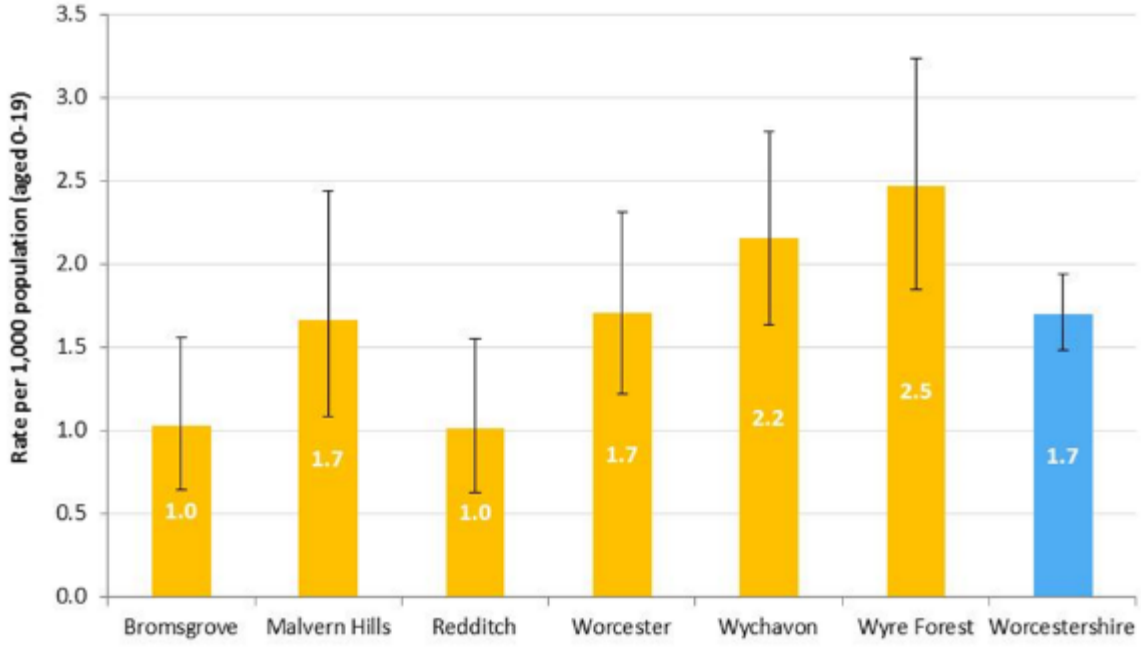
Figure 90 CAST Referrals rate (per 1000 population) by Deprivation Decile (Oct 17 to Jul 18)



Source: CAST Referrals- WHCT

The highest referrals were from Wyre Forest (2.5 per 1,000 population) and the lowest rate of referrals were from Redditch (1.0 per 1,000 population).

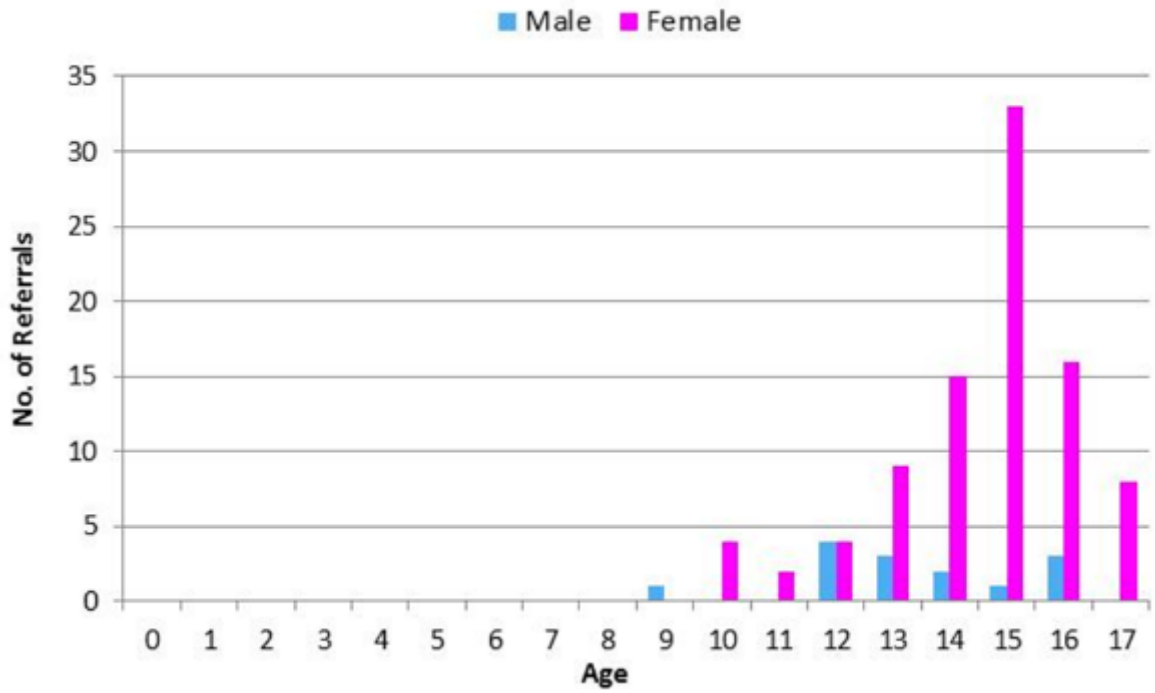
Figure 91 CAST Referral rates by District per 1,000 population (Oct 17 to Jul 18)



Source: CAST Referrals- WHCT

Between the period May 2017 to July 2018, there were 105 referrals to the new Community Eating Disorders Service. The majority of referrals were for girls (86.7%, n.91), with the highest referrals in 14, 15 and 16 year olds. Figure 106 shows the age and gender distribution of referrals to the service. As for the other CYP mental health services, boys are referred at an earlier age in comparison to girls. The majority of referrals were from Education (93.2%, n.205).

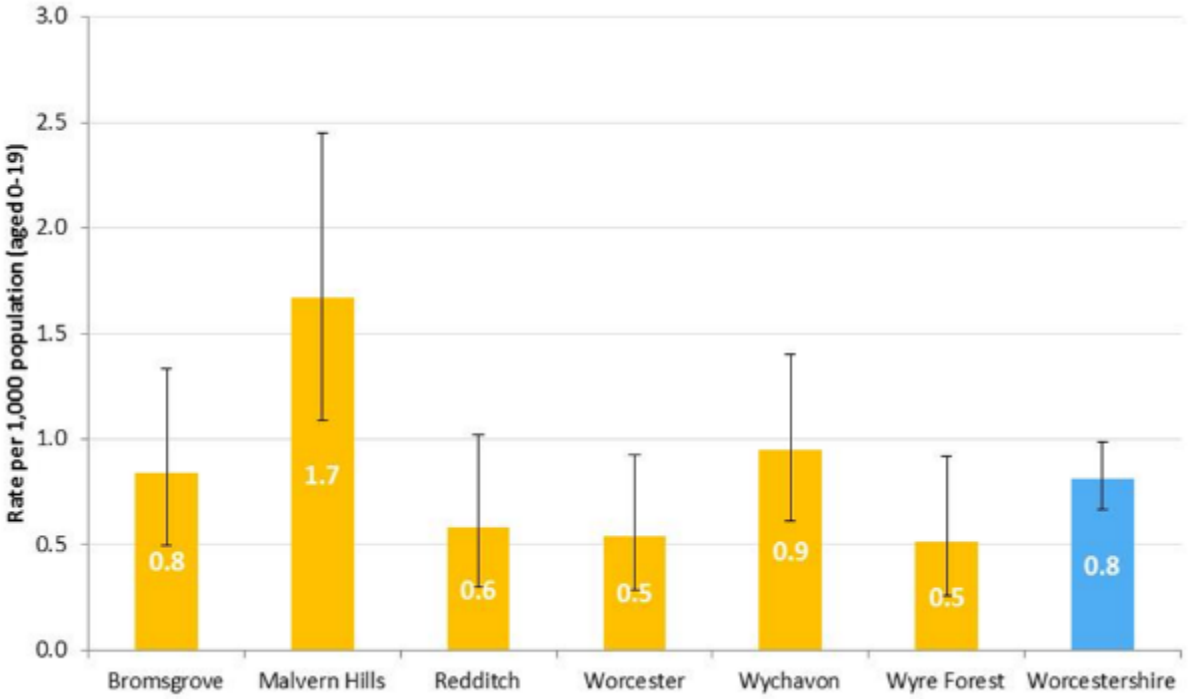
Figure 92 Referrals to Community Eating Disorders Service by age and gender (May 17-Jul 18)



Source: Community Eating Disorders Service Referrals- WHCT

The highest referral rate was for children and young people resident in Malvern Hills 1.7 per 1,000 population aged 0-19 (Figure 93). This was significantly higher than the Worcestershire rate 0.8 per 1,000 population aged 0-19. Although small numbers there was no significant difference between the rate of referrals from the most deprived and least deprived areas.

Figure 93 Referral rate to Community Eating Disorders Service by District (May 17 to Jul 18)



Source: Community Eating Disorders Service Referrals- WHCT

Local Data

The JSNA profile includes prevalence metrics to aid estimation of need and has some metrics which cover activity and quality of care services:

In services

new children and young people receiving treatment (CCG, STP)

children and young people's mental health admissions to hospital (CCG, STP)

There is little national data currently available which reports on mental health services for children and young people. This is being addressed through the Mental Health Services Dataset reporting, which incorporated CYPMH from January 2016.

The Mental Health Services Dataset produces a monthly report, published by NHS Digital, which provides an overview of access across all mental health services for CYP aged 0 to18. This data is still experimental so should be treated with caution. As the data quality and completeness improves and more data becomes available, new metrics will be reported in the JSNA and CYPMH&W profiles.

Commissioners will have access to further local data on outcomes and feedback from children, young people, parents and carers. The Child Outcomes Research Consortium (CORC) support registered members to collect and improve the quality of data relating to children and young people's mental health and wellbeing outcomes.

Detailed assessment of local support services will require direct contact with providers (such as Social Care and NHS and private Specialist Mental Health services). Local Health has indicators covering rates of hospital admissions for injuries in children at geographies below local authority level.

Healthwatch Worcestershire published a report on Children and Young People's Mental Health in March 2019[119] . This report makes some specific conclusions and recommendations under the following headings:

- Information for parents, carers and young people
- Access to appropriate support
- Waiting times for CAMHS
- Satisfaction with CAMHS service
- Support for children with Autism Spectrum Conditions and other additional needs

Evidence and Further Information

Key Data Sources

The Children and Young People's Mental Health and Wellbeing Profile: has a number of other metrics which can be used to identify levels of risk and protective factors in children between the ages of 0 and 18 years.

The National Child and Maternal Health Intelligence Network: a wealth of information and data around children and young people in general, in addition to a number of profiles.

Public Health England ROI tool: provides assessment of the ROI for school-based social and emotional wellbeing programmes and programmes to address bullying of young people.

Local Health: has a number of indicators around poverty and education which are reported at geographies below local authority level.

[119] https://www.healthwatchworcestershire.co.uk/wp-content/uploads/2019/03/HWW-CYP-Mental-Health-and-Wellbeing-Report-March-2019-v-1.0.pdf

Further Information

Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing: report from the Children and Young People's Mental Health and Wellbeing Taskforce brings together the core principles and requirements needed to create a system that can support the emotional wellbeing and mental health needs of children and young people.

Delivering With, Delivering Well

Developed by young people, professionals, commissioners and academics this sets out the principles and markers of a good service. These markers are currently recognised in the existing quality assurance and quality process mechanisms and have been included in the CQC:

Quality Network for Community CAMHS (QNCC)

Youth Wellbeing Directory with ACE-V Quality Standards (ACE-Value)

Choice and Partnership Approach (CAPA)

Child Outcomes Research Consortium (CORC)

THRIVE Elaborated (2015):

Example of service planning: THRIVE offers a set of principles and values to guide service implementation. It takes a whole system approach and focuses on building individual and community strengths and ensuring that children, young people and families are active decision makers in the process of choosing the right service approach. It also draws a clearer distinction between treatment and support. For the latest information about the i-THRIVE implementation please refer to the annual report (May 2017).

Choice and Partnership Approach (CAPA): example of service planning: CAPA is a clinical service transformation model that involves young people and their families, goal setting and regular review involving the young person and addressing demand and capacity and skills and job planning.

Evidence Based Practice Unit: Anna Freud National Centre for Children and Families: collection of booklets, leaflets and other publications on academic research and mental health practice, in support of children, young people and mental health practitioners. Including guides on using outcomes and feedback tools.

Joint Commissioning Panel for Mental Health: Guidance for commissioners of eating disorder services: guide to commissioning comprehensive mental health services for people with eating disorders.

NHS England: Access and Waiting Time Standard for Children and Young People with an Eating Disorder Commissioning Guide: guidance on establishing and maintaining a community eating disorder service. This guidance is being extended to include episodes of care in day or inpatient settings (paediatric wards, general medical wards, inpatient CAMHS units) and will be published late in 2017.

NHS England: Implementing the early intervention in psychosis access and waiting time standard: provides support to local commissioners and providers in implementing the access and waiting time standard.

NICE: ADHD National guidance: guideline to diagnosing and managing attention deficit hyperactivity disorder (ADHD) in children over 3 years, young people and adults.

NICE: Antisocial behaviour and conduct disorders in children and young people: recognition and management guidance and quality standard: guideline and standard for recognising and managing antisocial behaviour and conduct disorders in children and young people.

NICE: Anxiety disorders (quality standard): identification and management of anxiety disorders in primary, secondary and community care for children, young people and adults.

NICE: Attention deficit hyperactivity disorder: diagnosis and management guidance and quality standard: diagnosing and management of ADHD in children over 3 years, young people and adults.

NICE: Autism national guidance and standards: wide range of NICE guidance available for the recognition, referral and diagnosis of autism which varies according to age. The interactive pathway is a useful way to access the full amount of information available.

NICE: Bipolar disorder, psychosis and schizophrenia in children and young people (quality standard): recognition, early intervention and management of bipolar disorder, psychosis and schizophrenia in children and young people.

NICE: Depression in children and young people (guidance): identifying and managing depression in children and young people aged between 5 and 18 years.

NICE: Depression in children and young people (quality standard): the diagnosis and management of depression in children and young people aged 5 up to their 18th birthday.

NICE: Eating disorders (guidance): recommendations for the identification, treatment and management of anorexia nervosa, bulimia nervosa and atypical eating disorders in primary, secondary and tertiary care.

NICE: Psychosis and schizophrenia in children and young people: recognition and management (guidance): recognising and managing psychosis and schizophrenia in children and young people, aiming to improve early identification so they are given the treatment and care they need.

NICE: Self-harm in over 8s: long-term management (guidance): longer-term psychological treatment and management of self-harm in people aged 8 years and over.

NICE: Self-harm (quality standard): short-term management of self-harm and the provision of longer-term support for children and young people aged 8 years and over, and adults aged 18 years and over who self-harm.

NICE: Self-harm in over 8s: short-term management and prevention of recurrence (guidance): short-term management and prevention of self-harm in children and young people aged 8 years and over. It covers the first 48 hours following an act of self-harm.

NICE: Social anxiety disorder (guidance): recognising, assessing and treating social anxiety disorder in children and young people, from school age to 17 years, and adults (aged 18 years and older).

PHE: The Mental Health of Children and Young People in England: describes the importance of mental health and wellbeing among children and young people and the case for investment in mental health.

The following documents and supporting materials are useful sources of further information on this topic:

Early Intervention Foundation: Early Intervention Foundation Guidebook: interactive tool to find evidence and guidance on how to deliver effective early intervention for the family and the home and positive child development.

NICE: Social and emotional wellbeing in primary education & Social and emotional wellbeing in secondary education guidelines covering promoting social and emotional wellbeing in children in full time education. They include planning and delivering programmes and activities to help children develop social and emotional skills and wellbeing. They cover identifying signs of anxiety or social and emotional problems in children and how to address them.

PHE Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill Health includes sections on the effectiveness of school-based social and emotional wellbeing programmes and programmes to address bullying of young people.

PHE: Evidence Based Practice Unit UCL and Anna Freud National Centre for Children and Families: Measuring and monitoring children and young people's mental wellbeing: A tool kit for schools and colleges: toolkit aiming to make schools and colleges aware of the range of validated instruments that can be used to measure and monitor student mental wellbeing. Included are examples from across the primary, secondary, special and college sectors, where validated tools have been used in practice.

PHE: Improving young people's health and wellbeing: a framework for public health: gives practical support in addressing the specific health and wellbeing needs of children and young people aged 10 to 24 years. It takes an asset-based approach, focusing on wellbeing and resilience and placing young people at the centre of service design and delivery. It describes six core principles to promote an effective and integrated response to needs.

PHE: Measuring mental wellbeing in children and young people: provides signposting to evidence driven interventions and metrics to measure wellbeing and its risk and protective factors.

PHE: Promoting children and young people's emotional health and wellbeing: a whole school and college approach: eight principles, informed by evidence and practitioner feedback, contribute towards helping protect and promote student emotional health and wellbeing. The document signposts to Ofsted inspection criteria, practice examples and resources to support implementation.

PHE: Supporting public health: children, young people and families: a range of documents to support local authorities and providers in commissioning and delivering children's public health services aged 0 to 19 years. The documents include health and wellbeing, resilience, maximising learning and achievement, supporting complex and additional health needs and transition to adulthood. An extensive list of links to relevant resources and tools is also given.

PHE: The mental health of children and young people in England: report describing the importance of mental health in CYP, presenting the case for investing in mental health, and summarising the evidence of what works to improve mental health in CYP.

The British Psychological Society: The Child & Family Clinical Psychology Review: What good could look like in integrated psychological services for children, young people and their families: considers the challenges of providing services for children and young people in terms of capacity, demand and workforce development. It proposes integrated models of care to overcome these challenges.

Wellbeing of adolescent girls: An analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England: summarises data on girls' emotional health and wellbeing, informed by an analysis of data from the health behaviour in school-aged children (HBSC) study for England, 2014.

PHE. Cyberbullying: An analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England, 2014: summarises data on cyberbullying informed by an analysis of data from the Health Behaviour in School-aged Children.

Intentional self-harm in adolescence: An analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England, 2014: thematic analysis of the recent HBSC survey data to explore the rising trend in poorer emotional wellbeing of young people

Working-Age Adults

Introduction

This section focuses on the treatment of mental health problems in working-age adults. Opportunities to prevent mental ill health and develop community resilience are covered in the 'Understanding People' and 'Understanding Place' sections of this report.

When considering the mental health needs of the working-age population there are a wide range of conditions to include and this report covers these under two broad headings: **common mental health problems** and **severe mental illness**.

One of the aims of this section is to review whether the local population is accessing services in line with identified need and if, following treatment, the services available are helping people to recover and stay well.

Long-Term Mental Health Problems - GP Patient Survey Data

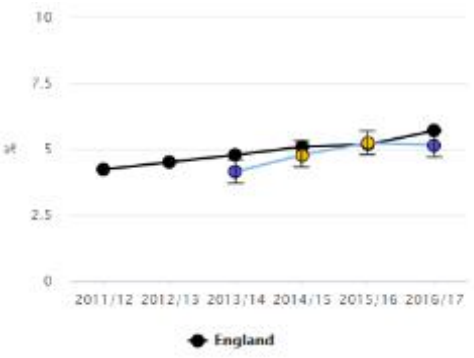
In Worcestershire 5.2% (95% CI 4.7-5.7) of respondents to the 2016/17 GP Patient Survey reported a long-term mental health problem. This value is significantly higher than the value in 2013/14 and similar to the England value which was 5.7% (95% CI 5.6-5.8) and (Figure 94)[120].

In the 2017/18 GP Patient Survey Redditch and Bromsgrove Clinical Commissioning Group (CCG) had a significantly lower percentage of people reporting a long-term mental health problem than the England average. South Worcestershire and Wyre Forest CCGs both had similar proportions (Table 33). It should be noted that 2017/18 data is not comparable to earlier years[121].

Figure 94 Self-reported Long-Term Mental Health Problem in Worcestershire - GP Patient Survey

[120] Data from the 2017/18 survey is not yet available at County level.

[121] The 2018 questionnaire was significantly redeveloped and analysis has found that these changes, together with the inclusion of 16 and 17 year olds, mean that the results are not comparable to previous years for most questions..



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2011/12		-	-	-	-	-	4.2
2012/13		-	-	-	-	-	4.5
2013/14		360	4.1	3.7	4.6	4.8*	4.8
2014/15		396	4.8	4.3	5.3	5.1*	5.1
2015/16		423	5.2	4.8	5.7	5.4*	5.2
2016/17		403	5.2	4.7	5.7	5.7*	5.7

Source: DH, GP patient survey

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Table 33. Prevalence of Self-Reported Long-term Mental Health Conditions 2017/18 – GP Patient Survey

Area	Percentage (95% CI)
England	9.1(9.0-9.1)
NHS Redditch And Bromsgrove CCG	7.4 (6.4-8.6)
NHS South Worcestershire CCG	9.1 (8.2-10.0)
NHS Wyre Forest CCG	7.7 (6.5-9.3)

Source: Public Health England Mental Health and Well-being JSNA Profile. Original source DHSC, GP Patient Survey.

Common Mental Health Problems

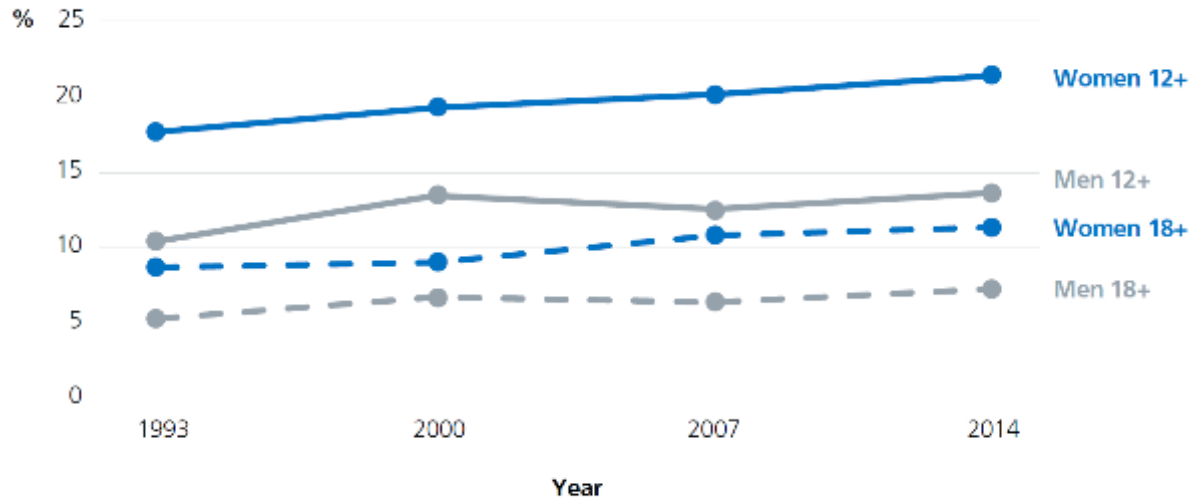
Common mental health problems include:

- Generalised anxiety disorder (GAD)
- Depression
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Agoraphobia
- Obsessive-Compulsive Disorder (OCD)
- Specific Phobia
- Post-Traumatic Stress Disorder (PTSD)
- Health Anxiety (Hypochondriasis)

The prevalence of common mental health problems is influenced by the wider determinants of health - with poor and disadvantaged people suffering disproportionately. Common mental health problems in turn can lead to reduced income and employment increasing the risk of further mental health problems. The large numbers of people experiencing these conditions has a significant cost to society.

The Adult Psychiatric Morbidity (APM) survey[122], conducted every seven years, surveys adult mental health in England. The latest survey was conducted in 2014 and this estimated that nationally the proportion of adults with symptoms of a common mental health disorder (depression and anxiety; CMD) was 15.7%[123]. Since 1993 there has been an increase in the proportion of people with symptoms of CMD and women have had higher rates of CMD than men (Figure 95). The latest survey found one woman in five having CMD (20.7%) compared with about one man in eight (13.2%). The survey found that young women 16-24 years had become a key high-risk group (Figure 96).

Figure 95 Trends in Common Mental Health Disorders 1993-2014; CIS-R scores[124]



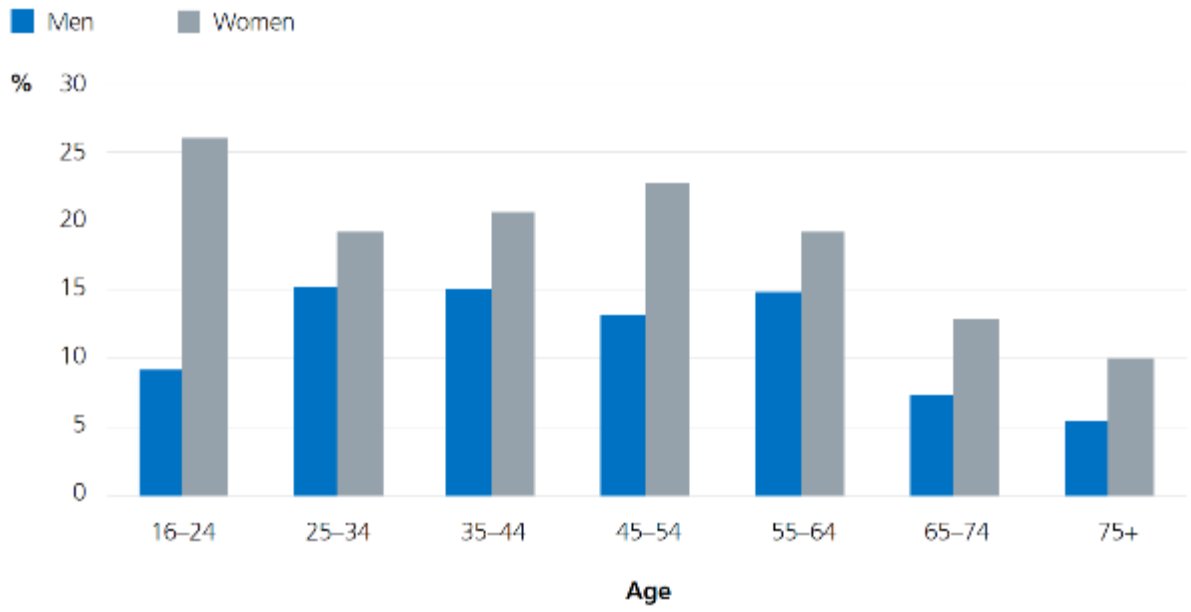
Source: Health and Social Care Information Centre. 2016. APM Survey 2014.

[122] Health and Social Care Information Centre. 2016. APMS 2014. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

[123] 95% Confidence Interval 14.7%-16.7%.

[124] The CIS-R is an interviewer administered structured interview schedule covering the presence of non-psychotic symptoms in the week prior to interview. It can be used to provide prevalence estimates for 14 types of CMD symptoms and six types of CMD, together with a continuous scale that reflects the overall severity of CMD psychopathology.

Figure 96 Adult Psychiatric Morbidity Survey 2014 Estimated Prevalence of Common Mental Health Disorder[125] by age and sex



Source: Health and Social Care Information Centre. 2016. APMS 2014.

Description and Prevalence of Common Mental Health Conditions

The adult population (16+) of Worcestershire is 484,129 (ONS Mid-year Estimate 2017). Applying the overall population prevalence rate from the Adult Psychiatric Morbidity Survey (APMS) of 15.7% suggests there could be around 76,000 adults (16+) in Worcestershire with a common mental health disorder (anxiety or depression).

Depression and Anxiety - GP Patient Survey Data

Public Health England note that 50% of patients attending GPs with depressive disorders do not have their symptoms recognised[126]. Self-reported prevalence of depression and anxiety in Worcestershire is measured through the GP Patient Survey. The GP Patient

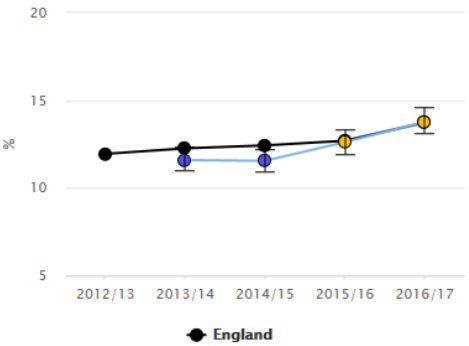
[125] CIS-R score of 12 or more. The CIS-R is an interviewer administered structured interview schedule covering the presence of non-psychotic symptoms in the week prior to interview. It can be used to provide prevalence estimates for 14 types of CMD symptoms and six types of CMD, together with a continuous scale that reflects the overall severity of CMD psychopathology (Lewis et al. 1992).

[126] House of Commons Library (2018). Briefing Paper: Mental Health Statistics for England: Prevalence, Services and Funding. Available at: http://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf

Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people across the UK[127].

In Worcestershire 13.8% (95% CI 13.1-14.6) of those answering the survey in 2016/17 reported having depression and anxiety. This value is significantly higher than the value in 2013/14 and similar to the England value which was 13.7% (95% CI 13.7-13.8).

Figure 97 Self-reported Depression and Anxiety in Worcestershire - GP Patient Survey (% respondents 18+)



Recent trend: –

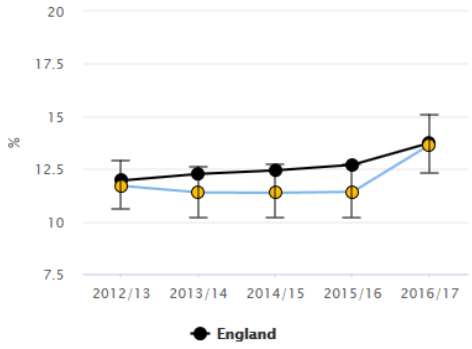
Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13		-	-	-	-	-	12.0
2013/14		1,074	11.6	11.0	12.3	12.7*	12.3
2014/15		1,010	11.6	10.9	12.2	12.9*	12.4
2015/16		1,085	12.6	11.9	13.3	13.3*	12.7
2016/17		1,130	13.8*	13.1	14.6	14.1*	13.7

Source: GP Patient Survey (NHS England) https://gp-patient.co.uk/

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Data from the GP Patient Survey is also available at Clinical Commissioning Group (CCG) level. In 2016/17 patient responses from all three Worcestershire CCGs showed self-reported rates of depression and anxiety that were similar to the England value. South Worcestershire CCG has seen a significant increase in people reporting depression and anxiety since 2012/13 (Figure 99).

Figure 98 GP Patient Survey - Depression and Anxiety Prevalence; Redditch and Bromsgrove CCG (% respondents 18+)



Recent trend: ➡

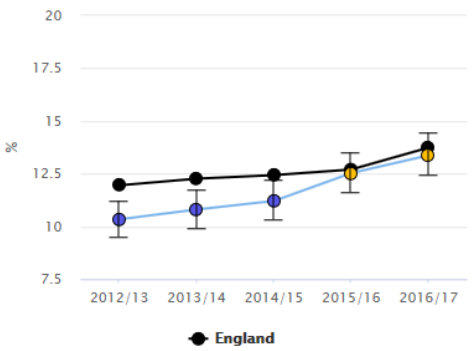
Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13		338	11.7	10.6	12.9	12.5*	12.0
2013/14		310	11.4	10.2	12.6	12.8*	12.3
2014/15		294	11.4	10.2	12.7	12.9*	12.4
2015/16		289	11.4	10.2	12.7	13.4*	12.7
2016/17		331	13.7	12.3	15.1	14.2*	13.7

Source: GP Patient Survey (NHS England) https://gp-patient.co.uk/

Source: Public Health England. Mental Health and Well-being JSNA Profile.

[127] It should be born in mind that this data does not represent validated diagnoses of conditions. There were 8,197 respondents to the survey in 2016/17.

Figure 99 GP Patient Survey - Depression and Anxiety Prevalence; South Worcestershire CCG (% respondents 18+)



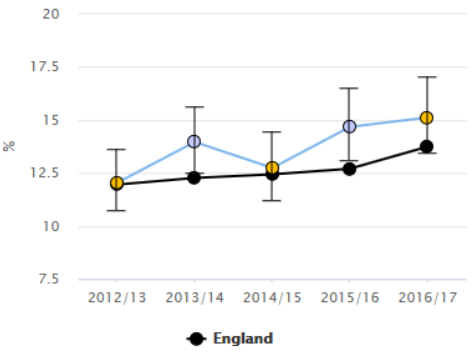
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13		511	10.3	9.5	11.2	12.5*	12.0
2013/14		509	10.8	9.9	11.7	12.8*	12.3
2014/15		498	11.2	10.3	12.2	12.9*	12.4
2015/16		551	12.5	11.6	13.5	13.4*	12.7
2016/17		567	13.4	12.4	14.4	14.2*	13.7

Source: GP Patient Survey (NHS England) https://gp-patient.co.uk/

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Figure 100 GP Patient Survey - Depression and Anxiety Prevalence; Wyre Forest CCG (% respondents 18+)



Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13		230	12.0	10.7	13.6	12.5*	12.0
2013/14		255	14.0	12.5	15.6	12.8*	12.3
2014/15		217	12.7	11.2	14.4	12.9*	12.4
2015/16		246	14.7	13.1	16.5	13.4*	12.7
2016/17		233	15.1	13.4	17.0	14.2*	13.7

Source: GP Patient Survey (NHS England) https://gp-patient.co.uk/

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Generalised Anxiety Disorder (GAD)

Generalised Anxiety Disorder (GAD) is characterised by excessive worry about many different things and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep.

Nationally, GAD was the most commonly reported disorder in the APM survey with 5.9% of people reporting it in the last week.

Depression

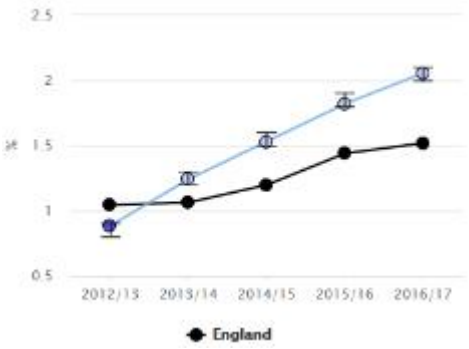
Depression is a mental health problem characterised by persistent low mood and a loss of interest and enjoyment in ordinary things. A range of emotional, physical and behavioural symptoms are likely such as sleep disturbance, change in appetite, loss of energy, poor concentration, low feelings of self-worth and thoughts of suicide. Depressive episodes can range from mild to severe.

The APMS 2014 found that nationally 3.3% of respondents reported having had a depressive episode in the last week.

Recorded Incidence and Prevalence of Depression in Worcestershire - QOF Data

The number of new cases of depression recorded on Worcestershire practice systems during the 2016/17 was 8,753. All three of the Worcestershire Clinical Commissioning Groups (CCGs) have a statistically higher recorded incidence of depression than England as a whole and all three have seen a rising trend in the recorded incidence of depression. Redditch and Bromsgrove CCG has a significantly higher incidence rate than the two other CCGs.

Figure 101 Recorded Incidence of Depression; % of practice register Redditch and Bromsgrove CCG



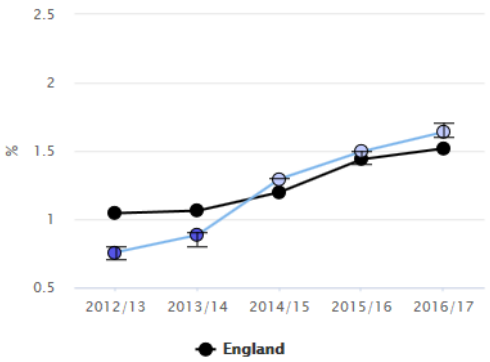
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13	●	1,207	0.9	0.8	0.9	1.0*	1.0
2013/14	○	1,696	1.2	1.2	1.3	1.0*	1.1
2014/15	○	2,104	1.5	1.5	1.6	1.2	1.2
2015/16	○	2,528	1.8	1.8	1.9	1.5	1.4
2016/17	○	2,885	2.1	2.0	2.1	1.5*	1.5*

Source: QOF

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Figure 102 Recorded Incidence of Depression; % of practice register South Worcestershire CCG



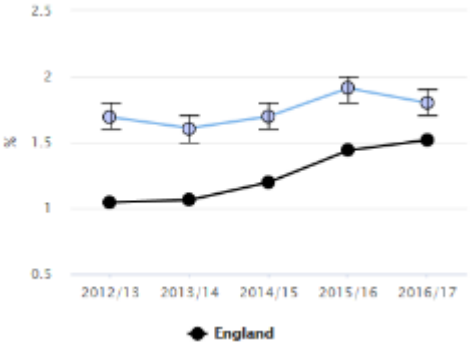
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13		1,799	0.8	0.7	0.8	1.0*	1.0
2013/14		2,109	0.9	0.8	0.9	1.0*	1.1
2014/15		3,117	1.3	1.3	1.3	1.2	1.2
2015/16		3,667	1.5	1.4	1.5	1.5	1.4
2016/17		4,082	1.6	1.6	1.7	1.5*	1.5*

Source: QOF

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Figure 103 Recorded Incidence of Depression; % of practice register Wyre Forest CCG



Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13		1,549	1.7	1.6	1.8	1.0*	1.0
2013/14		1,470	1.6	1.5	1.7	1.0*	1.1
2014/15		1,563	1.7	1.6	1.8	1.2	1.2
2015/16		1,760	1.9	1.8	2.0	1.5	1.4
2016/17		1,786	1.8	1.7	1.9	1.5*	1.5*

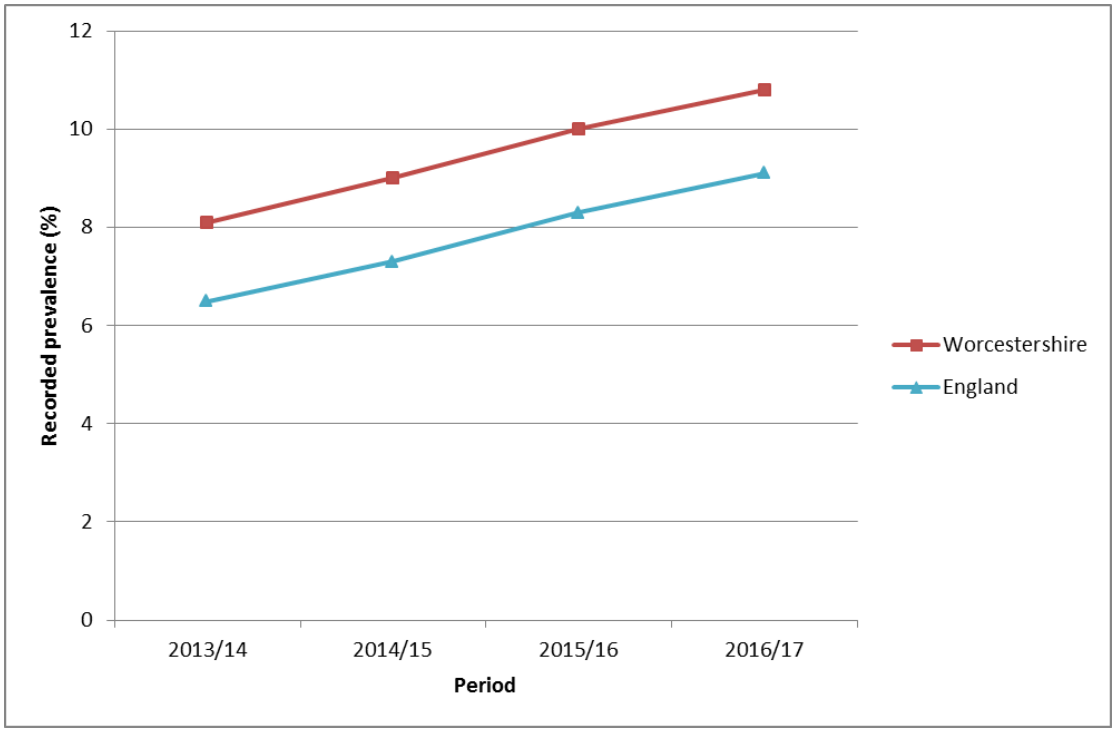
Source: QOF

Source: Public Health England. Mental Health and Well-being JSNA Profile.

The recorded prevalence of depression in Worcestershire is just over 1 in 10 of the GP registered population (10.8%). This represents 52,818 people. The local rate is higher than the national rate and has shown a rising trend in recent years (Figure 104). The recorded prevalence of depression in Worcestershire ranks relatively highly compared to 16 similar local authorities (Figure 105).

It is worth noting that QOF data is based on numbers of patients recorded on disease registers and is likely to be an underestimate of actual prevalence of common mental disorders as many cases go undiagnosed. Also, there may be some GP practices more active in identifying and treating depression or more active in recording for QOF purposes. It has been suggested locally, that Wyre Forest CCG practices have historically been better at recording for QOF purposes which might indicate why their rates are higher.

Figure 104 Recorded Prevalence of Depression (QOF Data) - Worcestershire



Source: Public Health England. Common Mental Health Disorders Profile.

Table 34 Recorded Prevalence of Depression (%)

Period	Count	Worcestershire	Lower CI	Upper CI	England
2013/14	37,591	8.1	8	8.1	6.5
2014/15	42,475	9	9	9.1	7.3
2015/16	47,547	10	9.9	10.1	8.3
2016/17	52,818	10.8	10.7	10.9	9.1

Source: Public Health England. Common Mental Health Disorders Profile. QOF Data.

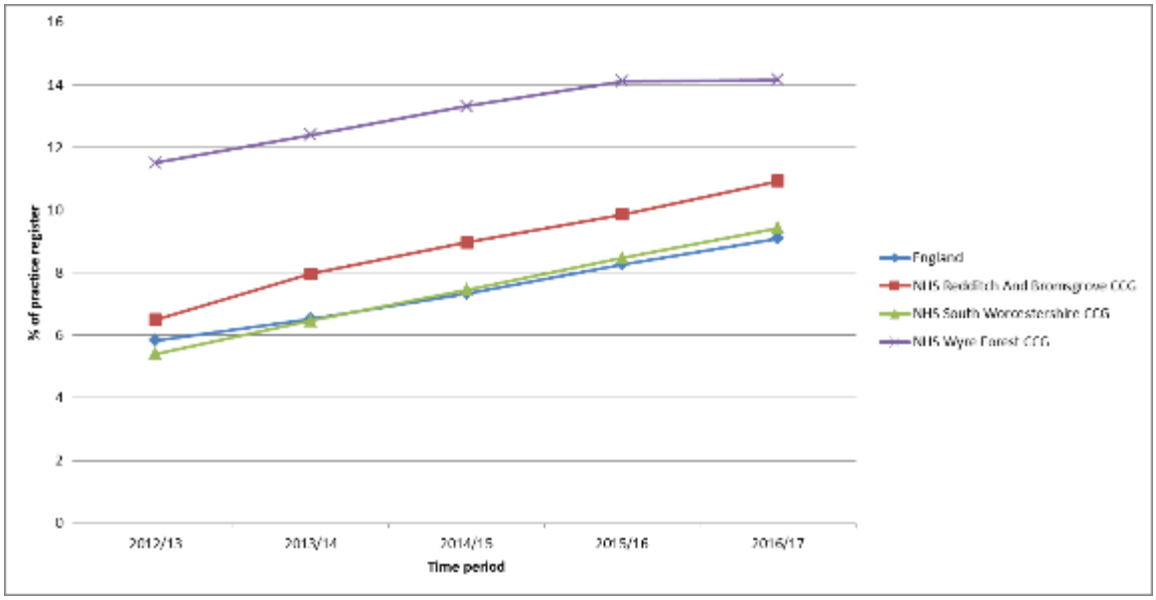
Figure 105 Recorded Prevalence of Depression (%) - Worcestershire and CIPFA neighbours 2016/17

Area	Value	Lower CI	Upper CI
England	9.1	9.1	9.1
Northamptonshire	11.5	11.5	11.6
Cumbria	10.9	10.8	11.0
Worcestershire	10.8	10.7	10.9
Derbyshire	10.6	10.5	10.6
Somerset	10.2*	10.1	10.3
Lincolnshire	10.1	10.0	10.2
Suffolk	9.7	9.6	9.7
Staffordshire	9.5	9.4	9.5
West Sussex	9.4	9.4	9.5
Devon	9.1	9.0	9.1
North Yorkshire	9.0	8.9	9.1
Nottinghamshire	8.9	8.9	9.0
Warwickshire	8.8	8.7	8.8
Norfolk	8.5	8.4	8.6
Essex	8.5	8.4	8.5
Gloucestershire	8.4	8.3	8.4

Source: Public Health England. Common Mental Health Disorders Profile.

Data is also available at CCG level (Figure 106). All three CCGs have higher recorded prevalence of depression than the national average. Of the three Worcestershire CCGs Wyre Forest has the highest recorded prevalence of depression.

Figure 106 Recorded Prevalence of Depression (QOF) – CCG Level



Source: Public Health England. Common Mental Health Disorders Profile

Table 35 Recorded Prevalence of Depression (QOF) - CCG Level (%)

Period	England	NHS Redditch And Bromsgrove CCG	NHS South Worcestershire CCG	NHS Wyre Forest CCG
2012/13	5.84 (5.83-5.84)	6.50 (6.38-6.64)	5.40 (5.31-5.49)	11.50 (11.30-11.71)
2013/14	6.52 (6.51-6.53)	7.96 (7.82-8.11)	6.46 (6.36-6.56)	12.39 (12.18-12.61)
2014/15	7.33 (7.32-7.34)	8.96 (8.81-9.11)	7.45 (7.35-7.56)	13.31 (13.09-13.53)
2015/16	8.26 (8.26-8.27)	9.85 (9.69-10.01)	8.46 (8.35-8.57)	14.10 (13.88-14.33)
2016/17	9.09 (9.08-9.09)	10.92 (10.75-1.08)	9.42 (9.31-9.54)	14.15 (13.94-14.37)

Source: Public Health England. Common Mental Health Disorders Profile

Public Health England also publishes depression prevalence for individual GP practices. This data can be accessed via their 'Fingertips' website[128].

Social Anxiety Disorder (Social Phobia)

Social Anxiety Disorder (Social Phobia) is a persistent and overwhelming fear of a social situation, such as shopping or speaking on the phone which impacts on a person's ability to function effectively in aspects of their daily life. People with social anxiety will fear doing or saying something that will lead to being judged by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress.

Estimates of lifetime prevalence vary but according to a US study, 12% of adults in the US will have Social Anxiety Disorder at some point in their lives[129].

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.

[128] https://fingertips.phe.org.uk/

[129] National Institute for Health and Care Excellence (NICE). Social anxiety disorder: recognition, assessment and treatment. Clinical guideline [CG159] Published date: May 2013.

In the UK, up to 2 people in 100 have panic disorder[130].

Agoraphobia

Agoraphobia is characterised by fear or avoidance of specific situations or activities that the person fears will trigger panic-like symptoms, or be difficult or embarrassing to escape from, or where help may not be available. Specific feared situations can include leaving the house, being in open or crowded places, or using public transport. Agoraphobia usually develops as a complication of panic disorder.

It is thought that around a third of people with panic disorder will go on to develop Agoraphobia. Agoraphobia is twice as common in women as men. It usually starts between the ages of 18 and 35 (NHS, 2018).

Obsessive-Compulsive Disorder (OCD)

Obsessive-Compulsive Disorder (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.

Studies have estimated the population prevalence of OCD to be between 1% and 3%[131].

Specific Phobia

Phobias are an overwhelming and debilitating fear of an object, place, situation, feeling or animal. This can include a fear of heights, flying, particular animals, seeing blood or receiving an injection. Phobias can have a significant impact on day to day life and cause significant distress. Phobias are the most common type of anxiety disorder.

Nationally, the Adult Psychiatric Morbidity Survey 2014 found that 2.4% of respondents reported a phobia in the last week.

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) is an anxiety disorder caused by very stressful, frightening or distressing events (NHS, 2018). Table 36 contains details of the predicted prevalence of PTSD based on the AMPS survey and population projections.

Table 36 The Prevalence of PTSD at the County, Region and National Level (2012)

Area	Prevalence of PTSD (16 years +)	
	Count	**% of Population (16+)**
England	1,193,945	3.0

[130] NHS website. Agoraphobia Overview. https://www.nhs.uk/conditions/agoraphobia/. Accessed 5th November 2018.

[131] National Institute for Health and Care Excellence (NICE) . Clinical Knowledge Summaries. Obsessive-compulsive Disorder. https://cks.nice.org.uk/obsessive-compulsive-disorder#!backgroundsub:2 Accessed 5th November 2018.

West Midlands region	121,957	3.0
Worcestershire	12,803	3.1

Source: PHE, Fingertips

The proportion of people (16+) suffering from PTSD in Worcestershire was estimated to be around 3.1% in 2012.

Health Anxiety (Hypochondriasis)

A central feature of Health Anxiety is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem. Normal or commonplace physical symptoms are often interpreted as abnormal and distressing, or as indicators of serious illness.

Although there are no official UK figures on the prevalence of health anxiety in the general population, an Australian study found that it affected almost 6% of people[132].

Prevention and Treatment of Common Mental Health Problems – A Stepped Model of Care.

Prevention and treatment of common mental health problems should follow a stepped model of care, meaning that the most effective but least resource intensive form of support is provided in the first instance (Table 37).

It is widely accepted that most mental health problems should be managed mainly in primary care, working collaboratively with other services, with access to specialist expertise and to a range of secondary care services as required. However, most common mental health problems can be dealt with in primary care and do not require secondary care services. National Institute for Health and Care Excellence (NICE) guidelines state that at the lower steps of the model medication should not be routinely prescribed for recent onset mild-to-moderate common mental health disorders (although, there are some risks, and exceptions do apply).

[132] Sunderland M, Newby JM & Andrews G. Health anxiety in Australia: prevalence, comorbidity, disability and service use. Br J Psychiatry 2013;202:56–61. doi: 10.1192/bjp.bp.111.103960

Table 37 Stepped-care model: a combined summary for common mental health disorders.

Focus of the intervention	Nature of the intervention
Step 3: Persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression; GAD with marked functional impairment or that has not responded to a low-intensity intervention; moderate to severe panic disorder; OCD with moderate or severe functional impairment; PTSD.	**Depression:** CBT, IPT, behavioural activation, behavioural couples therapy, counselling*, short-term psychodynamic psychotherapy*, antidepressants, combined interventions, collaborative care**, self-help groups. **GAD:** CBT, applied relaxation, drug treatment, combined interventions, self-help groups. **Panic disorder:** CBT, antidepressants, self-help groups. **OCD:** CBT (including ERP), antidepressants, combined interventions and case management, self-help groups. **PTSD:** Trauma-focused CBT, EMDR, drug treatment. All disorders: Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.
Step 2: Persistent subthreshold depressive symptoms or mild to moderate depression; GAD; mild to moderate panic disorder; mild to moderate OCD; PTSD (including people with mild to moderate PTSD).	**Depression:** Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes**, non-directive counselling delivered at home†, antidepressants, self-help groups. **GAD and panic disorder:** Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups. **OCD:** Individual or group CBT (including ERP), self-help groups. **PTSD:** Trauma-focused CBT or EMDR. **All disorders:** Support groups, educational and employment support services; referral for further assessment and interventions.
Step 1: All disorders – known and suspected presentations of common mental health disorders.	**All disorders:** Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions.

* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.

** For people with depression and a chronic physical health problem.

† For women during pregnancy or the postnatal period.

CBT, cognitive behavioural therapy; ERP, exposure and response prevention; EMDR, eye movement desensitisation and reprocessing; GAD, generalised anxiety disorder; OCD, obsessive compulsive disorder; IPT, interpersonal therapy; PTSD, post-traumatic stress disorder.

Source: National Institute for Health and Care Excellence (NICE), Clinical Guideline 123, 2011.

General Population Level Support Measures

Although not shown in Table 37 general population support measures should be considered as part of the stepped care approach and can be visualised as sitting below step 1. These measures should focus on enhancing community assets to prevent mental health problems and promote healthy behaviours. This may include providing support around housing, relationships, access to education, employment, discrimination, welfare rights, carer support and crime. General population support measures are explored in more detail in the 'Understanding Place' section of this report.

Social Prescribing

At the initial steps of the stepped model, primary care workers should be alert to the presenting symptoms of common mental health problems and have a clear understanding of the best practice protocols they can put in place and the onward referral routes available. This should include social prescribing.

Social prescribing is a form of prescribing to community resources such as volunteering opportunities, physical activity programmes and befriending services. It is a form of prescribing that is likely to increase confidence, build social networks and develop self-efficacy (an individual's belief in his or her innate ability to achieve goals; with increased self-efficacy, individuals have greater confidence in their ability and thus are more likely to engage in healthy behaviours).

Models of social prescribing are embedded across Worcestershire. Any adult registered with a Worcestershire GP is eligible for the scheme and can be referred by a healthcare or allied professional to a link worker who can, in turn, refer the individual onwards to a range of voluntary, community and social enterprises.

Figure 107. Social Prescribing Patient Pathway

Referral made to **Neighbourhood Team Social Prescriber** either embedded within GP practices or aligned to them

Schedule made for appointment with the Social prescriber (signpost may only be required)

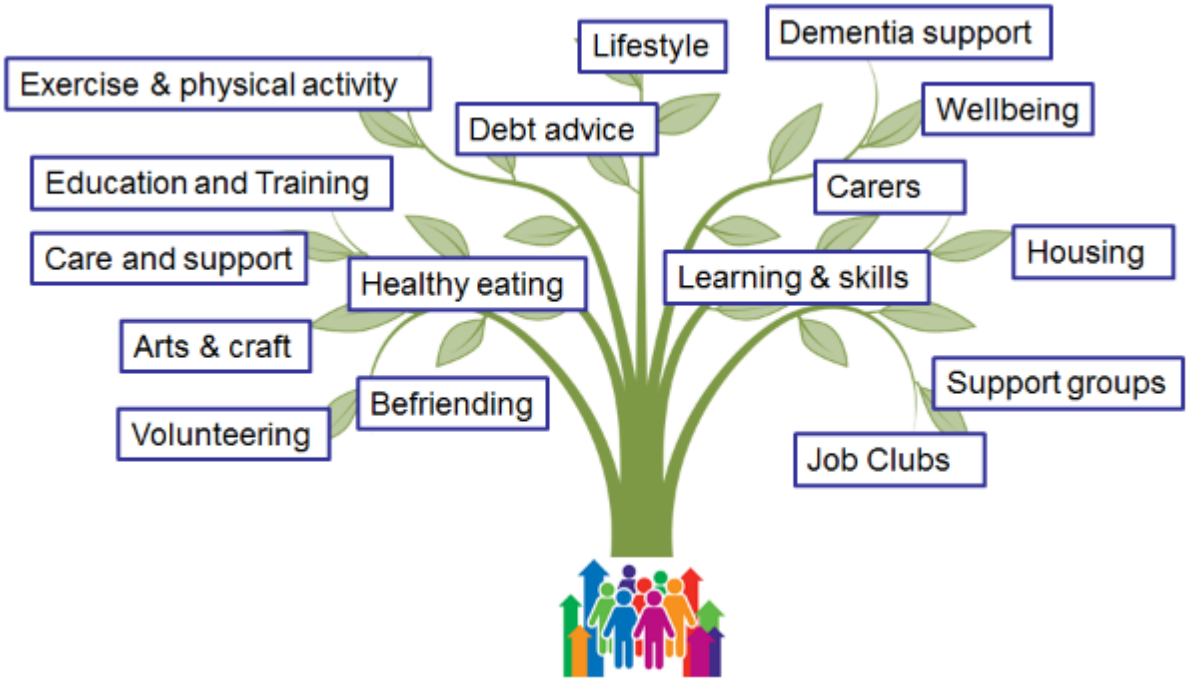
Personalised assessment and motivational discussion from the Social Prescriber using behaviour change techniques and evaluation requirements

Person centred and led goal setting, signposting, information and guidance

Scheduled review with the patient and feedback to referrer

Source: Worcestershire County Council

Figure 108. Resources Utilised in Social Prescribing - Worcestershire

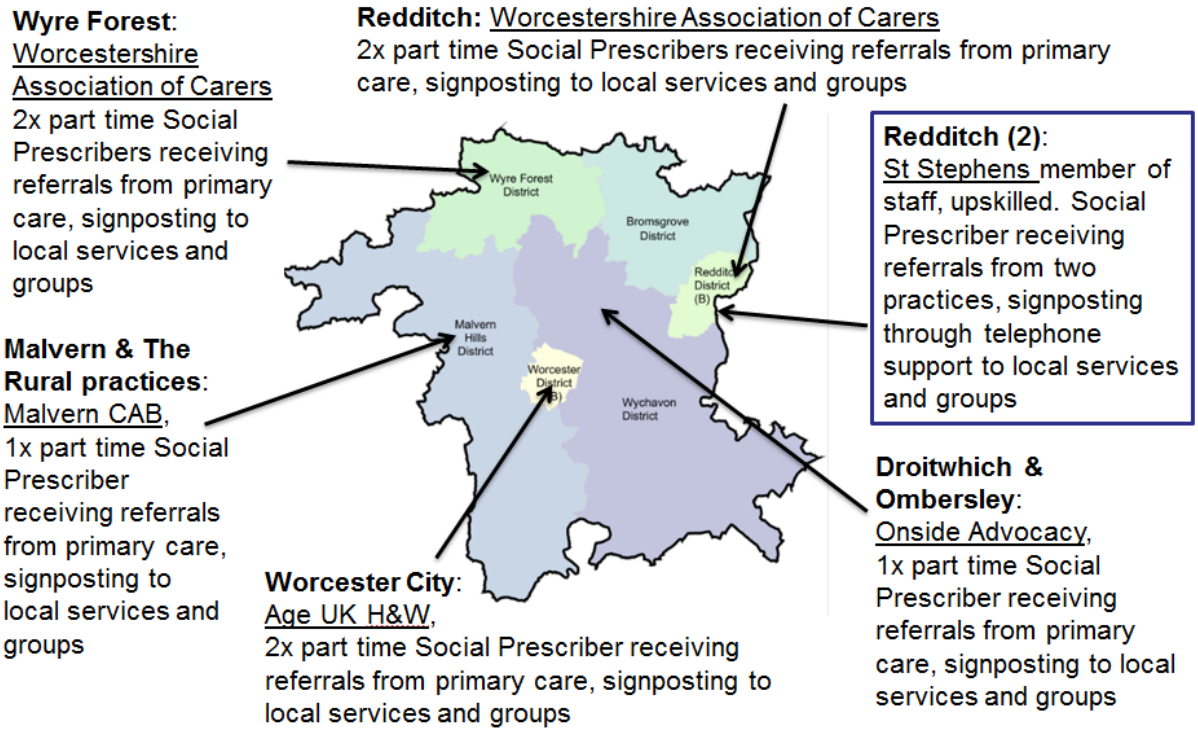


Source: Worcestershire County Council

Link workers or 'Social Prescribers' are based in Neighbourhood Teams and are either embedded in GP practices or aligned to them. National funding is available to each Primary Care Network.

Figure **109** shows how the social prescribing pilot scheme is organised in Worcestershire.

Figure 109 Social Prescribing in Worcestershire - Pilot Sites



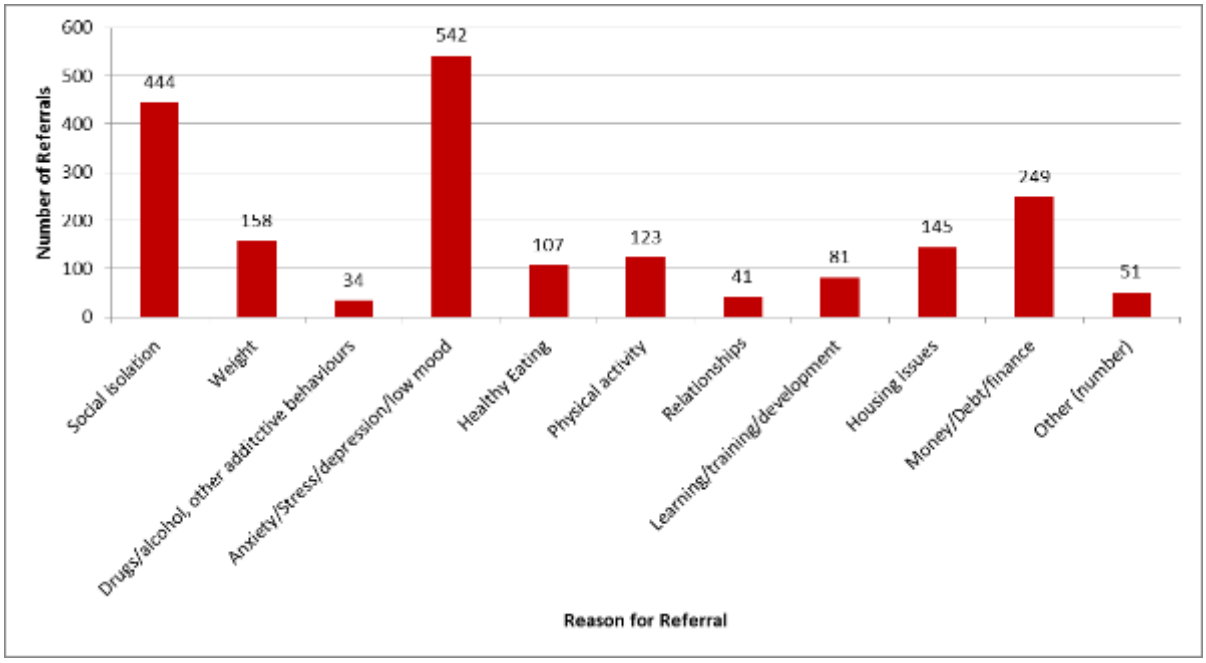
Source: Worcestershire County Council

An evaluation of the pilot scheme is underway, and this will be used to inform future commissioning. Data is available for Q1-3 of 2018/19. This data shows that, so far, in 2018/19, a total 1,050 patients have been referred into the service and of these 684 (65%) have 'engaged' (it is important to note that the proportion of patients who have engaged by year end may be higher).

The reasons given[133] for referrals have been recorded. In 2018/19 (to date) the most common reasons have been anxiety/stress/depression (25%) and social isolation (24%). Other common reasons have been money/debt/finance (14%) and weight (9%).

[133] by the healthcare provider.

Figure 110 Reasons Given for Social Prescribing Referral by Healthcare Provider 2018/19 (to Q3)



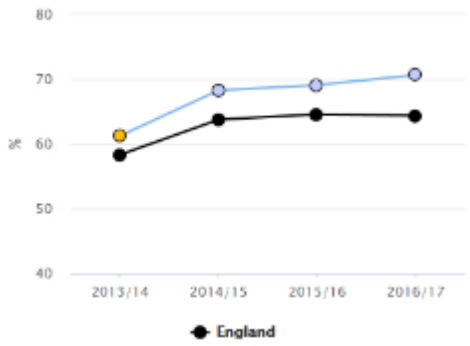
Source: Worcestershire County Council

Primary Care Reviews of Depression

Depression is often a chronic disease, yet treatment is often episodic and short-lived. If drug treatment is initiated a person should be followed up regularly for several months and even if drug treatment is not initiated people should be re-assessed to judge whether their symptoms have resolved or worsened.

The percentage of patients with newly diagnosed depression who are followed up 10-56 days after diagnosis is a useful measure of the quality of treatment. Worcestershire CCGs perform comparatively well against England on this indicator all having higher rates in 2016/17 (Figure 111, Figure 112 and Figure 113).

Figure 111 percentage of patients with newly diagnosed depression who are followed up 10-56 days after diagnosis; Redditch and Bromsgrove CCG



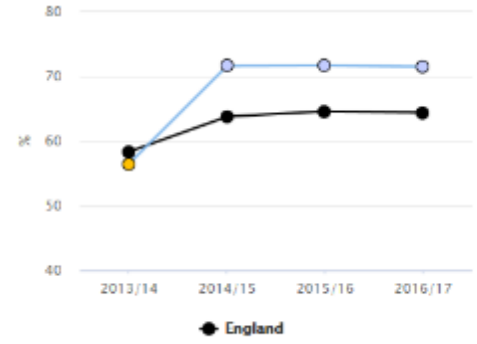
Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14		1,041	61.3	58.9	63.6	61.7*	58.4
2014/15		1,437	68.3	66.3	70.3	66.3	63.8
2015/16		1,747	69.1	67.3	70.9	66.0	64.6
2016/17		2,039	70.7	69.0	72.3	67.7	64.4

Source: QOF

Source: Public Health England. Mental Health JSNA Profile.

Figure 112 percentage of patients with newly diagnosed depression who are followed up 10-56 days after diagnosis; South Worcestershire CCG



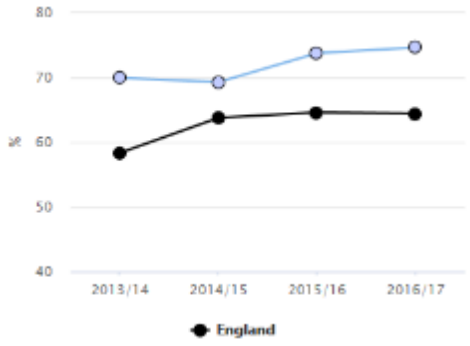
Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14		1,194	56.5	54.4	58.6	61.7*	58.4
2014/15		2,233	71.6	70.0	73.2	66.3	63.8
2015/16		2,630	71.7	70.2	73.2	66.0	64.6
2016/17		2,919	71.5	70.1	72.9	67.7	64.4

Source: QOF

Source: Public Health England. Mental Health JSNA Profile.

Figure 113 percentage of patients with newly diagnosed depression who are followed up 10-56 days after diagnosis; South Worcestershire CCG



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14		1,026	69.9	67.5	72.2	61.7*	58.4
2014/15		1,083	69.3	67.0	71.5	66.3	63.8
2015/16		1,313	73.8	71.7	75.8	66.0	64.6
2016/17		1,333	74.6	72.6	76.6	67.7	64.4

Source: QOF

Source: Public Health England. Mental Health JSNA Profile.

Primary Care Prescribing Spend on Mental Health

Quarterly data on the cost of primary care prescribing of antidepressants and hypnotics and anxiolytics is available by Clinical Commissioning Group (CCG).

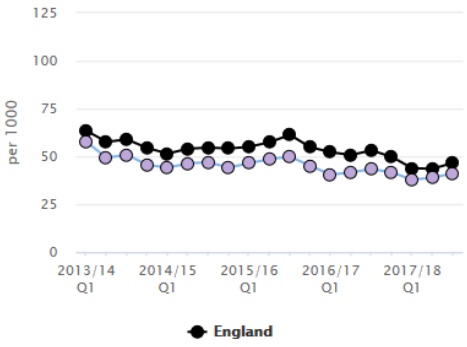
Using Specific Therapeutic Group Age-sex weightings Related Prescribing Units (STAR-PU) allows comparison between different populations. It should be noted that this measure does not include the cost of prescribing in other settings such as hospitals.

Antidepressants

Nationally the spend on primary care prescriptions for antidepressants has been falling. The same trend has been seen for all three of the Worcestershire CCGs. There are differences by CCG which can be seen in Figure 114, Figure 115 and Figure 116.

The decreasing trend in antidepressant prescribing is interesting because the recorded prevalence of depression has been increasing across all Worcestershire CCGs. This may indicate that the National Institute for Health and Care Excellence (NICE) guidance which states that antidepressants should not be used routinely to treat persistent sub-threshold depressive symptoms or mild depression[134] is being implemented[135].

Figure 114 Cost of GP prescribing for antidepressant drugs: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly); Redditch and Bromsgrove CCG.



Recent trend: ⬇

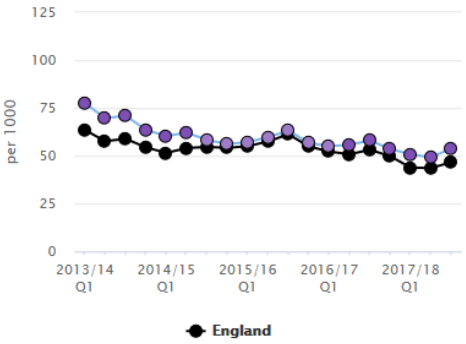
Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q1		220,598	57.7	-	-	58.2*	63.5
2013/14 Q2		188,595	49.3	-	-	51.8*	57.6
2013/14 Q3		194,710	50.9	-	-	52.9*	58.9
2013/14 Q4		174,256	45.6	-	-	48.2*	54.4
2014/15 Q1		168,917	44.2	-	-	44.2*	51.5
2014/15 Q2		177,580	46.4	-	-	45.9*	54.1
2014/15 Q3		180,165	47.0	-	-	45.9*	54.7
2014/15 Q4		169,908	44.2	-	-	45.5*	54.2
2015/16 Q1		178,914	46.5	-	-	46.1*	55.1
2015/16 Q2		187,676	48.7	-	-	47.7*	57.5
2015/16 Q3		192,906	49.9	-	-	49.3*	61.3
2015/16 Q4		175,214	45.2	-	-	43.4*	54.9
2016/17 Q1		157,295	40.5	-	-	41.0*	52.3
2016/17 Q2		162,392	41.7	-	-	39.8*	50.8
2016/17 Q3		169,854	43.5	-	-	42.2*	53.2
2016/17 Q4		163,200	41.7	-	-	40.6*	49.8
2017/18 Q1		148,533	37.9	-	-	35.8*	43.9
2017/18 Q2		153,299	39.0	-	-	36.3*	43.6
2017/18 Q3		162,291	41.2	-	-	40.2*	46.6

Source: HSCIC

Source: Public Health England. Mental Health JSNA Profile.

[134] Although there are circumstances where they should be considered.
[135] NICE (2011). Guideline CG123. Common mental health disorders: identification and pathways to care. Available at: https://www.nice.org.uk/Guidance/CG123

Figure 115 Cost of GP prescribing for antidepressant drugs: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly); South Worcestershire CCG.



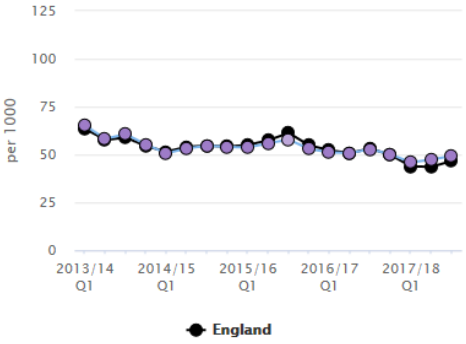
Recent trend: ↓

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q1		517,992	77.5	-	-	58.2*	63.5
2013/14 Q2		465,429	69.7	-	-	51.8*	57.6
2013/14 Q3		474,149	71.0	-	-	52.9*	58.9
2013/14 Q4		424,711	63.6	-	-	48.2*	54.4
2014/15 Q1		403,379	60.3	-	-	44.2*	51.5
2014/15 Q2		416,513	62.1	-	-	45.9*	54.1
2014/15 Q3		392,123	58.3	-	-	45.9*	54.7
2014/15 Q4		378,163	56.1	-	-	45.5*	54.2
2015/16 Q1		386,589	57.2	-	-	46.1*	55.1
2015/16 Q2		405,420	59.8	-	-	47.7*	57.5
2015/16 Q3		430,154	63.1	-	-	49.3*	61.3
2015/16 Q4		388,239	56.8	-	-	43.4*	54.9
2016/17 Q1		377,684	55.1	-	-	41.0*	52.3
2016/17 Q2		383,686	55.7	-	-	39.8*	50.8
2016/17 Q3		401,275	58.1	-	-	42.2*	53.2
2016/17 Q4		371,126	53.6	-	-	40.6*	49.8
2017/18 Q1		353,468	50.8	-	-	35.8*	43.9
2017/18 Q2		342,911	49.1	-	-	36.3*	43.6
2017/18 Q3		377,898	53.9	-	-	40.2*	46.6

Source: HSCIC

Source: Public Health England. Mental Health JSNA Profile.

Figure 116 Cost of GP prescribing for antidepressant drugs: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly); Wyre Forest CCG



Recent trend: ↓

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q1		167,840	65.2	-	-	58.2*	63.5
2013/14 Q2		150,018	58.3	-	-	51.8*	57.6
2013/14 Q3		156,284	60.7	-	-	52.9*	58.9
2013/14 Q4		142,220	55.2	-	-	48.2*	54.4
2014/15 Q1		130,594	50.7	-	-	44.2*	51.5
2014/15 Q2		137,432	53.3	-	-	45.9*	54.1
2014/15 Q3		141,323	54.6	-	-	45.9*	54.7
2014/15 Q4		139,876	54.0	-	-	45.5*	54.2
2015/16 Q1		139,455	53.8	-	-	46.1*	55.1
2015/16 Q2		145,441	55.9	-	-	47.7*	57.5
2015/16 Q3		151,051	57.9	-	-	49.3*	61.3
2015/16 Q4		138,442	53.0	-	-	43.4*	54.9
2016/17 Q1		134,099	51.2	-	-	41.0*	52.3
2016/17 Q2		133,360	50.8	-	-	39.8*	50.8
2016/17 Q3		139,024	52.8	-	-	42.2*	53.2
2016/17 Q4		132,056	50.2	-	-	40.6*	49.8
2017/18 Q1		121,046	45.9	-	-	35.8*	43.9
2017/18 Q2		125,474	47.4	-	-	36.3*	43.6
2017/18 Q3		130,522	49.2	-	-	40.2*	46.6

Source: HSCIC

Source: Public Health England. Mental Health JSNA Profile.

Hypnotics and Anxiolytics

Hypnotics and Anxiolytics are drugs used in the treatment of insomnia and anxiety. Prescribing of these drugs is widespread but dependence (both physical and psychological) and tolerance occur. This may lead to difficulty in withdrawing the drug after the patient has been taking it regularly for more than a few weeks. Hypnotics and anxiolytics should therefore be reserved for short courses to alleviate acute conditions after causal factors have been established[136]. Nationally there has been a decreasing trend in the prescribing of these drugs.

All three Worcestershire Clinical Commissioning Groups (CCGs) currently have higher levels of prescribing than those seen nationally (even after accounting for differences in their populations). There is some variation in the prescribing of these drugs by CCG (Figure 117

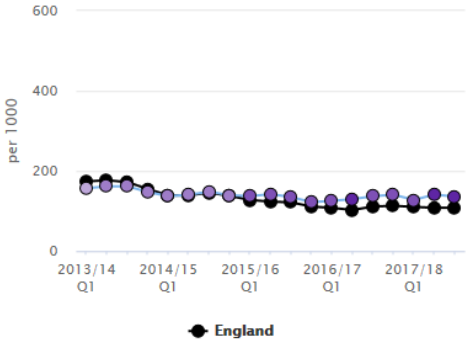
[136] BNF. Treatment Summaries. Hypnotics and Anxiolytics. Available from NICE Evidence: https://bnf.nice.org.uk/treatment-summary/hypnotics-and-anxiolytics.html Accessed 22nd November 2018.

Figure 118 and Figure 119). The rate of prescribing is particularly high in South Worcestershire CCG (

Figure **118**).

Does this merit reviewing whether the prescriptions are appropriate – are people becoming dependent?

Figure 117 Cost of GP prescribing for hypnotics and anxiolytics: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly); Redditch and Bromsgrove CCG



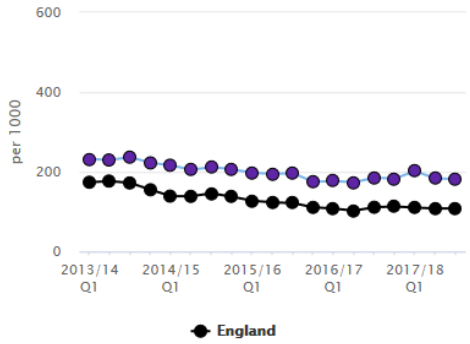
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q1		72,540	156.7	-	-	172.6*	173.8
2013/14 Q2		74,845	161.7	-	-	173.9*	176.8
2013/14 Q3		74,782	161.6	-	-	172.2*	172.1
2013/14 Q4		68,172	147.3	-	-	158.1*	155.0
2014/15 Q1		63,579	137.1	-	-	138.6*	139.0
2014/15 Q2		65,412	140.6	-	-	138.2*	138.9
2014/15 Q3		69,297	148.4	-	-	146.2*	146.1
2014/15 Q4		65,300	139.4	-	-	139.4*	137.5
2015/16 Q1		64,364	137.3	-	-	132.6*	127.6
2015/16 Q2		66,840	141.9	-	-	130.2*	123.3
2015/16 Q3		63,911	135.0	-	-	129.8*	121.7
2015/16 Q4		57,946	122.1	-	-	119.0*	111.0
2016/17 Q1		59,663	125.4	-	-	118.9*	107.9
2016/17 Q2		61,929	129.6	-	-	114.0*	102.5
2016/17 Q3		65,686	137.0	-	-	122.2*	111.2
2016/17 Q4		67,753	140.8	-	-	127.0*	113.2
2017/18 Q1		61,560	127.5	-	-	125.7*	110.3
2017/18 Q2		68,444	141.0	-	-	118.0*	108.1
2017/18 Q3		66,270	136.2	-	-	119.6*	107.9

Source: HSCIC

Source: Public Health England. Mental Health JSNA Profile.

Figure 118 Cost of GP prescribing for hypnotics and anxiolytics: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly); South Worcestershire CCG



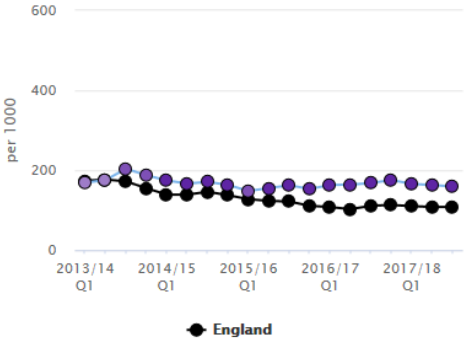
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q1		199,106	232.3	-	-	172.6*	173.8
2013/14 Q2		196,949	229.7	-	-	173.9*	176.8
2013/14 Q3		203,280	237.1	-	-	172.2*	172.1
2013/14 Q4		190,674	222.4	-	-	158.1*	155.0
2014/15 Q1		186,166	216.6	-	-	138.6*	139.0
2014/15 Q2		176,974	204.8	-	-	138.2*	138.9
2014/15 Q3		184,577	212.5	-	-	146.2*	146.1
2014/15 Q4		179,814	206.4	-	-	139.4*	137.5
2015/16 Q1		172,736	197.7	-	-	132.6*	127.6
2015/16 Q2		171,226	194.8	-	-	130.2*	123.3
2015/16 Q3		173,586	196.7	-	-	129.8*	121.7
2015/16 Q4		155,207	175.0	-	-	119.0*	111.0
2016/17 Q1		157,719	177.1	-	-	118.9*	107.9
2016/17 Q2		155,291	173.6	-	-	114.0*	102.5
2016/17 Q3		166,868	185.6	-	-	122.2*	111.2
2016/17 Q4		164,942	183.0	-	-	127.0*	113.2
2017/18 Q1		182,681	201.9	-	-	125.7*	110.3
2017/18 Q2		166,705	183.2	-	-	118.0*	108.1
2017/18 Q3		167,030	182.5	-	-	119.6*	107.9

Source: HSCIC

Source: Public Health England. Mental Health JSNA Profile.

Figure 119 Cost of GP prescribing for hypnotics and anxiolytics: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly); Wyre Forest CCG



Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q1		57,362	168.8	-	-	172.6*	173.8
2013/14 Q2		59,665	175.6	-	-	173.9*	176.8
2013/14 Q3		69,271	203.9	-	-	172.2*	172.1
2013/14 Q4		63,701	187.5	-	-	158.1*	155.0
2014/15 Q1		59,519	174.5	-	-	138.6*	139.0
2014/15 Q2		57,134	166.6	-	-	138.2*	138.9
2014/15 Q3		58,852	170.9	-	-	146.2*	146.1
2014/15 Q4		56,352	163.2	-	-	139.4*	137.5
2015/16 Q1		51,255	148.2	-	-	132.6*	127.6
2015/16 Q2		54,002	155.3	-	-	130.2*	123.3
2015/16 Q3		56,719	162.4	-	-	129.8*	121.7
2015/16 Q4		53,639	153.2	-	-	119.0*	111.0
2016/17 Q1		57,294	163.2	-	-	118.9*	107.9
2016/17 Q2		57,881	164.1	-	-	114.0*	102.5
2016/17 Q3		59,479	168.0	-	-	122.2*	111.2
2016/17 Q4		62,360	175.6	-	-	127.0*	113.2
2017/18 Q1		58,993	165.7	-	-	125.7*	110.3
2017/18 Q2		58,321	163.0	-	-	118.0*	108.1
2017/18 Q3		57,266	159.4	-	-	119.6*	107.9

Source: HSCIC

Source: Public Health England. Mental Health JSNA Profile.

Improving Access to Psychological Therapies (IAPT)

At higher levels of need treatment should be provided by Improving Access to Psychological Therapies (IAPT) services. IAPT is an NHS England programme that offers interventions approved by National Institute for Health and Care Excellence (NICE) for treating people with common mental health problems[137].

For mild-to-moderate common mental health conditions the following interventions should be available:

- individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised CBT
- structured group physical activity programmes
- group-based peer support (self-help) programmes (for those who also have a chronic physical health problem)
- non-directive counselling for depression delivered at home (for women during pregnancy or the postnatal period)

Once a service receives a referral there are several stages including assessment, treatment and referral end.

The programme is supported by the regular return of data generated by IAPT providers.

Data can be categorised into broadly three areas:

- Activity
- Waiting Times
- Outcomes

NHS England have set the following targets for the programme:

Access: The expansion of IAPT services aims to provide at least 1.5m adults with access to care each year by 2020/21. This means that IAPT services nationally will move from seeing around 15% of all people with anxiety and depression each year to 25%, and all areas will have more IAPT services.

Waiting times: 75% of new referrals to IAPT services should enter treatment within 6 weeks, and 95% within 18 weeks.

Recovery: 50% of eligible referrals should recover following a course of treatment.

[137] Including: Depression, Generalised Anxiety Disorder, Social Phobia, Panic Disorder, Agoraphobia, Obsessive Compulsive Disorder, Specific Phobias, Post Traumatic Stress Disorder, Health Anxiety, Body Dysmorphic Disorder and Mixed Anxiety and Depressive Disorder.

People can access IAPT through their GP or by self-referral and the NHS Choices website can be used to search for IAPT Services.

People who present with more severe common mental health problems or who fail to respond to the above treatments, should be offered one of a range of more intense psychological therapies (such as face to face CBT or couples' therapy), or a suitable medication, or both.

Whilst common mental health problems respond well to evidence-based interventions, there is a known high level of relapse. Services should ensure that relapse prevention approaches are included in treatment episodes as identified by the condition specific NICE guidance.

In Worcestershire a re-designed primary care mental health and IAPT service was implemented in April 2016.

Access to IAPT in Worcestershire

Figure 120 shows the number of referrals to IAPT services as a proportion of those estimated to have IAPT-relevant disorders in the wider population[138]. A yearly value has been calculated from monthly figures.

It can be seen that for Redditch and Bromsgrove CCG the proportion receiving IAPT has increased over time but still does not match the England value.

For South Worcestershire CCG the annual figure for the proportion of people estimated to have IAPT-relevant disorders in the wider population receiving IAPT is similar to the England value. However,

[138] Calculated from the Adult Psychiatric Morbidity Survey, 2000.

Figure 122 shows that the quarterly rate of people entering IAPT is currently lower than the national average and this has been following a downward trend.

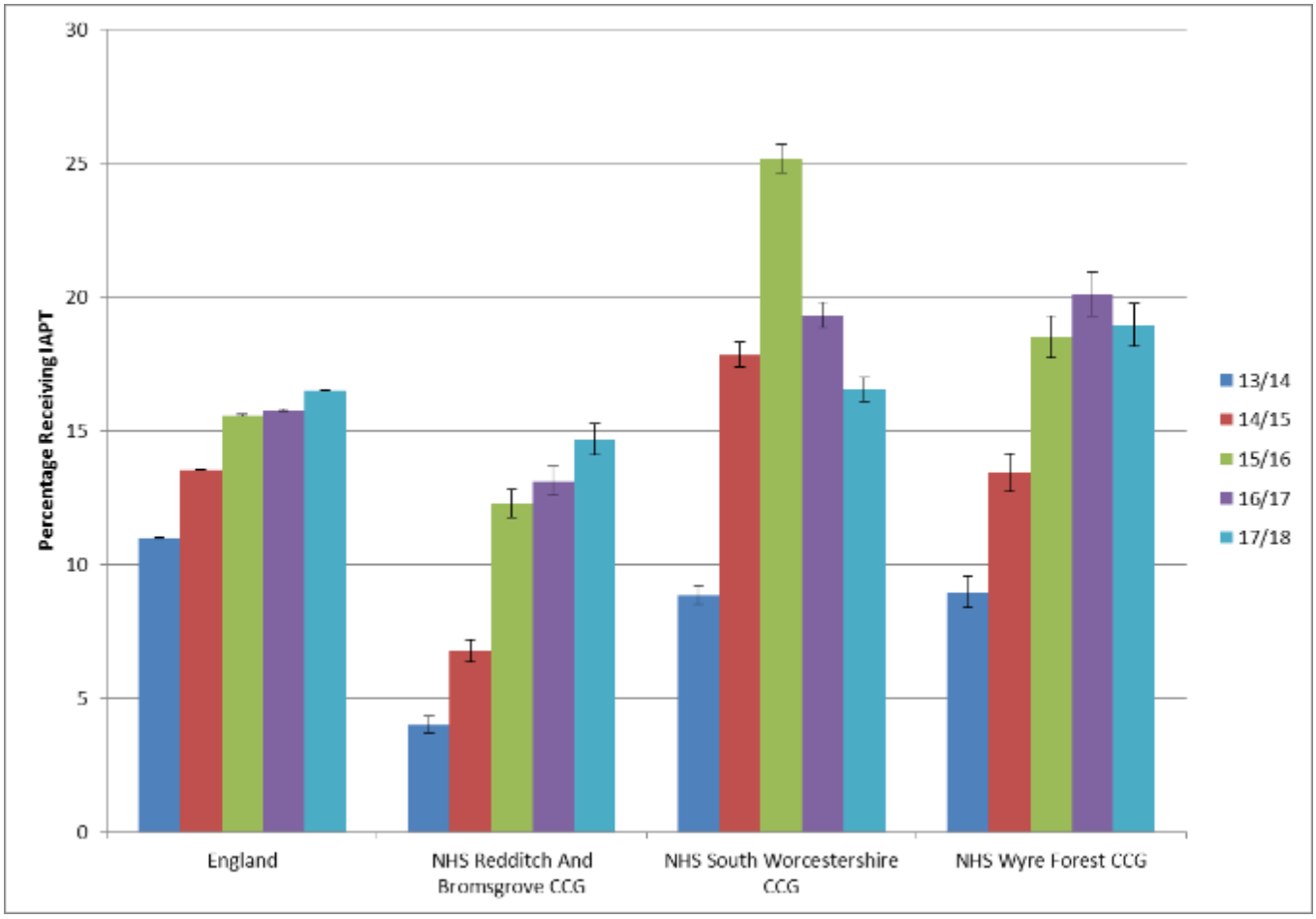
For Wyre Forest CCG the annual figure for the proportion of people estimated to have IAPT-relevant disorders in the wider population receiving IAPT are higher than the national average. Wyre Forest currently has a quarterly rate of people entering IAPT that is similar to the national average and following an upward trend (Figure 123).

Currently none of the Worcestershire CCGs meet the 2020/21 target set by NHS England of 25% of people with depression and anxiety accessing appropriate services each year although all three meet the current target which is 15%.

There is only one IAPT service listed on the www.NHS.uk website situated within Worcestershire. This is 'Worcestershire Healthy Minds' based at the Worcestershire Royal Hospital.

Information on self-referral available via www.NHS.uk contradicts the information on the Worcestershire Health and Care Trust site and it is not clear whether people can self-refer.

Figure 120 Access to IAPT services: people entering IAPT services as % of those estimated to have anxiety/depression



Source: Annual Figures calculated by the Public Health Team from monthly IAPT data available from the Public Health England Common Mental Health Disorders Profile.

Figures for SW CCG in March 2016 look too high.

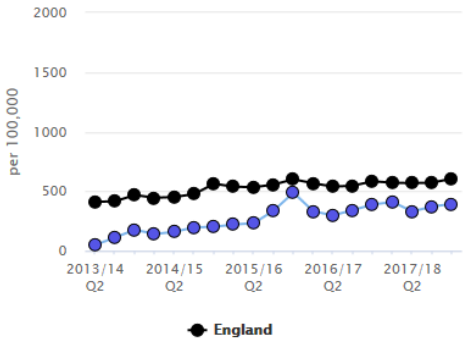
Denominators have been kept the same throughout the time-period 13/14 to 17/18.

Table 38 Access to IAPT services: number of referrals to IAPT services as a proportion of those estimated to have IAPT-relevant disorders in the wider population (%)

	13/14	14/15	15/16	16/17	17/18 (95% CI)	Comparison to England (17/18)
England	10.99	13.53	15.57	15.77	16.48 (16.45-16.51)	NA
NHS Redditch And Bromsgrove CCG	3.99	6.76	12.26	13.11	14.67 (14.11-15.25)	**Lower**
NHS South Worcestershire CCG	8.83	17.82	25.16	19.32	16.51(16.06-16.98)	**Similar**
NHS Wyre Forest CCG	8.96	13.42	18.49	20.08	18.93 (18.13-19.74)	**Higher**

Source: Annual Figures calculated by the Public Health Team from monthly IAPT data available from the Public Health England Common Mental Health Profile.

Figure 121 Entering IAPT treatment: rate (quarterly) per 100,000 population aged 18+; Redditch and Bromsgrove CCG



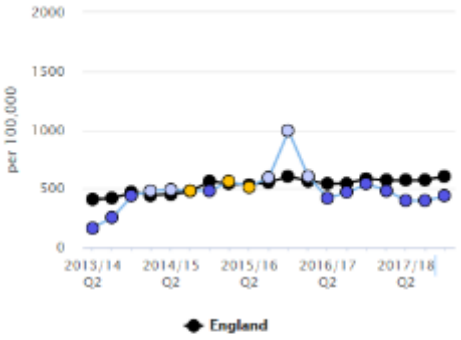
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q2		69	49	38	62	539*	411
2013/14 Q3		158	112	95	131	432*	416
2013/14 Q4		250	177	156	201	449*	469
2014/15 Q1		200	141	123	162	474*	446
2014/15 Q2		225	159	139	181	550*	452
2014/15 Q3		280	198	176	223	502*	477
2014/15 Q4		285	202	179	226	542*	564
2015/16 Q1		315	221	198	247	511*	539
2015/16 Q2		330	232	208	258	499*	535
2015/16 Q3		480	337	308	369	555*	557
2015/16 Q4		695	488	453	526	642*	601
2016/17 Q1		475	333	303	364	487*	568
2016/17 Q2		425	298	270	327	454*	540
2016/17 Q3		490	343*	313	375	526*	547*
2016/17 Q4		555	389*	357	422	542*	584*
2017/18 Q1		590	411*	378	446	542*	572
2017/18 Q2		475	331*	302	362	524*	569
2017/18 Q3		535	373*	342	406	526*	573*
2017/18 Q4		565	394*	362	427	560*	606

Source: IAPT

Source: Public Health England. Mental Health JSNA Profile.

Figure 122 Entering IAPT treatment: rate (quarterly) per 100,000 population aged 18+; South Worcestershire CCG



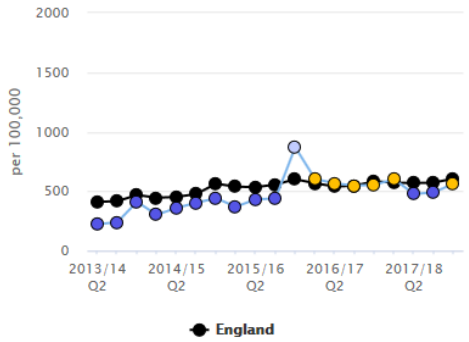
Recent trend: ⬇

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q2		396	169	153	186	539*	411
2013/14 Q3		591	252	232	273	432*	416
2013/14 Q4		1,025	437	411	465	449*	469
2014/15 Q1		1,140	482	454	511	474*	446
2014/15 Q2		1,155	488	460	517	550*	452
2014/15 Q3		1,145	484	456	513	502*	477
2014/15 Q4		1,140	482	454	511	542*	564
2015/16 Q1		1,345	564	534	595	511*	539
2015/16 Q2		1,230	516	487	546	499*	535
2015/16 Q3		1,425	598	567	630	555*	557
2015/16 Q4		2,360	990	950	1,031	642*	601
2016/17 Q1		1,455	606	575	637	487*	568
2016/17 Q2		1,010	420	395	447	454*	540
2016/17 Q3		1,125	468*	441	496	526*	547*
2016/17 Q4		1,295	539*	510	569	542*	584*
2017/18 Q1		1,180	486*	459	515	542*	572
2017/18 Q2		965	397*	373	423	524*	569
2017/18 Q3		965	397*	373	423	526*	573*
2017/18 Q4		1,065	439*	413	466	560*	606

Source: IAPT

Source: Public Health England. Mental Health JSNA Profile.

Figure 123 Entering IAPT treatment: rate (quarterly) per 100,000 population aged 18+; Wyre Forest CCG



Recent trend: ⬆

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14 Q2		177	224	192	259	539*	411
2013/14 Q3		189	239	206	276	432*	416
2013/14 Q4		325	411	367	458	449*	469
2014/15 Q1		240	303	266	344	474*	446
2014/15 Q2		285	360	319	404	550*	452
2014/15 Q3		320	404	361	450	502*	477
2014/15 Q4		350	442	396	490	542*	564
2015/16 Q1		295	370	329	415	511*	539
2015/16 Q2		345	433	388	481	499*	535
2015/16 Q3		350	439	394	487	555*	557
2015/16 Q4		695	871	808	939	642*	601
2016/17 Q1		485	604	552	660	487*	568
2016/17 Q2		455	567	516	621	454*	540
2016/17 Q3		440	548*	498	602	526*	547*
2016/17 Q4		445	554*	504	608	542*	584*
2017/18 Q1		485	602*	549	658	542*	572
2017/18 Q2		385	478*	431	528	524*	569
2017/18 Q3		395	490*	443	541	526*	573*
2017/18 Q4		455	564*	514	619	560*	606

Source: IAPT

Source: Public Health England. Mental Health JSNA Profile.

The following sections present further analysis of the 2016/17 IAPT data also produced by NHS Digital[139].

Figure 124 IAPT Referrals - Worcestershire CCGS, 2016/17

	Redditch and Bromsgrove	South Worcestershire	Wyre Forest	England
Referrals				
Referrals received	3525	7955	3220	1385664
Referrals aged 18-35	1635	3765	1545	648631
Referrals aged 65+	185	440	160	91073
Referrals per 1,000 population (total)	23.85	31.87	38.90	30.97
Referrals per 1,000 population aged 18-35	44.33	62.82	81.83	49.16
Referrals per 1,000 population aged 65+	5.10	6.51	6.62	9
Depression and anxiety prevalence from GP patient survey	0.14	0.13	0.15	0.14
Referrals entering treatment	1955	4860	1835	965379
Referrals finishing a course of treatment	775	1740	720	567106
Referrals ending prior to treatment	1730	3760	1580	417939

Source: NHS Digital, Psychological Therapies: Annual report on the use of IAPT services England, further analyses on 2016-17.

[139] This analysis is not yet available for the 2017/18 data.

Condition and Treatment

In 2016/17 99% of referrals made by Worcestershire CCGs were for an unspecified condition. This contrasts to 36% nationally.

Figure 125 IAPT Condition and Treatment - Worcestershire CCGS, 2016/17

Condition and Treatment	Redditch and Bromsgrove	South Worcestershire	Wyre Forest	England
Average first Work and Social Adjustment Scale (WSAS) score	0.00	0.00	0.00	20
Depression referrals	5	10	15	299656
Anxiety and stress referrals	40	55	15	468174
Number of referrals with unspecified condition	3475	7885	3190	502748
Percentage of referrals with unspecified condition	0.99	0.99	0.99	0.36
Referrals finishing that received only low intensity	-	-	-	198105
Referrals finishing that received only low intensity %	-	-	-	0.35

Source: NHS Digital, Psychological Therapies: Annual report on the use of IAPT services England, further analyses on 2016-17.

Waiting Times

In 2016/17, nationally, waiting times for first IAPT treatment varied considerably (from 5 days in Stoke to 135 days in Leicestershire). The average wait was 23 days[140].

In 2016/17 average waiting times for IAPT treatment in Worcestershire were higher than nationally - ranging from 68 days to 96 days - and all three Worcestershire CCGs featured in lists of the worst 10 CCGs in the country for waiting time to first treatment and percentage of patients waiting over 18 weeks.

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[140] House of Commons Library (2018). Briefing Paper: Mental Health Statistics for England: Prevalence, Services and Funding. Available at: http://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf

Table 39 Worst waiting times to first treatment by Clinical Commissioning Group

WORST IAPT WAITING TIME PERFORMANCE AGAINST 6 WEEK AND 18 WEEK TARGETS, 2016/17

Waiting over 6 weeks	%	Waiting over 18 weeks	%
Leicester City	67%	Leicester City	39%
Redditch & Bromsgrove	58%	South Worcestershire	30%
South Worcestershire	55%	Redditch & Bromsgrove	25%
Rotherham	49%	Wirral	19%
Wirral	45%	South Manchester	19%
Central Manchester	44%	Wyre Forest	17%
South Manchester	43%	Rotherham	16%
Wyre Forest	43%	Vale Of York	16%
North Manchester	40%	North Manchester	14%
Gloucestershire	36%	Thurrock	13%

Source: House of Commons Library (2018). Briefing Paper: Mental Health Statistics for England: Prevalence, Services and Funding.

Figure 126 IAPT Waiting Times - WORCESTERSHIRE CCGS, 2016/17

Waiting Times	Redditch and Bromsgrove	South Worcestershire	Wyre Forest	England
Mean days from referral to first treatment	86.60	95.70	67.50	23.00
Mean days between first and second treatment	48.40	44.70	43.80	40.70
Total mean days from referral to second treatment	135.00	140.40	111.30	63.70
Waiting less than 6 weeks	0.42	0.45	0.57	0.87

for first treatment				
Waiting less than 18 weeks for first treatment	0.75	0.70	0.83	0.98

Source: NHS Digital, Psychological Therapies: Annual report on the use of IAPT services England, further analyses on 2016-17.

Figure 127. Outcomes and Experience - WORCESTERSHIRE CCGS, 2016/17

Outcomes and Experience	Redditch and Bromsgrove	South Worcestershire	Wyre Forest	England
Reliably improved after treatment	0.57	0.49	0.50	0.65
Reliably deteriorated after treatment	0.09	0.12	0.13	0.06
Moved to recovery after treatment	0.44	0.40	0.37	0.49
Reliable recovery after treatment	0.42	0.37	0.36	0.47
Patient experience: "On reflection, did you get the help that mattered to you at all times?"	-	-	-	0.75

Source: NHS Digital, Psychological Therapies: Annual report on the use of IAPT services England, further analyses on 2016-17.

NHS Rightcare

NHS Rightcare and Public Health England have published data on how Worcestershire Clinical Commissioning Groups (CCGs) perform in comparison to their 10 most similar CCGs on certain mental health indicators. Each indicator is shown as the percentage difference from the average of the 10 most similar CCGs. This data is available in a 'Commissioning for Value Mental Health and Dementia Pack'.[141]

[141] Available at: https://www.england.nhs.uk/rightcare/products/ccg-data-packs/

Mental Health Problems and Long-Term Physical Conditions

There are high rates of mental health problems among people with long-term physical conditions. The relationship between mental and physical health is likely to be a two-way and causal. For example, people with a long-term condition are two to three times more likely to experience mental health problems than the general population. This can lead to:

- Increased hospitalisation rates
- Increased outpatient service use
- Less effective self-management

In Worcestershire in 2016/17 18.1% of people reporting a long term Musculoskeletal (MSK) problem also reported depression or anxiety. This is significantly lower than the national rate. Data is also available at District Level.

From April 2018 all CCGs are expected to expand Improving Access to Psychological Therapies (IAPT) by commissioning services integrated into physical healthcare pathways.

Medically Unexplained Symptoms

More than a quarter of primary care patients in England have unexplained chronic pain, irritable bowel syndrome, or chronic fatigue. In secondary and tertiary care, around a third of new neurological outpatients have symptoms thought by neurologists to be 'not at all' or only 'somewhat' explained by disease.

Persistent physical medically unexplained symptoms (MUS) account for up to a fifth of all GP consultations in the UK and are generally managed with limited psychological support. Without appropriate treatment, outcomes for many patients with MUS are poor.

Nationally, evidence-based treatments for MUS exist but have limited availability. Patients are often subjected to repeated diagnostic investigations, and unnecessary and costly referrals and interventions. Healthcare costs incurred by patients with MUS are estimated to be £3 billion, representing approximately 10% of total NHS expenditure on services for the working-age population. The resulting cost of sickness and decreased quality of life is estimated to cost over £14 billion.

Appropriate multi-disciplinary services for people with MUS should be commissioned in primary care, community, day services, A&E departments and inpatient facilities. This will enable people to access the services most appropriate for their problems, resulting in improved outcomes for patients and substantial cost-savings for the healthcare system.

Severe Mental Illness

The National Institute for Health and Care Excellence (NICE) have produced standards and guidelines that cover a wide range of severe mental health conditions including (but not exclusively): Psychosis and Schizophrenia, Bipolar Disorder, Severe Depression and Personality Disorders. These standards and guidelines stress that early recognition and rapid access to biopsychosocial care provides the best outcomes.

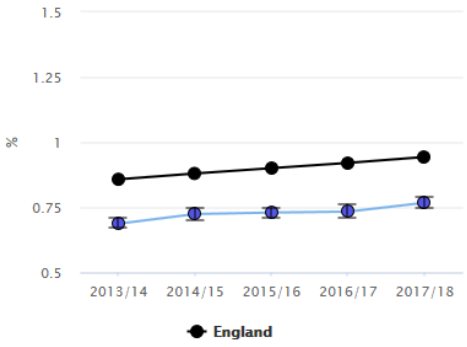
Nationally, commissioning and implementation of these services is subject to more variation than for comparable physical health conditions. Variation is seen in the duration of untreated mental health problems, access to full, rather than just partial effective interventions and in levels of resourcing.

Prevalence of Severe Mental Illnesses in Worcestershire

The recorded prevalence of severe mental illness[142] in Worcestershire in 2017/18 was 0.77% (95% CI 0.75-0.79) of those registered with a GP, equating to 4,649 people. This is a significantly lower prevalence than that seen nationally which is 0.94%. Amongst similar local authorities Worcestershire has a relatively low recorded rate (Figure 129)

As is the case nationally the recorded prevalence of severe mental illness has shown an upward trend in Worcestershire (Figure 128). There has been a significant increase in the recorded prevalence of severe mental illness for South Worcestershire CCG since 2012/13 (Figure 131).

Figure 128 Trends in the Recording of Severe Mental Illness - Worcestershire



Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2013/14		3,982	0.69	0.67	0.71	0.81*	0.86
2014/15		4,234	0.72	0.70	0.75	0.85*	0.88
2015/16		4,326	0.73	0.71	0.75	0.87*	0.90
2016/17		4,450	0.73*	0.71	0.76	0.89*	0.92*
2017/18		4,649	0.77	0.75	0.79	0.92	0.94

Source: Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof

Source: Public Health England. Mental Health and Well-being JSNA Profile.

[142] People diagnosed with schizophrenia, bipolar disorder or other psychoses or on lithium therapy. Does not include severe depression or personality disorders.

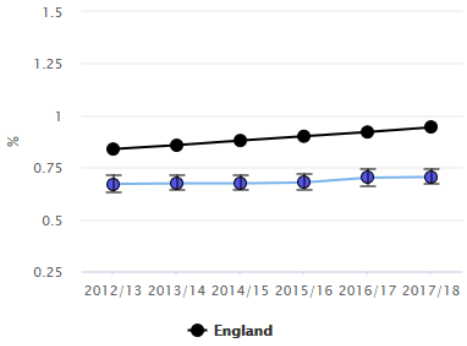
Figure 129 Recorded Prevalence of Severe Mental Illness - Worcestershire and CIPFA nearest neighbours 2017/18 (%)

Area	Value	Lower CI	Upper CI
England	0.94	0.94	0.95
Cumbria	1.00	0.97	1.03
Norfolk	0.90	0.89	0.92
Devon	0.90	0.88	0.92
Suffolk	0.88	0.86	0.90
West Sussex	0.87	0.85	0.89
Derbyshire	0.87	0.85	0.89
Somerset	0.84	0.81	0.86
Northamptonshire	0.83	0.81	0.85
Lincolnshire	0.82	0.80	0.84
North Yorkshire	0.80	0.78	0.83
Essex	0.80	0.79	0.82
Gloucestershire	0.79	0.77	0.82
Worcestershire	0.77	0.75	0.79
Warwickshire	0.75	0.73	0.77
Nottinghamshire	0.72	0.71	0.74
Staffordshire	0.72	0.71	0.74

Source: Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Figure 130 Trends in the Recording of Severe Mental Illness - Redditch and Bromsgrove CCG



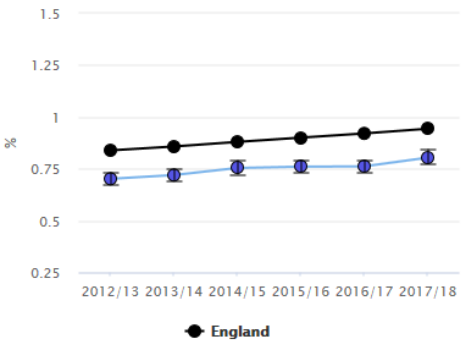
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13		1,154	0.67	0.63	0.71	0.85*	0.84
2013/14		1,161	0.67	0.64	0.71	0.87*	0.86
2014/15		1,167	0.67	0.64	0.71	0.89	0.88
2015/16		1,186	0.68	0.64	0.72	0.91	0.90
2016/17		1,240	0.70	0.66	0.74	0.94	0.92*
2017/18		1,252	0.70	0.67	0.74	0.96	0.94

Source: Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Figure 131 Trends in the Recording on Severe Mental Illness - South Worcestershire CCG



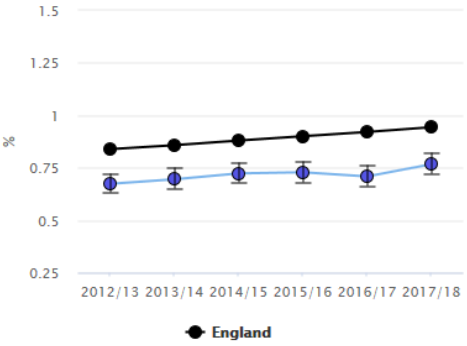
Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13		2,070	0.70	0.67	0.73	0.85*	0.84
2013/14		2,131	0.72	0.69	0.75	0.87*	0.86
2014/15		2,248	0.75	0.72	0.79	0.89	0.88
2015/16		2,305	0.76	0.73	0.79	0.91	0.90
2016/17		2,344	0.76	0.73	0.79	0.94	0.92*
2017/18		2,505	0.80	0.77	0.84	0.96	0.94

Source: Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Figure 132 Trends in the Recording of Severe Mental Illness - Wyre Forest CCG



Recent trend: ➡

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012/13	●	758	0.67	0.63	0.72	0.85*	0.84
2013/14	●	783	0.70	0.65	0.75	0.87*	0.86
2014/15	●	819	0.72	0.68	0.77	0.89	0.88
2015/16	●	835	0.73	0.68	0.78	0.91	0.90
2016/17	●	866	0.71	0.66	0.76	0.94	0.92*
2017/18	●	892	0.77	0.72	0.82	0.96	0.94

Source: Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof

Source: Public Health England. Mental Health and Well-being JSNA Profile.

Public Health England also publish the recorded prevalence of severe mental illness for individual GP practices. This data can be accessed via their Fingertips website.

Psychosis and Schizophrenia

Psychosis is a mental health problem that causes people to perceive or interpret reality differently from those around them. Sufferers may experience hallucinations or delusions. People with a history of psychosis are more likely than others to have drug or alcohol misuse problems and are at higher risk of self-harm and suicide[143]. There is no available data to date of the exact number of people suffering with psychosis, or new cases of psychosis.

PsyMaptic is an epidemiological tool which predicts the expected incidence of first episode psychosis in England & Wales every year, based on the sociodemographic characteristics (census data from 2011) of the underlying population (age, sex, ethnic group, LA population density and LA deprivation profile). Table 40 contains predicted figures for England, the West Midlands, Worcestershire and the three Worcestershire CCGs. The predicted rate of psychosis in Worcestershire is 17.5 per 100,000 population (age 16-64).

Table 40 New cases of psychosis: estimated incidence rate of psychosis per 100,000 population aged 16-64

Area	New Cases of Psychosis	
	Count*	Rate per 100,000 population (16-64 years)
England	2,427	18.1

[143] NHS Website. Psychosis. Available at: https://www.nhs.uk/conditions/psychosis/ Accessed 4th December 2018.

West Midlands NHS region	705	27.4
Worcestershire	62	17.5
NHS Redditch And Bromsgrove CCG	19	18.1
NHS South Worcestershire CCG	31	17.5
NHS Wyre Forest CCG	12	17.5

Source: www.psymaptic.org

*Estimated number of new, clinically-relevant cases of first episodes of psychosis (FEP) among people aged 16-64. The estimate is produced using a modelling approach to predict the number of cases based on area characteristics.

Schizophrenia is one possible cause of psychosis and doctors often describe schizophrenia as a type of psychosis. A person with schizophrenia may not always be able to distinguish their own thoughts and ideas from reality. Symptoms of schizophrenia include:

- hallucinations – hearing or seeing things that don't exist
- delusions – unusual beliefs not based on reality
- muddled thoughts based on hallucinations or delusions
- changes in behaviour

The condition may develop slowly, and the first signs can be hard to identify as they often develop during the teenage years. Symptoms such as becoming socially withdrawn and unresponsive or changes in sleeping patterns can be mistaken for an adolescent "phase". People often have episodes of schizophrenia, during which their symptoms are particularly severe, followed by periods where they experience few or no symptoms. This is known as acute schizophrenia[144].

[144] NHS Website. Schizophrenia. Available at: https://www.nhs.uk/conditions/schizophrenia/ Accessed 4th December 2018.

Personality Disorders (Anti-social and Borderline)

Estimates for bipolar disorder, psychotic disorder and personality disorders are usually measured over a person's lifetime, rather than each year. Estimates for the number of people with these diagnoses can vary quite a lot but the most recent reported findings from the Adult Psychiatric Morbidity Survey 2014[145] are:

Figure 133 Estimated Prevalence of Personality Disorders

Condition	Estimated Prevalence
Psychotic disorder	0.7%
Bipolar Disorder	2.0%
Antisocial Personality Disorder	3.3%
Borderline Personality Disorder	2.4%

Source: Adult Psychiatric Morbidity Survey 2014

Five Year Forward View for Mental Health

The independent Mental Health Taskforce published its 'Five Year Forward View' in February 2016. This set out the current state of mental health service provision in England and made recommendations in all service areas. More recently the NHS Long Term plan has been published and this re-affirms a commitment to put mental health on a level footing with physical health.

The Mental Health Five Year Forward View Dashboard brings together data to help monitor the performance of the NHS in delivering the plan. The most recent data available at the time of writing was for Q1 2018/19.

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

Models of Care

People need expert, evidence-based services at all stages of the pathway. This includes services that provide:

- early intervention for first episode psychosis
- rapid access to urgent and emergency care when in crisis
- coordinated case management, rehabilitation and recovery for on-going needs
- enhanced secure care when risk is high
- physical health care to reduce the 20-year premature mortality gap
- suicide prevention
- recovery to social inclusion, stable housing and employment

The model of mental health care has changed from a hospital-based specialty to one where most contacts take place in the community.

Community based mental health services should support people with mental health conditions in their journey from referral to longer term recovery. A service should be commissioned to consistently provide rapid access to a full NICE-recommended package of care, delivered in a person-centred and values-based way, which includes:

a person-centred and co- produced approach to the formulation, delivery and review of care planning

psychosocial and psychological therapy interventions for individuals and their families

optimisation of medication and regular medication review

physical health assessment and required interventions, including dental and ophthalmologic and healthy lifestyle promotion

effective recovery and rehabilitation in home and community settings including support with finding and maintaining stable housing, employment, financial wellbeing and social networks

Services should help people achieve and maintain recovery by providing:

- rapid referral for assessment and secondary care treatment and support where required
- enhanced primary care step-down support to maintain recovery following discharge from secondary mental health services
- rapid access to care to enable service users to step-up their care as required, or self-refer for re-assessment
- routinely record & publish patient and carer experience and outcome measures

Early Intervention in Psychosis

People who experience psychosis can, and do, recover. The time from onset of psychosis to the provision of evidence-based treatment has a significant influence on long-term outcomes. The sooner people are able to access evidence-based treatment the better the outcomes they achieve[146].

Early Intervention in Psychosis (EIP) services provide treatment and support to people experiencing or at risk of developing psychosis, typically for a three-year period.

Since April 2016, the Government and NHS England have been committed to the standard that 50% of people experiencing a first episode of psychosis should have access to early intervention care within two weeks.

The short and longer-term economic benefits of EIP services are significant. The net cost savings per person after the first four years is £7,972, with a further £6,780 saving per person in the next four to 10 years if full EIP provisions are provided. Over a 10-year period this would result in £15 of costs saved for every £1 invested in EIP services. The majority of these cost savings can be attributed to:

- the reduction in use of crisis and inpatient services
- improved employment outcomes
- the reduction in risk of future hospitalisation as a result of improved management and reduced risk of relapse

Local data on EIP is available from the Mental Health Five Year Forward View Dashboard[147]. In Q1 2018/19 all three Worcestershire Clinical Commissioning Groups recorded that 100% of people had started treatment within two weeks of referral.

Rehabilitation, Recovery and Secure Care

For people with continuing and rehabilitation needs, there is a range of service models with the emphasis on 24/7 community-based recovery focussed care. NHS England has committed to achieving the following objectives to improve the quality of community based mental health provision:

- at least 60% of people with first episode psychosis start treatment with a NICE-recommended package of care with an EIP service within two weeks of referral
- increasing access to integrated evidence-based psychological therapies for people with psychosis, bipolar disorder and personality disorder
- doubling the numbers who access Individual Placement and Support (IPS), which enables people with SMI to find and retain employment

[146] NHS England. Early Intervention in Psychosis. Available at: https://www.england.nhs.uk/mental-health/adults/cmhs/#eip

[147] NHS England. Mental Health Five Year Forward View Dashboard. Available at: https://www.england.nhs.uk/publication/mental-health-five-year-forward-view-dashboard/

Additionally, to the above, along with NHS Improvement, ensure that use of the Mental Health Act is closely monitored at both local and national level, and by 2020-21, through the provision of earlier intervention, reduce the rates of detention. Plans should include specific actions to substantially reduce avoidable Mental Health Act detentions and targeted work should be undertaken to reduce the current over-representation of BAME and any other disadvantaged groups in acute and forensic care.

Data on people subject to the Mental Health Act is available at CCG level. The rates presented have not been adjusted to account for different population characteristics, so caution should be applied when making comparisons. At the end of Q4 2017/18 the figures for the Worcestershire CCGs were:

Figure 134 people subject to the Mental Health Act by Clinical Commissioning Group; End Q4 2017/18 Snapshot

Clinical Commissioning Group	Time Point	Count	Crude Rate per 100,000	Lower CI	Upper CI
Wyre Forest	2017/18 Q4	25	31	20.1	45.8
South Worcestershire	2017/18 Q4	70	28.8	22.5	36.4
Redditch and Bromsgrove	2017/18 Q4	30	20.9	14.1	29.8

Source: Public Health England. Mental Health and Wellbeing JSNA

Urgent, Emergency and Acute Mental Health Care

Urgent, emergency and acute mental health care is provided by a range of teams and services.

Crisis Response and Home Treatment Teams

Based in a community setting, these services aim to assess and manage all patients in a mental health crisis and those also being considered for acute hospital admission. They offer intensive home treatment rather than hospital admission if safe and feasible. They also work to facilitate early discharge from hospital where possible and appropriate.

Mental Health Liaison Services

Situated in general hospitals, for example in the emergency department or in-patient wards, these services aim to provide psychiatric assessment and treatment to patients who may be experiencing distress whilst in hospital. They provide a valuable interface between mental and physical health. There is evidence that medical patients have a high rate of psychiatric disorder but can respond positively to psychological or drug treatments.

Psychiatric liaison teams are helpful in detecting these psychiatric disorders, such as depression or anxiety, and improving patient outcomes.

Acute Inpatient Services

Providing treatment when a person's mental health condition cannot be managed in the community, and where the situation is so severe that specialist care is required in a safe and therapeutic space. Admissions should be purposeful, integrated with other services, open and transparent, and as local and short as possible.

Nationally, the commissioning and provision of crisis care is variable with:

- only 14% of people report a positive experience of crisis care
- many Crisis Resolution and Home Treatment teams being unable to offer the full range of community-based treatment due to caseload capacity
- only 36% of people reporting a positive experience in A&E during a mental health crisis

People are routinely sent out of area for acute care due to a lack of bed capacity. Delays in the transfer of care are a major issue in mental health providers, with a lack of housing and capacity in community mental service as the main causes.

The following recommendations and investment initiatives have been set out to address aspects of urgent, emergency and acute mental health care:

- introduce a range of access and quality standards, including recommended response times and interventions for urgent, emergency and acute mental health care
- eliminate the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures by no later than 2020 to 2021
- by 2020 to 2021 24/7 community crisis response across all areas that are adequately resourced to offer intensive home treatment, backed by investment in crisis resolution and home treatment teams, with an equivalent model to be developed for children and young people
- by 2020 to 2021, no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, with at least 50% of acute hospitals meeting the 'core 24'33 service standard for adults and older adults
- new investment over four years from April 2017, with £400m for CRHTTs, and £249m in adult and older adult mental health liaison in A&E and acute hospital wards

Table 41 shows the number of referrals to adult mental health services in Worcestershire during 2017/18.

Table 41 Referrals for Adult Mental Health Services 2017/18

Service	No. of referrals
AMH Acute Psychology	206
AMH Approved Mental Health Professionals	615
AMH Bromsgrove CMHT	202
AMH Crisis Resolution	1,846
AMH Crisis Resolution (CAS)	*
AMH Droitwich CMHT	72
AMH Early Intervention in Psychosis	160
AMH Eating Disorders	182
AMH Evesham CMHT	196
AMH IPS - Individual Placement Service	172
AMH Liaison Team	2624
AMH Malvern CMHT	192
AMH Mental Health Job Retention	46
AMH Perinatal	633
AMH Placement Team	*
AMH Reablement Team	259
AMH Redditch CMHT	237
AMH Rehabilitation Team	*
AMH Worcester CMHT	429
AMH Wyre Forest CMHT	342
AMHHT Redditch & Bromsgrove	410
AMHHT South Worcester	*
AMHHT Wychavon	*
AMHHT Wyre Forest	290

New Opportunities Worcester	110

*Data is not available for the full financial year.

Premature Mortality in People with Serious Mental Illness

In Worcestershire people with serious mental illness are 3.4 times more likely to die prematurely (under the age of 75) than members of the general population (2014/15 figures). This is similar to the national rate[148].

Suicide and Self-Harm

People under the care of mental health services are at high risk for suicide and self-harm. A more detailed exploration of what can be done for people who present with significant risk or safety issues is made in the 'Understanding People' section of this report.

Severe Mental Health Problems and Poor Physical Health

Nationally, compared to the general population people in contact with specialist mental health services have:

- nearly four times the rate of deaths from diseases of the respiratory system
- just over four times the rate of deaths from diseases of the digestive system
- nearly three times the rate of deaths from diseases of the circulatory system

Much of the poor physical health amongst those with mental health problems can be explained by people's behaviour, for example, excessive smoking and alcohol use (see the 'Understanding People' section). However, other important factors also play a part. Nationally, less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

Spending on Mental Health

Commissioners are expected to attain the Mental Health Investment Standard, which means that the proportional increase on mental health spending each year should be larger than the proportional increase in overall spending by CCGs. In 2017/18, total CCG spending on mental health was planned to rise from 13.6% of total spending to 13.9%, so the national standard was expected to be met.

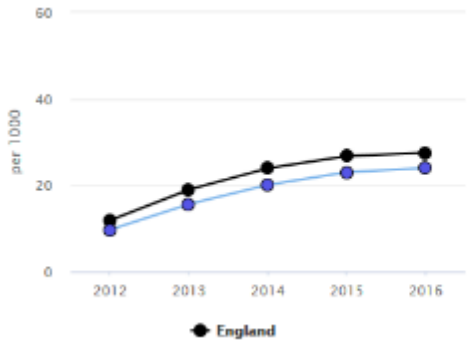
Cost of Mental Illness to the Wider Economy

In Worcestershire the rate of claimants of Employment Support Allowance (ESA) for mental and behavioural conditions is lower than nationally (24.0 per 1,000 working age population versus 27.5 per 1,000 working age population). However, since 2012 (the

[148] Public Health England. Mental Health JSNA Profile. Accessed 08/11/18.

earliest data available) this rate has been rising following a similar pattern to that seen nationally (**Figure 135**).

Figure 135 ESA claimants for mental and behavioural disorders: rate per 1,000 working age population - Worcestershire



Recent trend:

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012		3,470	9.7	9.4	10.1	12.4	11.9
2013		5,540	15.7	15.3	16.1	19.5	19.0
2014		7,100	20.1	19.7	20.6	25.0	24.0
2015		8,120	23.1	22.6	23.6	26.7	26.6
2016		8,440	24.0	23.5	24.5	29.4	27.5

Source: www.nomisweb.co.uk

This data is also available at District level via the Public Health England Mental Health and Well-being JSNA profile.

Mental Health Clients in Residential or Nursing Care

In 2013/14, compared to similar areas, Worcestershire had a relatively low rate of social care mental health clients in residential or nursing care (Figure 136).

Figure 136 Social care mental health clients in residential or nursing care: rate per 100,000 population aged 18-64 (2013/14)

Area	Value	Lower CI	Upper CI
England	31.9	31.3	32.5
Norfolk	55.6	49.3	62.5
Derbyshire	37.5	32.2	43.5
West Sussex	33.7	28.7	39.4
Lincolnshire	33.0	27.8	39.0
Northamptonshire	31.4	26.3	37.2
Essex	28.6	25.1	32.5
Staffordshire	28.1	23.7	33.1
Devon	25.3	20.8	30.5
Cumbria	22.1	17.1	28.2
Worcestershire	22.1	17.4	27.7
Gloucestershire	20.7	16.3	25.9
Suffolk	19.9	15.9	24.6
Nottinghamshire	18.8	15.1	23.1
North Yorkshire	18.5	14.3	23.6
Warwickshire	18.2	13.9	23.4
Somerset	16.2	12.0	21.4

Source: Referrals, Assessments and Packages of Care (RAP), National Adult Social Care Intelligence Service; Office for National Statistics

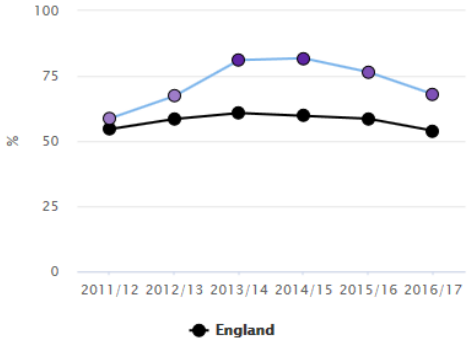
Mental Health Clients in Stable and Appropriate Accommodation

Housing service commissioners and providers have a key role in improving mental health outcomes - providing both settled housing and the services people need to maintain their homes as independently as possible. They can support people at risk of mental ill health to build resilience, as well as providing specialist support for people with mental health problems.

Figure 137 shows that in Worcestershire the proportion of adults in contact with secondary mental health services on the care programme approach who are recorded as living independently (with or without support) is better than the national average. The indicator is intended to improve outcomes for adults with mental health problems in stable and appropriate accommodation by improving their safety and reducing their risk of social exclusion. Maintaining stable and appropriate accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care.

There is some evidence that locally the trend in the proportion of adults in contact with secondary mental health services on the care programme approach who are recorded as living independently has been declining but further data would be needed to confirm this.

Figure 137 Percentage of Adults in Contact with Mental Health Services who are in Stable and Appropriate Accommodation, Worcestershire.



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2011/12		-	58.7	55.6	61.7	51.2	54.6
2012/13		-	67.3	64.0	69.9	60.3	58.5
2013/14		-	81.1	77.9	83.9	72.2	60.8
2014/15		-	81.8	78.8	84.4	71.2	59.7
2015/16		-	76.5	73.2	79.5	72.5	58.6
2016/17		-	68.0*	64.5	71.3	45.0*	54.0*

Source: NHS Digital. Measures from the Adult and Social Care Outcomes Framework, table 1H.

Source: Public Health England. Mental Health JSNA Profile.

Service Users Experience of Mental Health Services

In February 2016 Healthwatch Worcestershire published a report on people's experiences of support for mental health and well-being[149]. Across Worcestershire 68 Service Users were surveyed. The Healthwatch Worcestershire recommendations from this report were:

Access

1. Waiting times for mental health services to be reduced and the evidence for this to be monitored.

2. Consideration of how services might communicate with those on waiting lists in order to keep the patient informed.

3. Consideration of risks to ensure that people are not at risk of suicide or self-harm as a result of waiting times or lack of appropriate support.

4. Services to provide service users with accurate easy to understand information about how to access help in a crisis.

Quality of care and support

1. Co-produce the design and delivery of mental health services with service users to ensure they are personalised and not 'one size fits all'.

2. Consider how all services can ensure consistency in the quality of information provided to patients relating to their mental health needs.

3. Ensure that professionals involve service users in decisions about their care in order for services to better meet their needs.

4. Commissioners and providers to consider how they might monitor patient experience in a meaningful way to improve services.

Discharge

1. Consideration by providers about how the discharge process can be improved.

2. Providers should consider improving the quality and consistency of information given to service users on discharge.

3. Involve service users in decisions around discharge.

Crisis

1. Continued work by those involved in the mental health crisis concordat to improve access to help in a crisis to ensure a 'no wrong door'[150].

[149] http://www.healthwatchworcestershire.co.uk/wp-content/uploads/2017/01/FINAL-REPORT-Sharing-your-experiences-of-support-for-Mental-Health-and-Wellbeing-Vs-1.0.pdf

[150] The Mental Health Crisis Concordat has recently been stepped down and will continue on an information update basis going forward.

2. Consideration by providers on how crisis support can be person centred and not a one size fits all approach.

3. Mental health training for non-mental health professionals who come into contact with service users.

Evidence and Further Information

The following documents and supporting materials are useful sources of further information on this topic.

Common Mental Health Problems

NHS: Adult Improving Access to Psychological Therapies programme: overview of the IAPT programme, priorities for development and a range of links to service standards and workforce requirements.

NICE: Common mental health disorders: identifies common mental health disorders in people aged 18 and over in primary care and the principles for treatment and referral. From this pathway it is possible to access specific guidance on depression, generalised anxiety, PTSD, OCD, social anxiety and panic disorder.

Integrating Physical and Mental Health

King's Fund: Bringing together physical and mental health: integration of physical and mental health assessments, treatments, care pathways and services.

Institute for Public Policy Research: Patients in control: why people with long-term conditions must be empowered: overview of self-management and peer support in long term conditions.

PHE: Wellbeing in mental health: applying All Our Health: examples to help healthcare professionals make interventions to promote physical health and wellbeing in mental health.

Medically Unexplained Symptoms

JCPMH: Guidance for commissioners of services for people with medically unexplained symptoms: commissioning of comprehensive MUS services across the healthcare system. In developing this guide, we recognise that 'medically unexplained symptoms' is an unsatisfactory term for a complex range of conditions.

Severe Mental Illness

Care Quality Commission: Right Here Right Now: review of the quality, safety and effectiveness of care provided to those experiencing a mental health crisis.

Centre for Mental Health: IPS Resources: collection of materials brought together from the IPS Centres of Excellence to help services develop IPS supported employment or vocational services.

Commission on Acute Adult Psychiatric Care: Old Problems, New Solutions (2016): describes the problems with finding care beds or receiving good home treatment and

points to the improvements that can be made. It gives examples where people are being well cared for in good services.

JCPMH: Rehabilitation services for people with complex mental health needs: the commissioning of good quality mental health interventions and services for people with complex and longer-term problems to support them in their recovery.

NICE/NHS England: Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance: guidance on establishing, developing and maintaining urgent and emergency liaison mental health services for adults and older adults in emergency departments (EDs) and general hospital wards. The appendices provide examples of successful implementation and useful resources to share learning.

NICE/NHS England: Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance: provides support to local commissioners and providers in implementing the standard. An information pack accompanies this publication to provide commissioners and providers with helpful resources to support implementation.

NICE: Transition between inpatient mental health settings and community or care home settings: covers the period before, during and after a person is admitted to, and discharged from, a mental health hospital.

Premature Mortality in People with Serious Mental Illness

Academy of Medical Royal Colleges: Improving the physical health of adults with severe mental illness: essential actions: recommends practical ways to improve physical healthcare services for people with psychoses and those on antipsychotic medications.

Department of Health: Improving the physical health of people with mental health problems: Actions for mental health nurses: draws on the available evidence to improve the monitoring of and reduction of the risk factors that have a detrimental effect on people's physical health and ultimately reduce health inequalities.

Living Well in Older Years

Introduction

Good mental health and well-being are just as important in our older age as in our younger years. This section explores factors relating to mental health and well-being in older people. It covers the demographics of older people, the prevalence of mental health conditions, risk factors and protective factors for mental health, services currently available and best practice.

At each life stage, there are different contributory factors to having good mental health and many that are similar and applicable to all life stages. The people and place factors included in the Understanding Place and Understanding People sections apply equally to the older population and should be considered when planning to meet the needs of older adults.

Physical and mental health are closely linked. Many older adults will suffer from physical ill health and this can lead to mental health problems. Nationally, the risk of developing depression is over seven times higher in those with two or more chronic physical problems. Older adults with mental health problems and physical disorders use more health and social care services and have poorer outcomes. The interaction of physical and mental health problems is described in more detail in the Working Age Adults section.

Mental health problems in older people are common and often undiagnosed. People with these problems are likely to respond to treatments as well in older age as they do in the younger population.[151]

One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary[152]

It is estimated that depression affects 22% of men and 28% of women aged 65 or over, and 40% of older people in care homes, yet the Royal College of Psychiatrists has estimated that 85% of older people with depression receive no help at all from the NHS.[153]

[151] Joint Commissioning Panel for Mental Health. Guidance for commissioners of older people's mental health services (2013) and Department of Health. Annual Report of the Chief Medical Officer 2013 - Public Health Priorities (2014).

[152] Health in all policies: health, austerity and welfare reform A briefing from the board of science :https://www.bma.org.uk//media/files/pdfs/working%20for%20change/improving%20health/public%20and%20population%20health/bos-health-in-all-policies-austerity-briefing-2016.pdf?la=en

[153] AgeUK (2016) Hidden in Plain Sight: The unmet mental health needs of older people, [Online], Available from: https://www.ageuk.org.uk/brandpartnerglobal/wiganboroughvpp/hidden_in_plain_sight_older_peoples_mental_health.pdf Accessed: 26/10/2018

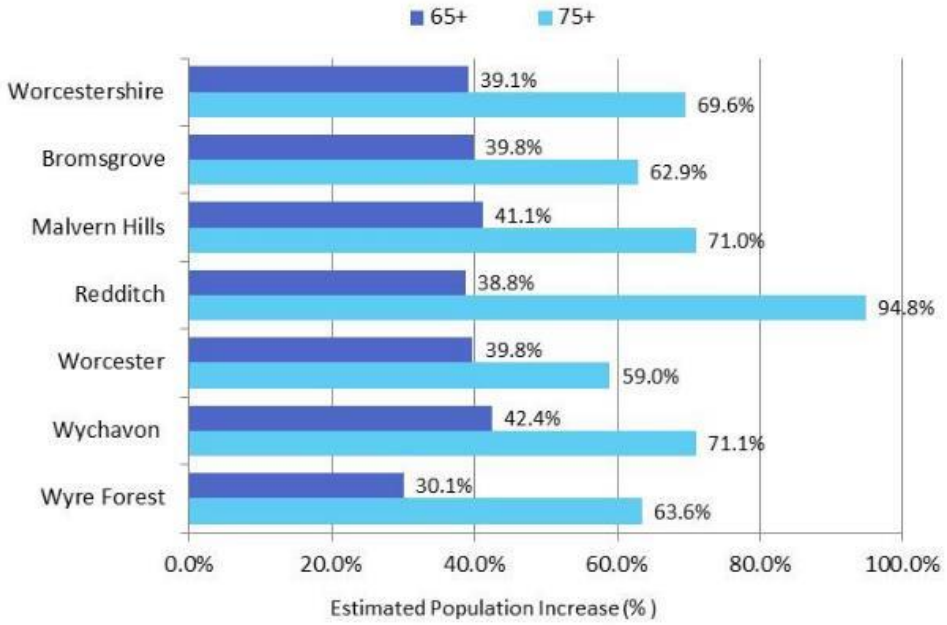
Demographics and Projections of the Older Population[154]

In Worcestershire, there are a total of 130,400 people aged 65 and over who make up over a fifth of the population (22.2%).[155] The highest proportions of people aged 65 and over are in Bromsgrove and Malvern Hills districts.

Figure **138** shows the projected increase in the 65 and over and 75 and over population in Worcestershire and for the Worcestershire districts. As is the case nationally, the proportion of the population aged 65 and over is projected to increase over the next few years. Between 2017 and 2035 it is projected that there will be an increase in the 65 and over population of 39.1% and in the 75 and over population the increase is projected to be even higher at 69.6%.

The largest increase in people aged 65 and over is expected to be in Wychavon with a projected increase of 42.4% - from 32,000 people in 2017 to 43,000 in 2035. The projected increase in people aged 75 and over is 94.8% - from 5,800 in 2017 to 11,300 in 2035. The projected increase in the older population means that it is important that commissioners plan now to meet their needs in the future.

Figure 138 Projected population increase in people aged 65+ and 75+ between 2017 and 2035



[154] All projections are from the 'Projecting Older People Population Information System' (POPPI). Oxford Brookes University (2018) which is available from: http://www.poppi.org.uk

[155] Office for National Statistics (2017) Mid-year population estimates [Accessed: 26/10/2018], Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

Source: Oxford Brookes University (2018). Projecting Older People Population Information System, [Online], Available from: http://www.poppi.org.uk

People Living Alone

People living alone are at greater risk of a decline in their independence and well-being.[156]

By 2035 there are projected to be 22,072 people aged 65 and over living alone in Worcestershire - an increase of 47.2%. The largest increases are expected to be in Redditch where, in 2017 there were estimated to be 5,186 people 65 and over living alone and is projected to increase to 7,925 by 2035 (an increase of 2,739 people or 52.8%). In Wychavon the number of people 65 and over living alone in 2017 was estimated to be 10,795, this figure is projected to increase to 16,212 in 2035 (an increase of 5,417 or 50.2%).

People Living in a Care Home

Nationally, the prevalence of depression is higher amongst older people who live in a care home compared to older people in general (two in five compared to one in five).[157]

It has been projected that in Worcestershire there is likely to be an increase in people aged 65 and over who will be living in a care home from 4,124 (3.2%) in 2017 to 7,804 (4.3%) in 2035.

The largest increase is predicted to be in Bromsgrove, where in 2017 there were estimated to be 1,143 (5.2%) people aged 65 and over living in a care home and is projected to increase to 2,084 (6.7%) by 2035.

People 65 and Over Providing Unpaid Care

In Worcestershire it is projected that there will be an increase in the numbers of people aged 65 and over providing unpaid care from 19,403 in 2017 to 25,785 in 2035 - a total increase of 6,382. The highest increase is projected to be in Wychavon where there is predicted to be an increase of 1,614 people.

[156] NICE. Mental wellbeing and independence for older people (2016) [Online], Available from: https://www.nice.org.uk/guidance/QS137/chapter/Quality-statement-1-Identifying-those-at-risk-of-a-decline

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

People 65 and Over Unable to Manage at Least One Domestic Task on Their Own

Between 2017 and 2035 there is projected to be an increase in the numbers of people aged 65 and over who are unable to manage at least one domestic task on their own in Worcestershire. This is an increase of 28,319 people or 44.5%.

People Aged 65 and Over Unable to Manage at Least One Self-Care Activity on Their Own

In Worcestershire there is projected to be an increase in the numbers of people who are unable to manage at least one self-care activity on their own between 2017 and 2035. This increasing is projected to be from 43,035 to 66,167. This is an estimated increase of 23,132 people needing support in self-care.

Prevalence of Mental Health Conditions in the Older Population

On measures of Health-Related Quality of Life for Older People Worcestershire performs significantly better than England as a whole and is one of the few areas in the West Midlands to do so.

Anxiety/depression is one of the five factors that contribute to the quality of life score, the others being mobility, self-care, usual activities and pain/discomfort. The score is a value between 0 and 1, where 1 is perfect health.

Figure 139 Health related quality of life for older people- Worcestershire Districts 2016/17

4.13 - Health related quality of life for older people 2016/17 — Mean - Score

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	0.735	0.734	0.736
Worcestershire	-	0.758	0.749	0.766
Malvern Hills	-	0.769	0.750	0.787
Wychavon	-	0.767	0.750	0.784
Worcester	-	0.761	0.733	0.788
Redditch	-	0.755	0.733	0.777
Wyre Forest	-	0.749	0.727	0.772
Bromsgrove	-	0.745	0.725	0.764

Source: GP Patient Survey

Figure 140 health related quality of life for older people - Worcestershire 2016/17

4.13 - Health related quality of life for older people 2016/17 — Mean - Score

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	0.735	0.734	0.736
West Midlands region	-	0.721	0.719	0.724
Herefordshire	-	0.768	0.754	0.781
Shropshire	-	0.761	0.751	0.771
Worcestershire	-	0.758	0.749	0.766
Warwickshire	-	0.751	0.742	0.759
Solihull	-	0.744	0.730	0.758
Telford and Wrekin	-	0.736	0.717	0.755
Staffordshire	-	0.736	0.730	0.743
Dudley	-	0.713	0.701	0.724
Coventry	-	0.703	0.691	0.716
Wolverhampton	-	0.697	0.684	0.710
Birmingham	-	0.696	0.688	0.704
Stoke-on-Trent	-	0.692	0.679	0.706
Walsall	-	0.683	0.671	0.695
Sandwell	-	0.660	0.647	0.672

Source: GP Patient Survey

Depression

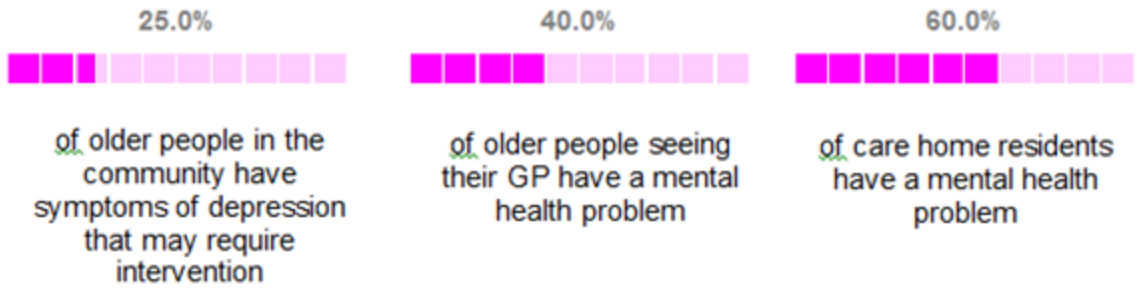
Depression is regarded as the most common mental health problem in later life and is associated with worse general health. A systematic review found a prevalence rate for major depression ranging from around 4% to 9%, and for depressive disorders ranging from around 4% to just over 37%. The prevalence of depression is reported to be even higher in nursing home residents and figures of between 29% and 40% have been reported across nine European countries[160].

Only a small proportion of older people with depression seek treatment - although 20-40% of older people in the community show signs of depression meriting treatment only 4-8% consult a GP. A Centre for Policy on Ageing review found widespread evidence of under-recognition and late diagnosis of depression in older adults and it has been suggested that depression is often seen simply as a part of ageing[158].

Figure 141 Prevalence of Mental Health Problems in Patients Aged 65+[159]

[158] Age UK (2018) Later Life in the United Kingdom , [Online], Available from: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf , Accessed: 30/10/2018

[159] Age UK (2018) Later Life in the United Kingdom , [Online], Available from: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf , Accessed: 30/10/2018



Adult Psychiatric Morbidity Survey 2014 may be useful (mainly national) https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

Dementia

The term dementia describes a collection of symptoms including memory loss, problems with reasoning and communication, and a reduction in a person's ability to carry out daily activities such as washing, dressing and cooking. Dementia is a progressive condition that varies from person to person and each will experience dementia in a different way – people may often have some of the same general symptoms, but the degree to which these affect each person will vary.

Dementia prevalence increases with age. It is currently estimated that there are 8,273 people aged 65+ with dementia in Worcestershire (or 6.3% of the 65+ population, the England rate is 6.5%). This is predicted to increase to 11,257 people by 2028 and to 14,382 people by 2038. The biggest proportionate increase will be in those aged 85+.

Currently many people with dementia do not have a diagnosis. In Worcestershire, 4,847 people aged 65+ are registered as having dementia (this is an estimated diagnosis rate of 58.6%)

A national target rate for dementia diagnosis has been set at 66.7% of people estimated to have dementia. The current diagnostic rates are:

Figure 142 Dementia Diagnostic rates Worcestershire CCG

	NHS Redditch & Bromsgrove CCG	**NHS South Worcestershire CCG**	**NHS Wyre Forest CCG**	***Herefordshire & Worcestershire STP***	***NHS West Midlands***
Dementia Diagnostic Rate	64.0% (56.7-70.2%)	55.9% (49.9-61%)	58.9% (51.9-65%)	58.1%	62.9%

Source: NHS Digital (https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof/quality-and-outcome-framework-qof-business-rules/recorded-dementia-diagnoses)

Following a review by NHS England Mental Health Intensive Support Team a Dementia Partnership Board has been created to enact an action plan to improve diagnostic rates across the county

Factors that Impact Mental Health in Older People

Risk Factors

As with other age groups there are many risk factors associated with the mental health of older adults. Levels of discrimination, presence of meaningful activities and relationships, physical health condition and poverty are key factors that affect the mental health and well-being of older people.[160]

Older people who have experienced any of the following are at a greater risk of a decline in their independence and wellbeing[161] if:

- their partner died in the past 2 years
- they are a carer
- they live alone and have little opportunity to socialize
- they are recently separated or divorced
- they are recently retired (particularly if involuntarily)
- unemployed in later life
- on low income
- they have recently experienced or developed a health problem
- they have had to give up driving
- they have an age-related disability
- they are aged 80 or older

Some risks for older people's mental health and well-being are discussed in more detail in the section below.

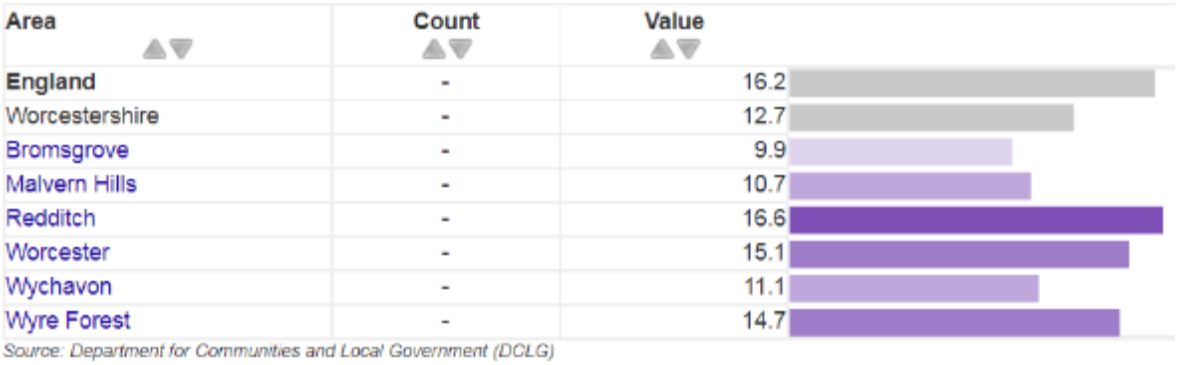
A more general discussion of the wider determinants of mental health can be found in the 'Understanding Place' section of this report.

[160] Age Concern, Mental Health Foundation. Promoting mental health and well-being in later life. A first report from the UK Inquiry into Mental Health and Well-Being in Later Life (2006)
[161] NICE. Mental wellbeing and independence for older people (2016)

Income Deprivation

The Income Deprivation Affecting Older People Index (IDAOPI)[162] measure is based on the percentage of the population aged 60 and over who receive income support, income-based job seekers allowance, pension credit or child tax credit.

Figure 143 Income Deprivation Affecting Older People Index (IDAOPI)



Area	Population aged 60+	IDAOPI (%)	Estimated Numbers
Bromsgrove	27154	9.9	2688
Malvern Hills	25886	10.7	2770
Redditch	19543	16.6	3244
Worcester	21587	15.1	3260
Wychavon	37358	11.1	4147
Wyre Forest	30117	14.7	4427
Worcestershire	**161645**	**12.7**	**20529**

Source: ONS mid-year population estimates (2015), Department for Communities and Local Government

Figure 143 shows Redditch District has the highest proportion of older people with income deprivation, at 16.6%, while Bromsgrove district has the lowest at 9.9%. The England average is 16.2%.

[162] A subset of the English Indices of Deprivation using the Income Deprivation Domain

Fuel Poverty

Fuel poverty and living in a cold home has a significant effect on the mental health of older people. Even after controlling for debt, low income, and socio-demographic factors such as education national research has found that living in a home that is cold predicts both poor physical health and poor mental health.[163] People with a common mental disorder (CMD) were far more likely to report fuel related financial strain than people without a CMD. 27% of people with a CMD said they had used less electricity, gas or other fuel due to worry about cost, compared with 12% of people without a CMD.

In England Fuel Poverty is measured using the low income-high cost definition, which states that a household is in fuel poverty if:

- Their income is below the poverty line (considering energy costs) and;
- Their energy costs are higher than is typical for their household type

Nationally, under this definition, households with one or more people aged over 60 account for approximately a quarter of those in fuel poverty.[164]

In Worcestershire 12.3% of households are classified as being in fuel poverty. This is between the levels seen in England (11%) and the West Midlands (13.5%).

The Malvern Hills district has the highest proportion of households living in fuel poverty.

Figure 144. Fuel Poverty in Worcestershire (2015)

Area	Count	Value
England	2,502,217	11.0
Worcestershire	30,001	12.3
Bromsgrove	4,124	10.6
Malvern Hills	5,100	15.6
Redditch	3,696	10.5
Worcester	5,181	12.1
Wychavon	6,398	12.7
Wyre Forest	5,502	12.6

Source: Department for Business, Energy and Industrial strategy

[163] Harris, J., et al., Health, mental health and housing conditions in England. 2010, eaga Charitable Trust: London.

[164] https://www.gov.uk/government/statistics/fuel-poverty-detailed-tables-2013

Figure 145. Fuel Poverty in the West Midlands (2015)

Area	Count	Value
England	2,502,217	11.0
West Midlands region	315,987	13.5
Birmingham	65,117	15.6
Coventry	18,878	14.4
Dudley	15,648	11.8
Herefordshire	13,287	16.6
Sandwell	17,684	14.3
Shropshire	21,139	16.0
Solihull	9,261	10.6
Staffordshire	43,330	12.0
Stoke-on-Trent	15,349	14.0
Telford and Wrekin	7,903	11.7
Walsall	14,458	13.2
Warwickshire	28,774	12.2
Wolverhampton	15,158	14.6
Worcestershire	30,001	12.3

Source: Department for Business, Energy and Industrial strategy

The Quality of Indoor Living Environment measure in the Index of Multiple Deprivation 2015 is made up of two items; the proportion of houses that do not have central heating and the proportion of homes that fail to meet the Decent Homes Standard. On this measure **a higher score indicates a higher level of deprivation**. Figure 146 shows there are variations in the quality of the indoor living environment across Worcestershire. Malvern Hills has the worst score for quality of indoor living environment, at 26.9 and worse than the England average and Redditch the best at 8.0 and better than the England average.

Figure 146 Quality of Indoor Living Environment IMD Score 2015

Area	Count	Value
England	-	22.1
Worcestershire	-	-
Bromsgrove	-	13.6
Malvern Hills	-	26.9
Redditch	-	8.0
Worcester	-	25.8
Wychavon	-	18.3
Wyre Forest	-	22.9

Source: English indices of deprivation:

Substance Misuse

Substance misuse in older people is an overlooked area and, amongst older people, there is a significant increase in rates of legal and illegal drug use and misuse, together with rises in alcohol-related hospital admissions and mortality. Only 6–7% of high-risk people with substance misuse problems over 60 years of age receive the treatment that they require[165]

Worcestershire has a significantly higher rate of people aged 65 and over who have an admission episode for alcohol-related conditions (narrow).[166] Wyre Forest, Worcester and Wychavon all have significantly higher rates of hospital admissions for alcohol-related conditions compared to other districts. It has been identified that there has been a significant fall in admission episodes in both Bromsgrove and Redditch and that this is likely due to a number of factors including the possibility of differences in treatment pathways, hospital episode coding, or new initiatives.

Poor Physical Health and Co-morbidities

An issue that can complicate older people's access to appropriate services is the increased likelihood for those aged 65 and over to present with a number of both physical and mental health conditions. The King's Fund estimates that around 50% of people aged over 50 and 80% of those over 65 live with one or more long-term conditions. This makes the need to improve mental health treatment for older people even more pressing, given the well-established link between poor physical health and poor mental health.

A 2004 study found that an estimated 70% of new cases of depression in older people are related to poor physical health. Older adults with physical health conditions, such as heart disease, have higher rates of depression than those who are medically well. Conversely, untreated depression in an older person with heart disease can negatively affect the outcome of the physical disease. Providing good mental health treatment therefore not only improves the well-being of the individual, it could also generate significant savings for health services through the prevention of further physical health conditions.[153]

Worcestershire has greater numbers of those in the older age groups (85+), many of whom will have poor physical health.

[165] Admissions where alcohol is wholly or partially attributable to the hospital admission and where here is an alcohol attributable code in the primary diagnosis code and an alcohol attributable external cause code (e.g. Accidents, Falls)

[166] Admissions where alcohol is wholly or partially attributable to the hospital admission and where here is an alcohol attributable code in the primary diagnosis code and an alcohol attributable external cause code (e.g. Accidents, Falls)

Multi-morbidity (two or more long-term conditions)

A study by the National Institute of Health Research has estimated that nationally by 2035, around two thirds (67.8%) of people will be living with two or more long-term conditions (multi-morbidity). By 2035, there is estimated to be double the number of people aged over 65 living with four or more conditions at 17% compared with 9.8% in 2015.

Nationally, in 2015, 54.0% of people aged over 65 had two or more conditions (multi-morbidity). By age group, the prevalence of multi-morbidity was predicted at 52.8% for people aged 65-74, 75.9% for those aged 75-84, and 90.5% for those above the age of 85.[167]

Figure 147 Estimated Multi-morbidity for People Aged 65 and Over by Age Group (2015)

Source: National Institute for Health Research (2018)

Multi-morbidity and Mental Illness

The NIHR study also explored the link between physical illness and mental illness. It found that the contribution of mental illness (depression, dementia or cognitive impairment) to overall multi-morbidity increases with the number of diseases or impairments.

In 2015, 4.1% of people with two or more conditions had mental ill-health, this increased to 34.1% of people with four or more conditions.[167] This means that individuals with four or more co-morbidities are over eight times more likely to experience a mental health issue when compared to individuals with 2-3 co-morbidities.

Figure 148 Multi-morbidity and Mental Health Issue by Number of Co-morbidities by Age Group

Source: National Institute for Health Research (2018)

[167] National Institute for Health Research (2018) Multi-morbidity predicted to increase in the UK over the next 20 years, [Online] Available from: https://discover.dc.nihr.ac.uk/content/signal-00572/multi-morbidity-predicted-to-increase-in-the-uk-over-the-next-20-years Accessed: 30/10/2018

Loneliness and Social Isolation

The terms loneliness and social isolation are often confused, but they have distinct meanings. Loneliness is a subjective feeling about the gap between a person's desired levels of social contact and their actual level of social contact. It refers to the perceived quality of the person's relationships. Whereas, social isolation is an objective measure of the number of contacts that people have. It describes the quantity not quality of relationships and some people may choose to have a small number of contacts.[168]

Feeling lonely isn't in itself a mental health problem, but the two are strongly linked. Having a mental health problem increases your chance of feeling lonely and feeling lonely can have a negative impact on your mental health. People can become socially isolated for a variety of reasons, such as getting older or weaker, no longer being the hub of their family, leaving the workplace, the deaths of spouses and friends, or through disability or illness.[169]

Social isolation can cause loneliness, anxiety and stress and is a predictor for cognitive decline, impairment and dementia, even when controlling for symptoms of depression[170].

[168] Age UK. Loneliness-Isolation Understanding the Difference. Available at: https://www.ageuk.org.uk/our-impact/policy-research/loneliness-research-and-resources/loneliness-isolation-understanding-the-difference-why-it-matters/

[169] MIND. Loneliness. Available at: https://www.mind.org.uk/information-support/tips-for-everyday-living/loneliness/loneliness/?o=15405#.XFmkF8tLEuU

[170] Dr Jessica Allen, Ms Sorcha Daly (2018), Older People and the Social Determinants of Health, British Medical Association

Older people are especially vulnerable to loneliness and social isolation and it can have a serious effect on their health:

- Social isolation and loneliness can increase risk of mortality by a quarter[171]
- Loneliness has strong associations with, and may be an independent or synergistic risk factor for depression[171]
- In addition, it is linked adversely to hypertension, impaired sleep and impaired cognition in older people[171]
- People with a high degree of loneliness are twice as likely, compared to those with a low degree of loneliness, to develop Alzheimer's disease[171]
- Loneliness can be as harmful for health as smoking 15 cigarettes per day[171]
- A higher proportion of those aged 80 and over reported feeling lonely when compared to other age groups (46% compared to the average of 34% for all aged 52 and over) [171]

According to Age UK, more than 2 million people in England over the age of 75 live alone, and more than a million older people say they go for over a month without speaking to a friend, neighbour or family member.

An analysis of potential risk factors for loneliness was produced by Worcestershire County Council in 2015. This showed that there is considerable variation in the risk of loneliness by geographical area. The analysis is based on Middle Super Output Areas (MSOAs) which typically have a population of 6,000-7,000. There are 85 such areas in Worcestershire.

[171] NHS Right Care (2016) Commissioning for Value – Long Term Conditions Pack, [Online], Available from: https://www.england.nhs.uk/rightcare/products/ccg-data-packs/long-term-conditions-packs/ Accessed: 29/10/2018

Each of the factors listed in the table below were assumed have the effect of increasing the prevalence of loneliness.

Table 42. Risk Factors for Loneliness

Risk Factor	Data
Geographical isolation	Index of Multiple Deprivation (IMD) 2010 Geographical Barriers Sub-domain Score
Long term illness or disability	Day-to-day activities limited a little or a lot (Census 2011)
Living in a care home	% aged 65+ living in communal establishments (Census 2011)
Living alone	One Person Household; Aged 65 and Over (Census 2011)
Poverty	Index of Multiple Deprivation (IMD) 2010 Income Deprivation Affecting Older People supplementary index (people aged 60 and over who are IS/JSA-IB claimants)
Caring responsibilities	% of people aged 65+ who provide 20 or more hours of unpaid care per week (Census 2011)
Size of potential problem	% of population aged 65 and over (Census 2011)

Source: Worcestershire County Council

Table 43 shows the ten worst ranking MSOAs in Worcestershire for risk of loneliness[172] and these areas might be expected to have a greater prevalence of loneliness and isolation. The table also helps to pick out the most prominent risk factors in each area by listing factors where the MSOA was in the highest 20% (Quintile 1) and the next highest 20% after that (Quintile 2) MSOAs for that factor.

Table 43. Highest Ranking MSOAs for Loneliness Risk - Worcestershire

MSOA code	MSOA name	District	In Quintile 1	In Quintile 2	Rank of average rank
E02006724	Enfield & Smallwood	Redditch	Income Deprivation Unpaid Care Long Term Illness Single Person Households	Access	1
E02006750	Droitwich East	Wychavon	Single Person Households OP Percentage	Income Deprivation LLTI Communal Est	2
E02006735	Gorse Hill North	Worcester	Income Deprivation Unpaid Care Long Term Illness Single Person Households	Communal Est	3
E02006706	Bromsgrove East Central (St Johns & Whitford)	Bromsgrove	Long Term Illness Communal Est	Income Deprivation Op Percentage	4

[172] The ranking from 1-85 in each of the factors (where 1 is highest) is averaged for each MSOA to produce an "average rank".

MSOA code	MSOA name	District	In Quintile 1	In Quintile 2	Rank of average rank
			Single Person Households		
E02006723	Batchley	Redditch	Income Deprivation Long Term Illness Communal Est	Access Single Person Households	5
E02006705	Bromsgrove North West (Sidemoor & Norton)	Bromsgrove	Unpaid Care Communal Est	Income Deprivation LLTI Single Person Households	6
E02006749	Droitwich West	Wychavon	Income Deprivation Unpaid Care Long Term Illness Single Person Households	Access	7
E02006731	Headless Cross & Oakenshaw	Redditch	Unpaid Care Single Person Households	Income Deprivation Long Term Illness	8
E02006751	Droitwich Central	Wychavon	Communal Est	Income Deprivation Unpaid Care Long Term Illness	9

MSOA code	MSOA name	District	In Quintile 1	In Quintile 2	Rank of average rank
				Single Person Households OP Percentage	
E02006722	Moons Moat	Redditch	Income Deprivation Unpaid Care Long Term Illness Single Person Households		10

According to 2011 census data there were 31,300 over 65s living alone in Worcestershire. This is a significantly higher proportion of older people living alone than nationally; 5.63% of all households compared to 5.24% in England. However, it is important to note that this data is taken from the 2011 Census and is now quite old.

The Adult Social Care Survey found that in Worcestershire a significantly higher proportion of adult social care users reported having as much social contact as they would like at 49.7% compared to 45.4% in England.

Educational and social activity group interventions that target specific groups and in which older people are active participants can alleviate social isolation and loneliness among older people.[173] Initiatives which aim to address social isolation and loneliness are particularly important in older age and can have significant benefits.[174]

Falls

A significant consideration for older people that have experienced a fall is the psychological impact that it can have upon an individual. A research study carried out by Royal Voluntary Service[175], measuring the impact of falls on older people and highlighted that around a fifth of people who had experienced a fall in the last five years had lost their confidence as a result, of those who were aged 80 or over, 17% reported that experiencing a fall has made them worry about leaving their house. Fear of falling means that 5% of people aged over 75 won't leave the house by themselves, furthermore contributing to loneliness and isolation and potentially having a significant impact upon mental health and wellbeing.

33% of people aged 65 and over fall every year. This increases to 50% in people aged 80 and over.[176]

In Worcestershire, there are approximately 2,245 injuries due to falls each year in persons over 65, and as a result there are approximately 721 hip fractures throughout the county in 2016-17[177].

173 http://ow.ly/vfiu305LPIk or http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-647

174 Department of Health. Social action for health and well-being: building co-operative communities (2011)

175 WRVS (2012) Falls: measuring the impact on older people, [Online] Available from: https://www.royalvoluntaryservice.org.uk/Uploads/Documents/Reports%20and%20Reviews/Falls%20report_web_v2.pdf Accessed: 29/10/2018

176 Worcestershire County Council (2018) Falls Needs Assessment, [Online] Available from: http://www.worcestershire.gov.uk/download/downloads/id/9828/2018_falls_needs_assessment.pdf Accessed: 29/10/2018

177 177 WRVS (2012) Falls: measuring the impact on older people, [Online] Available from:

Risk factors that lead to people falling are varied. They include: memory loss, postural hypotension, psychoactive medications, poor strength and balance, poor foot care and footwear, incontinence, visual impairment and home hazards.

https://www.royalvoluntaryservice.org.uk/Uploads/Documents/Reports%20and%20Reviews/Falls%20report_web_v2.pdf Accessed: 29/10/2018

Risk Factors for Dementia

National Institute for Health and Care Excellence (NICE) guidance identifies five key risk factors that increase the risk of dementia. These are: physical inactivity, smoking, being overweight, excess alcohol consumption and poor diet.

The county is comparable to the national average for level of physical inactivity, alcohol consumption and unhealthy diet. Levels of smoking are better than the national average, but the number of people estimated to be obese is higher. These risk factors are already significantly targeted by general public health measures provided by multiple agencies including the NHS, Local Authority Public Health and voluntary and charity sector organisations.

Dementia risk reduction advice is given through the NHS Health Check programme (this advice has recently been extended to all age groups attending the check).

Protective Factors for Mental Health

Volunteering

Volunteering can give older people a sense of purpose and self-esteem, facilitate meaningful interaction with others and also contributes positively to the wider community.[178] Table 44 shows results from the Worcestershire Viewpoint Survey. The survey found that people aged 65 and over reported higher participation rates in volunteering activities than those aged 18-64 (with the exception of activities involving children and young people).

Table 44. Volunteering - Worcestershire Viewpoint Survey (2018)

Question	18-64		65 and over	
Would you personally be prepared to volunteer some time to be involved in…	Yes, I already do	Yes, I don't do this currently but would be interested in doing so	Yes, I already do	Yes, I don't do this currently but would be interested in doing so
Countryside and open spaces?	9.0%	21.2%	10.6%	9.8%
Supporting older or vulnerable people (e.g. Community Meals)?	7.8%	10.0%	13.7%	5.4%
Libraries or cultural services?	3.6%	11.0%	4.8%	9.0%
Community transport?	2.0%	6.2%	3.4%	5.0%
Activities for children and young people?	10.3%	8.0%	6.5%	3.0%
Maintaining the local area (e.g. conservation)?	9.2%	18.9%	10.2%	13.0%
Supporting health services?	5.7%	9.0%	7.6%	13.2%
Other?	10.6%	4.3%	22.4%	2.1%

Source: Viewpoint Survey 2018, Worcestershire County Council

[178] Department of Health. Social action for health and well-being: building co-operative communities (2011)

Social Capital

Social capital broadly refers to characteristics of effectively functioning social groups including: good interpersonal relationships, a shared sense of identity, a shared understanding, shared norms, shared values, trust and co-operation. High levels of social capital can promote mental health and prevent mental ill-health in older people.

A systematic review found older people are more vulnerable to decreasing social networks as they are at greater risk of losing their partner and friends, which at the same time makes them more dependent on other social resources including social capital within the society[179]. Being socially integrated in society in terms of participation and frequent social contacts has been proven to be important health resource for older people.

Worcestershire County Council's Viewpoint Survey asks about a number of issues connected with social capital and how individuals relate with the local community. On most measures, the results for those aged 65 and over compare favourably with those for 18-64 year olds.

Table 45. Social Capital - Worcestershire Viewpoint Survey (2018)

Question (Yes response)	18-64	65+
How strongly do you feel you belong to your local area? (very or fairly strongly)	71%	78%
Do you agree that you can influence decisions affecting your local area? (definitely or tend to agree)	34%	36%
To what extent do you agree or disagree that your local area is a place where people from different backgrounds get on well together? (definitely or tend to agree)	76%	83%
In your local area, how much of a problem do you think there is with people not treating each other with respect and consideration? (very big/fairly big)	21%	16%
How safe or unsafe do you feel when outside in your local area after dark? (very safe or fairly safe)	69%	67%

Source: Viewpoint Survey 2018, Worcestershire County Council

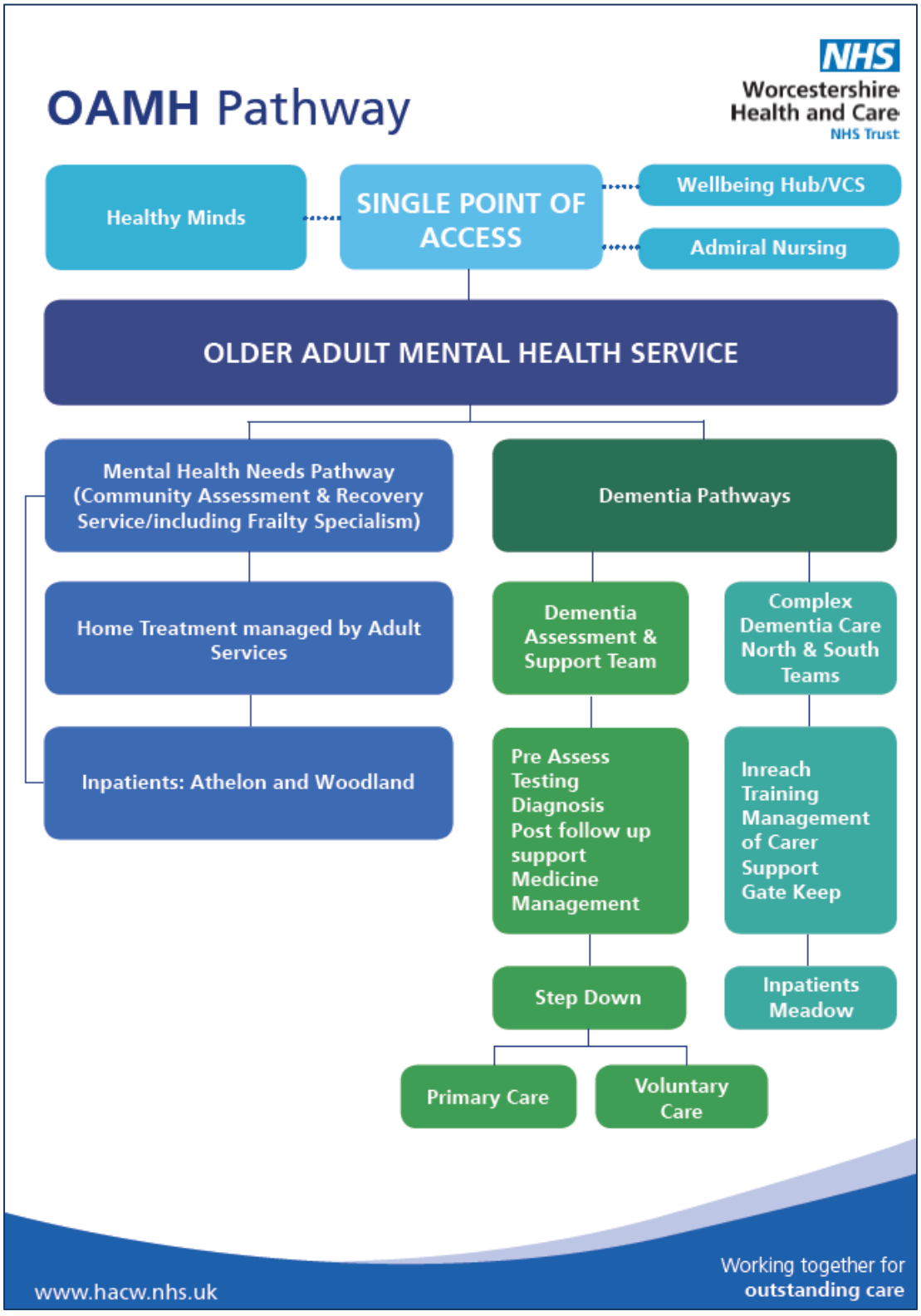
[179] Fredrica Nyqvist, Anna K. Forsman, Gianfranco Giuntoli & Mima Cattan (2013) Social capital as a resource for mental well-being in older people: A systematic review, Aging & Mental Health, 17:4, 394-410

Access to Services

Services for older people commissioned from Worcestershire Health and Care Trust, the local NHS Secondary Care provider, have recently undergone a full-service re-model. Services now include:

- Dementia Assessment and Support Team (DAST) Memory Services
- Older Adult Community Mental Health Teams Complex Dementia Service
- Older Adults Inpatient Services (Athelon Ward, Newtown and Woodland and Meadow Wards, Newhaven)
- Admiral Nurse Service
- Older Adult Community Mental Health Teams

Older people can also access other services including 'Healthy Minds' who provide support for low mood, anxiety and depression.



Source: Worcestershire Healthcare Trust

Key Services and Service Use Data

In supporting older people with mental health conditions there is a need to consider the importance of 'triple integration'; integration of health and social care, primary and specialist care, and physical and mental health care.[180]

Dementia Diagnostic Services

Recent change to Older Adult Mental Health (OAMH) pathway including dementia pathway (awaiting initial evaluation)

~1,000 people per year are seen through Early Intervention Dementia Service

Other Dementia services

~3,000 people per year registered with dementia are admitted to acute hospital. Compared to the national and regional level, this is fewer admissions than expected

1,521 individuals with 'cognitive impairment' coding aged 65+ used community mental health services 2017-18, totaling 10,024 clinical activities

382 users of advocacy services – majority for Independent Mental Capacity Advocacy in regard to Deprivation of Liberty Safeguards

The proportion of residential care and nursing home beds suitable for people with dementia which have been Care Quality Commission (CQC)-rated is higher in Worcestershire (94.7%) compared to nationally (88.2%)

~2,000 people caring for people with dementia are using Worcestershire Association of Carer services

NHS Health Checks

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and more recently includes dementia awareness for anyone aged 65 and over. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of these diseases. A high take up of NHS Health Check is important to identify early signs of poor health and leads to increased opportunities for early intervention.[181]

In Worcestershire, the proportion of eligible population aged 40-74 who received an NHS Health check was significantly higher (51.3%) than the England average (44.3%).

[180] British Medical Association (2016) Briefing paper Older people's mental health and wellbeing [Online], Available from: https://www.bma.org.uk Accessed 26/10/2018

[181] Public Health England (2018) Older Peoples Health and Wellbeing, [Online] Available from: http://fingertips.phe.org.uk Accessed: 26/10/2018

Psychological Therapies (IAPT)

Improving Access to Psychological Therapies (IAPT) is primarily for people who have mild-to-moderate common mental health difficulties such as depression, anxiety, phobias and post-traumatic stress disorder (PTSD). The programme seeks to use the least intrusive method of care possible to treat people at the time when it will be of most help to them. More information on the programme can be found in the 'Working Age Adults' section of this report.

It is estimated that around 25% of people aged 65 and over experience a common mental health difficulty. In 2011 the Department of Health set a target of 12% of referrals to the IAPT programme being for people aged 65 and over. Nationally, five years later, this target was still not close to being met with reporting showing it to be 6.1%.[153]

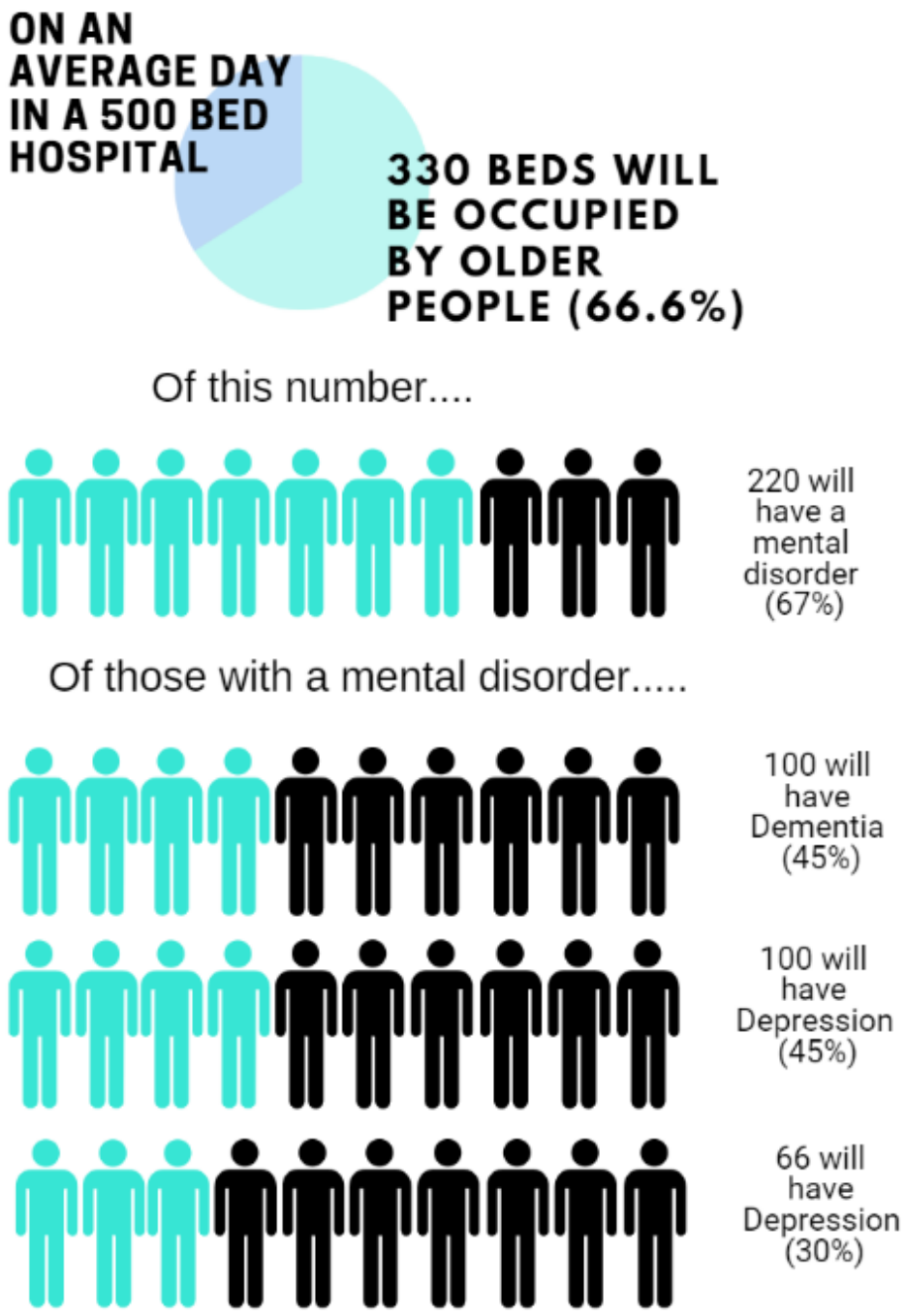
Data shows an increasing proportion of IAPT referrals in Wyre Forest Clinical Commissioning Group (CCG) were for people aged 65+[182] and in Q4 2017/18 this proportion was 8.1%. This was the highest proportion across all CCG areas in Worcestershire and higher than the national average for England where, the proportion of IAPT referrals for 65's and over was 6.8% in Q4 2017-18.

In Q4 2017-18 approximately 4.8% of all referrals for IAPT in South Worcestershire CCG, were for people aged 65 and over and in Redditch and Bromsgrove CCG this figure was approximately 4.1%.

[182] NHS England (2018) Mental Health Five Year Forward View Dashboard, Q4 2017-18, [Online] Available from: https://www.england.nhs.uk/publication/mental-health-five-year-forward-view-dashboard/ Accessed 26/10/2018

Hospital Services

National figures show that in 2015, on an average day, in a 500 bed hospital, 330 beds were occupied by older people, of whom 220 had a mental disorder, 100 each had dementia and depression and 66 delirium[153]. This shows that there is significant need for appropriate older adult mental health care and support during hospital inpatient stays.



Source: AgeUK (2016) Hidden in Plain Sight: The unmet mental health needs of older people, [Online], Available from:

https://www.ageuk.org.uk/brandpartnerglobal/wiganboroughvpp/hidden_in_plain_sight_older_peoples_mental_health.pdf Accessed: 26/10/2018

Of people aged over 70 admitted as emergencies to an acute hospital, 50% have cognitive impairment, 27% have delirium, and 8-32% have depression.

Mental Health and Learning Disability Services

Worcestershire has a lower rate of people aged 65+ who have contact with Mental Health or Learning Disability services than England as a whole. Of the Worcestershire Clinical Commissioning Groups (CCGs) South Worcestershire has the highest rate at 48.9 per 1,000 population, Redditch and Bromsgrove has a rate of 46.4 per 1,000 population and Wyre Forest a rate of 46.2 per 1,000 population.

The Government and Office for National Statistics have understood the need to have national measures of wellbeing. Research shows that people who have higher levels of wellbeing have lower rates of illness, recover more quickly and for longer and have better physical and mental health.[183] There are two measures of wellbeing, both self-reported, that are important when considering older people's mental health, happiness and life satisfaction scores.

Worcestershire has a significantly higher proportion of individuals who reported a high happiness score (75.9%) compared to England (74.7%) and has a significantly higher proportion of individuals who reported a high satisfaction score (84.0%) compared to in England (81.2%).

Another significant aspect to consider when looking at the mental health and wellbeing of older people, relates to loneliness and social isolation, research shows that loneliness impacts upon mental and physical health. In the Adult Social Care Users survey, individuals are asked if they have as much social contact as they would like. Compared to England a significantly higher proportion of adult social care users in Worcestershire reported having as much social contact as they would like at 49.7% vs 45.4%.

Evidence and Further Information

This section provides a variety of evidence and further information that relates to older people's mental health and well-being.

NHS: Adult Improving Access to Psychological Therapies programme: Older people: a web page providing an overview of the specific consideration which should be given to the

[183] Public Health England (2019) Indicator Descriptions and Supporting Information – Self Reported well-being – High happiness score, Available from: https://fingertips.phe.org.uk/search/happiness%20score#page/6/gid/1/pat/6/par/E12000005/ati/102/are/E10000034/iid/92617/age/164/sex/4 , Accessed: 06.02.2019

provision of IAPT services for older adults, including a range of links to specific older adults practice guidance.

NICE guidance: Dementia, disability and frailty in later life: mid-life approaches to delay or prevent onset: guideline covering mid-life approaches to delay or prevent the onset of dementia, disability and frailty in later life. It aims to increase the amount of time that people can be independent, healthy and active in later life.

NICE: Older People: Independence and mental wellbeing: covers the commissioning of services by local government and other local providers to help promote and protect mental wellbeing and independence of older people.

NICE: Mental wellbeing of older people in care homes: this quality standard covers the mental wellbeing of older people (65 years and over) receiving care in all care home settings, including residential and nursing accommodation, day care and respite care.

NICE: Older people with social care needs and multiple long-term conditions: guideline covering planning and delivering social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services.

PHE: Changing risk behaviours and promoting cognitive health in older adults: summary of reviews supporting the commissioning of interventions across a range of health behaviours for older adults.

PHE: Mental health promotion return on investment tool: includes information on interventions that address loneliness to protect the mental health of older people.

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Glossary of Terms

Agoraphobia

Characterised by fear or avoidance of specific situations or activities that the person fears will trigger panic-like symptoms, or be difficult or embarrassing to escape from, or where help may not be available. Specific feared situations can include leaving the house, being in open or crowded places, or using public transport.

Anxiolytics

Drugs used in the treatment of anxiety.

Bipolar Disorder

People with bipolar disorder have periods or episodes of: depression – feeling very low and lethargic and mania – feeling very high and overactive (less severe mania is known as hypomania). Symptoms of bipolar disorder depend on which mood someone is experiencing. Unlike simple mood swings, each extreme episode of bipolar disorder can last for several weeks (or even longer), and some people may not experience a "normal" mood very often.

Biopsychosocial Care

Biopsychosocial Care recognises “the importance of biological factors, psychological factors and social factors”.

Cognitive Behavioural Therapy (CBT)

CBT is a therapy based on the concept that thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap people in a vicious cycle. People are shown how to change these negative patterns to improve the way they feel. CBT aims to help people deal with overwhelming problems in a more positive way by breaking them down into smaller parts and unlike some other treatments, deals with someone's current problems, rather than focusing on issues from their past. It looks for practical ways to improve someone's state of mind on a daily basis.

Confidence Interval (95% CI)

When making inferences from a sample to a population this represents the range of values within which (usually) we are 95% confident the true value is likely to lie. It is a measure of the uncertainty around the estimate or the precision of the estimate. When confidence intervals do not overlap it can be said that there is a statistically significant difference between values.

Depression

A mental health problem characterised by persistent low mood and a loss of interest and enjoyment in ordinary things. A range of emotional, physical and behavioural symptoms are likely such as 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.

Generalised Anxiety Disorder (GAD)

An anxiety disorder characterised by excessive worry about many different things and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep. Condition specific NICE guidance is available.

Health Anxiety (Hypochondriasis)

A central feature is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem. Normal or commonplace physical symptoms are often interpreted as abnormal and distressing, or as indicators of serious illness.

Hypnotics

Drugs used in the treatment of insomnia.

Incidence

The number of new cases of a disease during a defined time period.

Social Anxiety Disorder (social phobia)

A persistent and overwhelming fear of a social situation, such as shopping or speaking on the phone which impacts on a person's ability to function effectively in aspects of their daily life. People with social anxiety will fear doing or saying something that will lead to being judged by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress. Condition specific NICE guidance is available.

Social Prescribing

A form of prescribing to community resources such as volunteering opportunities, physical activity programmes and befriending services.

Obsessive-compulsive disorder (OCD)

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 both9. Condition specific NICE guidance is available.

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.

Personality Disorders

Conditions in which an individual differs significantly from an average person in terms of how they think, perceive, feel or relate to others.

Post-traumatic Stress Disorder (PTSD)

A set of psychological and physical problems that can develop in response to threatening or distressing events, such as physical, sexual or emotional abuse, severe accidents, disasters and military action. Typical features of PTSD include repeated and intrusive distressing memories that can cause a feeling of 'reliving or re-experiencing' the trauma. PTSD is often comorbid with other mental health conditions such as depression11. Condition specific NICE guidance is available.

Prevalence

The proportion of individuals with a disease at a given time or over a defined time period.

Psychosis

Psychosis is a mental health problem that causes people to perceive or interpret reality differently from those around them. Sufferers may experience hallucinations or delusions.

Self-efficacy

An individual's belief in his or her innate ability to achieve goals; with increased self-efficacy, individuals have greater confidence in their ability and thus are more likely to engage in healthy behaviours.

Schizophrenia

Doctors often describe schizophrenia as a type of psychosis. This means the person may not always be able to distinguish their own thoughts and ideas from reality. Symptoms of schizophrenia include: hallucinations – hearing or seeing things that don't exist, delusions – unusual beliefs not based on reality, muddled thoughts based on hallucinations or delusions, and changes in behaviour.

Statistically Significant

There is sufficient evidence at a certain level to reject the null hypothesis (that there is no difference between values). The level chosen is usually a 5% probability that the null hypothesis is falsely rejected (or $P<0.05$). See also Confidence Interval.

Stepped Model of Care/Stepped Care Model

The most effective but least resource intensive form of support is provided in the first instance.

Specific Phobia

An overwhelming and debilitating fear of an object, place, situation, feeling or animal. This can include a fear of heights, flying, particular animals, seeing blood or receiving an injection. Phobias can have a significant impact on day to day life and cause significant distress.