

Mental Health in Leicester: A Joint Specific Needs Assessment

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Contents

Executive Summary.....	3
Key Findings and Recommendations	4
Introduction	18
Leicester Population	29
Policy Background.....	39
Mental health promotion	53
Perinatal maternal mental health.....	62
Child and adolescent mental health	70
Student mental health and wellbeing.....	91
Mental health of working age adults.....	99
Mental health of older people.....	131
Equalities and mental health	138
Suicide	169
Offenders	178
Dual diagnosis	184
Thematic Index.....	191
Appendices.....	194
References	207

Executive Summary

Mental illness is the largest single cause of disability in the UK. Leicester has high rates of risk factors associated with mental illness, improving rates of diagnosed mental health problems. The rate of emergency care use for mental illness is high, but recovery is poor. The rate of death from suicide and undetermined injury is stable, but higher than the England average. Whilst most mental illness is treated in primary care, most commissioning focuses on secondary care. In addition to improving secondary care commissioners should meet mental health need, and establish parity of esteem with physical health, by developing the capacity and capability of non-specialist resources.

Mental health promotion	Mental health is everyone's business. Policies to improve the economy, education, environment and transport, as well as health and social care, can contribute to mental wellbeing. 5 Ways to Wellbeing is an important initiative. More investment is needed for mental health promotion.
Perinatal maternal mental health	Moderate to severe depressive perinatal maternal mental illness affects 150-250 women in Leicester each year. Resources available to help women include universal and specialist outreach services. The closest in-patient mother and baby unit for perinatal mental illness is in Nottingham. Better use of universal services will help women and families.
Children and adolescents	Most mental illness results from childhood experience. 3,500-5,000 children have mental illness in Leicester each year. Statutory and voluntary providers work with specialist CAMHS. Protecting childhood mental health now will sustain future mental wellbeing. Commissioners should to develop joint frameworks to ensure better use of non-specialist resources. Services should target the vulnerable; those in deprived areas and looked after children.
Students	There are 35,000 students in Leicester. Mental illness can negatively impact on study and have long term effects. Universities offer specialist mental health support and counselling. Local GPs, IAPT, PIER team and the voluntary sector offer support. Strategic support is required to develop student mental health services.
Working age adults	A GP with 2,000 patients would expect to treat 50 people with depression, 10 people with a serious mental illness, 180 people with anxiety disorders and a further 180 or so with milder degrees of depression and anxiety. Adult mental health care is based on a stepped care model and includes Open Mind IAPT, Community Mental Health, Access and Complex Care Services. Voluntary and Community Sector organisations provide essential support. Commissioners should develop services in primary care and the community to sustain mental wellbeing and to support people with mental illness. Commissioners should work with service providers and other partners, such as the Police and voluntary sector to develop crisis care provision.
Older People	As people live longer so mental illness in old age is becoming more of a problem. Depression is the most common mental disorder in later life, affecting 3,000-4,500 older people in Leicester; Schizophrenia affects about 1% of the older population. Dementia, delirium and substance misuse are also linked with poor mental health in older people. Mental illness in old age is affected by deprivation, bereavement, isolation and physical illness.
Equalities	Mental illness disproportionately affects minorities, but these groups have difficulty accessing appropriate care. Although services, such as Assist, Inclusion Healthcare and Open Mind IAPT have improved treatment for minorities, more services are needed to sustain mental wellbeing, improve access to specialist therapy and reduce Mental Health Act detentions. Commissioning must also meet the needs of those with learning disability, veterans and carers.
Suicide	In Leicester about 32 people take their own lives each year; the second highest rate in England. Most deaths are from hanging or overdose. Most at risk are males aged 35-54. There is a need for real time surveillance of information to enable better review and response to suicide.
Offenders	Prisoners and offenders have high rates of mental illness compared with the general population. IAPT and the Probation Trust work together to provide better access to mental health care. Local and specialist commissioners should learn from this model, to work together to improve mental healthcare for prisoners and offenders.
Dual Diagnosis	There is an association between mental illness and substance misuse. Mental health services should take the lead in treating people with dual diagnosis.

Key Findings and Recommendations

The aim of this section is to present the key findings and recommendations from each chapter in the Joint Specific Needs Assessment (JSpNA). The JSpNA on mental health in Leicester is an evidence based resource for local policy makers, providers and commissioners. It identifies key issues and, rather than providing an action plan, it sets the agenda for improving local mental health and wellbeing.

The findings and recommendations suggested in the JSpNA aim to increase individual and community resilience to protect against mental illness and to increase individuals' control over their own lives. They offer suggestions which may help to integrate mental health and social care, driving forward improvements across Leicester. In addition to information about health and social care, the report touches on employment, accommodation, education, and transport for the purpose of sustaining population mental health. The recommendations emphasise the importance of mental health service users and carers in the development of high quality mental health services.

Key Findings

Mental health in Leicester

Although a range of national and local health and social care policies have a bearing on mental health and wellbeing, some other policies will have a positive impact too, such as the Leicester City Mayor's Delivery Plan. It is important therefore that commissioners use every strategic opportunity to link mental health and wellbeing to cross-cutting initiatives (**Recommendation 1.1; 1.2**).

When people experience mental illness they should have timely access to the right treatment, be treated with respect, have their views and preferences valued. In 2008 local commissioning and provider organisations signed a commitment to the Charter for Mental Health, a clear set of statements for service users and carers about what they can expect from local mental health services in Leicester, Leicestershire and Rutland (LLR). Organisations in the new commissioning and provider landscape should confirm their commitment to renew and endorse the spirit of the original Charter (**Recommendation 1.3**).

There is a stepped care approach to mental health, in which services should be accessed appropriately for the greatest health gain. Most people with mental health problems are self-caring; they attend schools, colleges, university or work, sometimes they may receive social care or primary health care. However, most commissioning focuses on more specialist level services, which are needed by fewer service users. Therefore, there is a need to ensure that mental health and social care improves the capacity and capability of universal services to address less complex mental health needs, as well as improving specialist services (**Recommendation 1.4**).

Mental health commissioning cuts across different organisations, including the Clinical Commissioning Group, Local Authority, NHS England and the Police and Crime Commissioner. Commissioners should work to ensure that provision for mental health across the life course is contiguous, that the different organisations do not commission work in isolation (**Recommendation 1.5**).

Poor mental health is linked to poor lifestyle choices and increased risk taking behaviour, such as smoking, drinking and drug taking, higher risk sexual behaviour, lack of exercise, poor diet and obesity. These are associated with excess early mortality for people with mental illness, emphasising the need of parity of esteem between mental and physical health care (**Recommendation 1.6**).

Risk factors for poor mental health are high in Leicester. Most ward areas experience deprivation. Mental illness is higher in the most deprived areas, with recorded depression being significantly higher in Aylestone, Braunstone Park and Rowley fields, Eyres Monsell, Freeman and Humberstone and Hamilton. However, recorded depression is lower in Belgrave, Castle, Coleman, Latimer, Rushey Mead, Spinney Hills, and Stoneygate ward areas. These areas have similar rates of deprivation, but are characterised by a higher proportion of residents from black and minority ethnic (BME) communities **(Recommendation 1.7)**.

Deprivation may be worsened by the impact of the economic recession. Welfare benefits changes are likely to have a negative impact on service users and providers. Many claimants, who are service users, may lose their entitlement to benefit and service providers may no longer have adequate resources to meet increased need **(Recommendation 1.8)**.

Local strategies from the Health and Wellbeing Board and the Clinical Commissioning Group emphasise the importance of improved mental health and mental health care. Just as *No health without Mental Health* is a cross-cutting strategy, linked to other policies, local commissioners should consider that improved mental health and wellbeing relies on a broad strategic approach and a range of resources not just restricted to mental health service provision **(Recommendation 1.1)**. The commissioning landscape is still evolving, for instance there are important changes in the criminal justice system, with commissioning to prisons and for offenders in the community linked to transformed probation services, NHS England and the Police and Crime Commissioner **(Recommendation 1.5)**.

Better Care Together and the LLR 5-year strategy both call attention to the links between mental health and the health and social care economy. 5-year strategy workshops suggested at least 6 problems related to mental health. These are low levels of screening and prevention; lack of systematic detection and risk assessment in primary care; poor information sharing and communication; misinformation regarding care pathways; lack of enhanced recovery pathways/early discharge and anticipatory care; and lack of stratified risk pathways for patient-led post treatment care. Better Care Together focuses on 3 key priorities for improving mental health care; prevention and early intervention, an integrated approach to primary and secondary care, better crisis care. The strategy accepts the need to use the JSNA process to underpin these improvements **(Recommendation 1.9)**.

Mental Health Promotion

Promoting mental health carries significant social, economic and health benefits, including preventing mental ill health and improving mental and physical health and wellbeing. Although resources are available in adjacent systems which have an impact on health, there is a need for specific funding for mental health promotion **(Recommendation 1.17)**.

Mental wellbeing is integral to health; it is connected to physical health and behaviour. Obesity disproportionately affects people with mental illness, learning and physical disability. Antipsychotic medication can cause significant weight gain, dyslipidaemia and diabetes. People with serious mental illness are less likely to exercise. Regular physical activity is associated with improved mental wellbeing and lower rates of depression and anxiety. Public Health Guidance makes recommendations for community engagement with the most vulnerable as a way of improving health and wellbeing and tackling health inequalities **(Recommendation 1.11)**.

The World Health Organisation, the Foresight Report and the Report of the Chief Medical Officer 2013 each consider the challenges to mental health and wellbeing. They highlight a number of signposts for action, including improved diagnosis and treatment, addressing stigma and discrimination, targeting risk factors and strengthening protective factors (**Recommendation 1.13; 1.14**).

One way in which commissioners and providers may help to improve population mental health is through the Five Ways to Wellbeing. These are a set of actions which individuals can do in their everyday lives, namely: Connect, Be Active, Take Notice, Keep Learning and Give. Culture and creativity can protect mental wellbeing, and there are many resources available to communities, such as libraries and neighbourhood centres which can act as hubs for this work. Arts in mental health projects may help individuals and populations at risk to sustain their mental wellbeing (**Recommendation 1.14; 1.15**).

Paid work is important for wellbeing and financial security. Many people who require some support to get into work, especially those with mental health problems, have difficulties getting employment support. Employment and mental wellbeing have a reciprocal connection. People with mental health problems are less likely to be in paid employment, and people who are unemployed are more likely to develop depression or other mental disorders (**Recommendation 1.10; 1.12; 1.16**).

Perinatal Maternal Mental Health

Perinatal maternal mental health has an impact on the health and wellbeing of women, children and families. The incidence of some conditions, such as anxiety, may not be significantly different in the perinatal period to that of the general population. However, perinatal obsessive compulsive disorder and puerperal psychosis are specifically associated with pregnancy and childbirth. Women with no history of mental illness may experience it for the first time during the perinatal period. Others may have a pre-existing condition which recurs or persists, or may have experience of previous trauma which hampers their wellbeing. The severe impact of such conditions emphasises the need to protect women and families against them (**Recommendation 2.2**).

Many women with postnatal depression had experienced depressive symptoms during pregnancy, and could have been identified earlier. Better antenatal detection of depression offers an opportunity for earlier intervention. Primary care has a role to play in facilitating better detection of depression. Adult mental health services should counsel women with serious affective disorders about the reciprocal effects of pregnancy, mental illness and medication (**Recommendation 2.6**).

Healthcare professionals (midwives, obstetricians, health visitors and GPs) should screen women for experience of past or present severe mental illness, previous treatment by a psychiatrist/specialist mental health team. They should use assessment tools such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire 9 (PHQ9). Public health is well placed to ensure that the development of the Health visitor service can have a positive impact on the mental health of women and families (**Recommendation 2.10**).

Although perinatal mental illness can affect all women, having a first-degree relative affected by mental illness is an added risk factor. Socio-economic factors can increase the risk of mental illness or exacerbate its effects. Rates of perinatal depression are higher amongst women experiencing poverty or social exclusion, and the risk of depression is twice as high amongst teenage mothers. The stress caused by issues such as poor housing, domestic violence and poverty can exacerbate symptoms of anxiety and depression.

If there are 5,000 births in Leicester in a year, then commissioners should expect at least 10 cases of post-partum psychosis; 10 cases of chronic serious mental illness; 150 cases of severe depressive mental illness; 500-750 cases mild-moderate depressive illness/anxiety; 150-250 cases of post-traumatic stress disorder and 750-1,500 cases of adjustment disorders and distress. Given the wider context of mental wellbeing, commissioners should develop a broad strategic response which ensures capacity for high quality perinatal mental health care in Leicester **(Recommendation 2.1)**.

Research shows that training community midwives and health visitors in psychological approaches can have a protective effect on women in the antenatal and postnatal periods. Better use of all available resources may help to improve collaboration between primary care, obstetricians, midwives and health visitors and specialist mental health services **(Recommendation 2.7)**.

The Leicestershire Perinatal Psychiatry inpatient service did not meet Royal College of Psychiatry and NICE guidelines, and has recently closed. Women who require inpatient care should be treated in a mother and baby unit which is accredited by the Royal College of Psychiatrists' quality network for perinatal services, possibly in Nottingham **(Recommendation 2.2; 2.3; 2.4)**, to ensure that they are not admitted on to a general adult mental health admission ward **(Recommendation 2.5)**.

Community care for women with perinatal mental illness in Leicester should be integrated to cover all levels of severity of mental illness, possibly with the development of a perinatal care outreach team and more capacity in primary care **(Recommendation 2.8; 2.9)**. This integrated practice should include regular links with the regional clinical network for perinatal maternal mental health.

Child and adolescent mental health

Most lifelong mental illness is acquired before the age of 14. Treatment of mental illness and resilience to future mental illness in Leicester largely depends on commissioners and policy makers planning to protect the health and wellbeing of children and families. This requires a system wide approach, with frameworks for integrated care. A coherent integrated service will only be achieved through effective joint commissioning, and a better understanding of the factors which impact on childhood mental illness.

Available resources include services for children and young people, families, Clinical Commissioning Groups, local authorities, health care professionals, voluntary sector organisations, schools and educational psychology **(Recommendation 3.1; 3.5)**.

The Annual Report of the Chief Medical Officer 2012 defined children and young people as those who are aged up to 25 years. The rationale for this primarily concerns the continuation of emotional development of young people into their early 20s. However, it also relates to the difficulty adolescents have in accessing adult services. Commissioners should therefore work together to ensure that service provision fits with emerging national initiatives around the care of young people to age 25 **(Recommendation 3.2)**. Learning about how to develop such services may be gained from the PIER team, which provides service for people aged 14-35 years.

Mental health disorders and difficulties encountered during childhood and the teenage years include: Attention deficit hyperactivity disorder (ADHD); anxiety disorders ranging from simple phobias to social anxiety; Post-traumatic stress disorder (PTSD); autism and Asperger syndrome (the Autism Spectrum Disorders, or ASD); behavioural problems; bullying; depression; eating disorders (including anorexia nervosa and bulimia); obsessive compulsive disorder (OCD); psychotic disorders, in particular schizophrenia; and substance abuse.

Good childhood mental health depends on many factors, such as having good physical health, eating a balanced diet and regular exercise. Children need time to play indoors and outdoors, they need to be part of a family that gets along well most of the time, to attend a school concerned with pupil wellbeing and to take part in activities for young people.

Mental health problems are higher among children who experience poverty, low educational attainment, domestic violence and bullying. Childhood poverty is higher in ward areas such as Spinney Hills, New Parks, Braunstone Park and Rowley fields, Stoneygate and Charnwood.

Mental health problems are also higher among children who do not engage in activities which protect mental health, such as exercise and eating a balanced diet. Public health is well placed to work with schools and relevant services to build on efforts to increase child participation in physical activity and to promote healthy lifestyles (**Recommendation 3.4**). This may be done, for instance, by increasing health visitor and school nurse numbers and developing them to be better equipped to meet mental health needs. It may also be done by using initiatives, such as the Early Help and Prevention Offer and THINK family, as leverage to co-ordinate services for children and families who are at risk of poor emotional health and wellbeing.

One way of organising prevention services to meet the needs of children is to use the principle of proportionate universalism, with greater resources targeted at the ward areas with greater disadvantage (**Recommendation 3.6**).

In Leicester between 3,500 and 5,250 children have a mental health problem. There are higher risks of poor mental health in Looked after Children, there are about 520 such children in Leicester. 9-10% women and 5-6% of men will be parents with a mental health problem, equivalent to 9,700 women and 6,400 men in Leicester and 25% of children aged 5-16 years have mothers at risk of common mental health problems, equivalent to 12,000 children in Leicester.

Child and Adolescent Mental Health Services (CAMHS) in Leicester are organised in tiers. Universal health care services and services adjacent to health care, such as schools, all have a part to play in protecting mental health. Health visitors and school nurses are well placed to prevent escalation of mental illness and to ensure that children and young people join mental health pathways at the appropriate tier, when necessary (**Recommendation 3.3**). Specialist services care for children with severe and enduring mental illness. They improve access to psychological therapy for children, support victims of abuse and those who have been bereaved, and can improve parenting skills.

Student Mental Health

There are 2 universities in Leicester which contribute to the economic and cultural life of the city. There are 20,000 students at DMU, 10.5% from outside the EU and 15,000 from University of Leicester, 27% are non-EU residents.

Whilst education is generally protective against mental illness the stresses associated with attending university can precipitate mental distress and may cause a relapse into poor mental health. This occurs at a time of challenge as young people progress from adolescence into adulthood, when there is a high risk of developing serious mental illness.

Young adults entering Higher Education have additional challenges as a consequence of moving away from home, having autonomy and responsibility, living communally in halls of residence or shared housing, developing new social relationships, financial pressures and balancing academic work and part-time paid work.

Often health care is not a high priority for students. They are less likely, for example, to register with a general practice and may use the emergency department for non-emergency care. Students may be reluctant to admit a mental health problem, because it may impact on their academic work. Underachievement or failure at this stage can have long-term effects on self-esteem, employment, debt and progression through life. Tutors may not feel equipped to deal with the mental health problems of their students **(Recommendation 4.2)**.

A student may feel that referral to secondary mental health care may have a negative impact on their ability to study, reach their full potential and graduate. Furthermore, as students are a transient population, with the academic year being 35 weeks, actually accessing secondary care may be a problem **(Recommendation 4.3)**.

Universities in Leicester offer specialist mental health support. There are counselling services to support students with their academic studies. Local general practices at Victoria Park Health Centre and De Montfort Surgery are central to student health care **(Recommendation 4.4)**. The Open Mind IAPT service provides regular support to students in Leicester. As some students experience severe mental ill-health, often because they have not accessed timely support, the Crisis Team and the Emergency Department are important points of care. There is a need therefore to develop strategies to understand the role of specialist student mental health services, to enable students to gain appropriate access to mental health services and to investigate how University counselling services fit in the stepped care model **(Recommendation 4.1; 4.5)**.

Mental health of working age adults

Prevalence rates from national surveys show 16-18% of working age adults may experience a common mental health problem at any time. Applied to the 2011 Census population of Leicester aged 18-64 years, this equates to somewhere between 34,000 and 38,000 people. Half of adults with mental health problems have symptoms severe enough to require treatment. Common mental health problems are more frequent among females than males (19.7% and 12.5% respectively). The estimated number of people in Leicester with serious and enduring mental illnesses, such as schizophrenia, bipolar affective disorder and other psychosis, is about 3,400 people.

In Leicester rates of diagnosed depression are improving, there are higher than average rates of hospital admission for mental illness and worse than average outcomes. Commissioners should continue to work to improve diagnosis of mental health problems, tackling issues such as stigma and assigning parity of esteem to mental and physical health **(Recommendation 5.5; 5.6)**.

Adult mental health services are organised according to a stepped care model. More than 90% of people with mental health problems are managed entirely in primary care. General practice is also the main point of referral to other parts of the pathway, which includes the Improving Access to Psychological Therapies Service (IAPT), Mental Health Facilitators, and Community Mental Health Teams, Liaison Psychiatry and Access and Complex Care services.

Commissioners should focus on preventing mental illness from worsening and enabling earlier access to appropriate care. This means improving the capacity and capability of resources in primary care. There is an opportunity to do this, using the proximity of Clinical Commissioning Groups (CCGs) to local problems to develop an integrated approach to mental illness, inclusive of statutory and voluntary sector organisations **(Recommendation 5.4)**. CCG commissioners should work with service providers, users and carers to develop the recovery model of care, for instance through the Recovery College **(recommendation 5.3)**.

Some people with a mental health crisis are treated out of area. Commissioners should work with service users (**Recommendation 5.1**) and providers from all sectors to improve crisis response to mental illness. This should include models of care to meet acute mental health need, such as the crisis house (**Recommendation 5.2**).

Mental health of older people

As people live longer so protecting the mental health and wellbeing of older people will become more of a problem. Depression is the most common mental disorder in later life, affecting 3,000-4,500 older people in Leicester. Schizophrenia affects about 1% of the older population; equating to about 400 people aged over 65 years in Leicester. Dementia, delirium and substance misuse are also linked with poor mental health in older people. Mental illness in old age is affected by deprivation, bereavement, isolation and physical illness. There is a need to meet the combination of mental and physical health problems where they co-exist in older people (**Recommendation 6.3**

Mental health services for older people in Leicester should be commissioned on the basis of need (**Recommendation 6.1**) rather than focusing specifically on age or disease. Although there is an integrated approach between health, social care and voluntary and community sector services this needs to be improved to ensure that mental health needs of older people are addressed as early and effectively as possible, including access to crisis services, psychiatric liaison in the Emergency Department and routes for safe discharge into the community (**Recommendation 6.2; 6.4; 6.5; 6.6**).

Equalities and mental health

Mental illness disproportionately impacts on people from minority groups, whilst these groups have difficulty accessing appropriate services.

Leicester has a diverse population compared with England as a whole; 50% of Leicester residents are from BME backgrounds compared with only 13% in England overall. 37.1% of people in Leicester are of South Asian ethnic backgrounds, 6.2% are Black/British, 3.5% mixed and 2.6% from other ethnic origins. The age profile of Leicester's BME population is relatively younger than the White/White British population.

There are cultural differences in how mental illness is perceived across different communities; this may impact on access to, and experience of, statutory services. The issues vary widely between and within BME groups by factors like age and gender. This means that there is no single 'BME mental health problem'. Those affected may range from a person whose first language has no word to describe depression through to a person who has no trust of statutory services.

Recent data shows that there has been some progress in meeting mental health needs of people from BME communities, but inequalities still persist. For instance, evidence has consistently shown an over representation of people from Black/Black British and White/White British ethnic backgrounds among those Leicester residents who were detained under provision of the Mental Health Act.

With regard to access to specialist cognitive behavioural therapy in 2013/14 there was an over representation of people from White/White British backgrounds, an under representation of people from Asian/Asian British ethnic and people from Black/Black British ethnic backgrounds. IAPT services showed in 2013/14 a slight under representation of people from Asian/Asian British ethnic backgrounds, but no difference for those from White/White British or Black/Black British ethnic backgrounds.

Leicester is the dispersal centre for 800 asylum seekers. Mental illness is more prevalent among asylum seekers and refugees than the population generally. A number of factors have a detrimental impact on the mental health of asylum seekers and refugees, for instance experiences in their country of origin, the journey to the UK and the process of claiming asylum have an impact on the mental health of this group. Commissioners need to establish effective multi-agency working through the local New Arrivals Strategy Group **(Recommendation 7.8; 7.9)**.

It is likely that the LGBT community comprises 2-2.5% of the general population, somewhere between 6,000-7,500 people. Compared to the population generally LGBT people have greater detrimental exposure to the wider determinants of health, poorer experiences of hospital and residential care, poorer access to health and social care provision and are particularly subject to stigmatisation, discrimination and insensitivity. LGBT people have higher rates of poor mental health. There is a need to develop specialist care for transgender people **(Recommendation 7.3)**. Commissioners should work with statutory and voluntary sector providers to address issues of access and outcome for people from minority communities **(Recommendation 7.1; 7.2)**.

The carers' needs assessment showed that in Leicester there are an estimated 30,000 carers. While not all need formal support, there is a large gap between need and service provision. For instance there are more recipients of adult social care than those with recorded carers' assessments. There is inconsistent recording of carers on general practice registers. There are 249 young carers known to social care services, but the census indicates that there are 4 to 5 times as many young carers in Leicester. There is a need for commissioners of mental health and social care to work with colleagues and key stakeholders to improve the mental health care of carers **(Recommendation 7.4)**.

When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. The duty of care owed to service personnel can be found in the armed forces covenant. All veterans are entitled to priority access to NHS hospital care for any condition as long as it's related to their service, regardless of whether or not they receive a war pension. Veterans are encouraged to tell their GP about their veteran status in order to benefit from priority treatment. A minority of people leaving the armed forces need access to mental health services, while others might require it later in civilian life. Post-traumatic stress disorder, stress and anxiety are problems commonly experienced by veterans. Commissioners should ensure that the mental health care of veterans is commensurate with the obligations under the armed forces covenant **(Recommendation 7.5)**.

Mental illness is more common among homeless people. Serious mental illness is present in 25-30% of those people who are sleeping rough or in hostels. There is a need for commissioners to work in partnership with the Homelessness Strategy Group to develop specialist homelessness services and to ensure that the health and social care needs of homeless people are a considered holistically **(Recommendation 7.10)**.

People with learning disabilities are amongst the most vulnerable members of society. They have a wide range of social and health care needs, and they may have coexisting conditions which contribute to need, such as physical or developmental disabilities, mental and physical ill-health and a range of behavioural problems. It is often the presence of these conditions that defines need for services. They also have needs which occur as a result of social exclusion, such as poverty, unemployment and lack of adequate accommodation. Health and social care commissioners should work together to consider the mental health of people with learning disabilities, when developing frameworks and care pathways. In addition, they need to work together to implement the findings

of the Winterbourne View Concordat which resulted from the report into the emotional and physical abuse of people at Winterbourne View Hospital (**Recommendation 7.6; 7.7**).

Suicide

The rate of death from suicide includes deaths from self-inflicted injury and deaths for which the cause was undetermined. Cases are decided by the coroner. From a medical and mental health perspective some verdicts, including open and misadventure, may have been viewed as suicide. Coroners' verdicts are often 18 months after a death has occurred, there is a need therefore for real time surveillance to ensure that key learning from incidents are shared in a timely fashion (**Recommendation 8.1**).

Evidence suggests that the act of a person taking their own life is often impulsive and dependent on different factors, in addition to mental illness, such as the presence of a physically disabling or painful illness; alcohol and drug misuse; deprivation and the level of support that a person receives. Stressful life events such as the loss of a job, imprisonment, a death or divorce may also play a significant part. For many of those who take their own life it is the combination of factors which may be important. There is a need therefore to raise awareness of the issue of suicide and to audit and learn from cases where people have taken their own lives (**Recommendation 8.2; 8.6**). Each case is a tragedy for individuals, their families, friends and colleagues. There is a need to support those who are bereaved by a case of suicide (**Recommendation 8.5**).

In Leicester, on average, approximately 32 people take their own lives each year. The rate for suicides is calculated on a 3 year rolling average. In the period 2010-2012 there were 96 deaths from suicide and undetermined injury in Leicester, giving a rate of 10 per 100,000. As there are a small number of suicides each year in Leicester, an increase or reduction in the numbers can result in a large change in the rate. Furthermore, as deaths from suicide and undetermined injury disproportionately affect younger people, it is a cause for a high proportion of years of life lost. Most deaths occur as a result of hanging or overdose; most occur in a person's own home. The rate is higher among males.

The incidence of self-harm is different, in that it occurs equally among males and females and the population affected is generally younger. Commissioners should ensure that the current guidance on self-harm is being implemented by key stakeholders (**Recommendation 8.3; 8.4**).

Offenders

The commissioning architecture for the mental health of prisoners and offenders is complex, and includes local health and social care bodies, NHS England and the Police and Crime Commissioner. This requires greater monitoring and collaboration when developing the mental health care pathway for prisoners and offenders (**Recommendation 9.2; 9.3**).

Approximately 90% of prisoners have a psychotic, a neurotic or a personality disorder or suffer with a substance misuse problem which impacts on their mental health. Prisoners are also likely to have with more than one concurrent mental health problem, with remand prisoners more likely to suffer with multiple problems. As a Category B Local Prison for male prisoners, HMP Leicester has a large throughput of prisoners, including those on remand; this makes mental healthcare in the prison a major challenge.

Studies show a higher level of need for mental health services, and worse outcomes, for offenders in the community than in the general population. There is a need to develop improved care pathways

for offenders in the community and on release from prison, with particular focus upon health and social care services (**Recommendation 9.1**).

Initiatives to improve mental healthcare for prisoners and offenders include the development of mental health in-reach teams and the transfer of prison healthcare to the NHS. There has also been guidance on improving mental health provision for offenders in general and in particular to improve access to mental health services for 16 and 17 year olds, as people in this age group are responsible for the majority of youth crimes and for the more serious crimes. However, more work is needed to ensure that frameworks and accessible pathways are developed for prisoners and offenders (**Recommendation 9.4**).

Dual Diagnosis

The co-existing problems of mental ill health and substance misuse represent a difficult challenge for mental health services. Elements of care, such as diagnosis and treatment are difficult and service users represent high risk of relapse, readmission to hospital, self-harm and suicide. Substance misuse among people with mental health problems is usual rather than exceptional; treatment for substance misuse problems often improves mental health; and the healthcare costs of untreated people with dual diagnosis are likely to be higher than for those receiving treatment.

People with co-existing mental illness and substance misuse disorders have high rates of physical ill health. The provision of integrated care for people with a combination of mental health problems and substance misuse requires an effective links across health, social care, and the voluntary sector and criminal justice services.

People with dual diagnosis often receive sub-optimal care because of concerns about the need to treat either mental health or substance misuse. Whilst commissioners should ensure that all staff in mental health and substance misuse teams are trained and equipped to work with co-morbidly issues (**Recommendation 10.2**), governance frameworks should be developed to ensure that mental health teams take the lead in cases of dual diagnosis (**Recommendation 10.1; 10.3**).

Number	Commissioners are recommended to:	CCG	Local Authority	Other
Promoting Mental Health and Wellbeing				
1.1	Ensure that mental health and wellbeing is everybody's business	√	√	√
1.2	Link mental health promotion activity to all health and leisure activities	√	√	
1.3	Confirm commitment to renew, and endorse the spirit of, the Mental Health Charter	√	√	
1.4	Improve the capacity of education, workplaces and universal services to support people with mental health problems	√	√	
1.5	Recognise that services should be contiguous and ensure that they are not developed in isolation	√	√	√
1.6	Ensure that there is parity of esteem between mental and physical health care	√	√	√
1.7	Ensure equity of access to mental health care across all Leicester ward areas	√	√	√
1.8	Recognise the link between deprivation and mental illness, which has worsened with the recession and austerity	√	√	√
1.9	Note the similar themes in the 5 year strategy and the JSpNA on mental health in Leicester	√	√	
1.10	Make a commitment to mindful commissioning of services to	√	√	√

	protect mental health and challenge the stigma of mental illness in the workplace			
1.11	Use mental health promotion impact assessment tools to ensure strategies and initiatives do not produce unintended negative outcomes for mental health	√	√	√
1.12	Influence employers in Leicester to develop robust mental health in the workplace programmes and implement strategies to promote employment of people with mental health problems	√	√	
1.13	Promote anti stigma messages and support action to reduce discrimination	√	√	√
1.14	Ensure that mental health and wellbeing cuts across all local strategies, such as economic development, transport, arts and culture and the environment	√	√	
1.15	Support 5 Ways to Wellbeing	√	√	√
1.16	Support human interventions and case management as a way of helping people back to employment	√	√	√
1.17	Fund specific mental health promotion projects	√	√	
Perinatal Maternal Mental Health				
2.1	Develop a strategic response to perinatal maternal mental health across Leicester, Leicestershire and Rutland which ensures capacity for perinatal maternal mental health need in Leicester	√	√	√
2.2	Ensure that there is an integrated pathway for perinatal mental health in Leicester which covers all levels of service provision and severities of disorder and the mental health of other family members	√		√
2.3	Ensure that local perinatal maternal mental health service offers timely access to services compliant with NICE Guidance	√		√
2.4	Ensure mother and baby units for Leicester are accredited by the Royal College of Psychiatrists' quality network for perinatal services	√		√
2.5	Ensure all women requiring admission in late pregnancy or after delivery are admitted with their infant to a mother and baby unit not an adult mental health admission ward	√		√
2.6	Ensure adult mental health services counsel women with serious affective disorder about the effects of pregnancy on their condition and the possible effects of their medication on pregnancy	√		
2.7	Support additional training in perinatal mental health and the detection of at-risk patients for providers such as health visitors and midwives	√		
2.8	Create capacity in primary care to ensure that mental health promotion can be delivered effectively	√		
2.9	Develop a Perinatal Mental Health Outreach Team, including obstetricians, midwives, community, primary care staff, and the voluntary sector, to work across primary and secondary care to allow early identification and prevention of serious problems; plan care for antenatal period, labour, birth and the postnatal period.	√		
2.10	Support health visiting to identify women at risk of perinatal depressive illness		√	
Child and Adolescent Mental Health				
3.1	Adopt system wide thinking to ensure that key resources are identified and properly used to improve the health and wellbeing of children (including schools and voluntary sector organisations)	√	√	√
3.2	Recognise that support for young people extends beyond	√	√	√

	teenage years, and should include people up to age 25			
3.3	Commission a range of services to meet the needs of children, young people and parents, including more integrated work at Tier 1 and improved timely access to specialised services.	√	√	
3.4	Ensure all professionals involved in the identification of mental and emotional health receive training to improve the mental health care of children and young people.	√	√	
3.5	Work with schools and relevant services to build on efforts to increase child participation in physical activity and to promote healthy lifestyles			
3.6	Target prevention resources at ward areas with greater disadvantage	√	√	
Student Mental Health				
4.1	Develop strategic level contact with student welfare services to develop an integrated approach to student mental health in Leicester		√	
4.2	Recognise and develop the role of primary care mental health for students in Leicester, focusing on interested clinicians, social support and good liaison with secondary care services.		√	
4.3	Develop strategies to enable students to gain appropriate access to mental health services		√	
4.4	Investigate whether student mental health support and counselling services have any role to play in the stepped model of care for mental health		√	
4.5	Gain an understanding of how the specialist mental health teams in the universities work, and commission services which work in partnership with these services	√		
Working Age Adults				
5.1	Facilitate increased support for the involvement of service users and carers in the planning, development and delivery of mental health services	√	√	
5.2	Develop the crisis response, including a crisis house, to reduce the number of people with acute mental illness who are treated out of area	√	√	
5.3	Improve commitment to the recovery model; for instance by better support of the Recovery College	√	√	
5.4	Improve the capacity and capability of primary care teams to manage mental health problems as early as possible	√	√	
5.5	Improve timely diagnosis of mental illness	√	√	
5.6	Ensure that services offer non-stigmatising support for people with mental illness	√	√	√
5.7	Work towards delivering parity of esteem between mental and physical health	√	√	√
Mental Health of Older People				
6.1	Ensure mental health services are commissioned on the basis of need; recognise that the needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people	√	√	√
6.2	Develop an integrated approach between health, social care and voluntary and community sector services to ensure co-ordination between secondary and primary care and community services	√	√	
6.3	Meet the combination of mental and physical health problems which often co-exist in older people	√	√	
6.4	Develop a multi-disciplinary approach to older people's mental	√	√	

	health; including integrated input from nurses, psychologists, physiotherapists, occupational therapists and speech and language therapists when necessary			
6.5	Ensure older people have access to crisis services, with extended hours of working and intensive crisis management, home treatment workers help to reduce the need for admission, facilitate early discharge and reduce transfer to residential care	√	√	
6.6	Develop older person's psychiatric liaison expertise in University Hospitals Leicester	√	√	
Equalities and Mental Health				
7.1	Work with key stakeholders to address the needs of people in minority communities, and ensure that they have access to the appropriate level of care and better outcomes	√	√	
7.2	Integrate VCS organisations which represent minority communities into the care pathways	√	√	√
7.3	Develop specialist care for transgender people	√	√	√
7.4	Work with key stakeholders to improve the mental health and wellbeing of carers	√	√	
7.5	Ensure that the mental health care of veterans is commensurate with the obligations under the Armed Forces Covenant	√	√	√
7.6	Work together to consider the mental health of people with learning disabilities, when developing frameworks and care pathways	√	√	√
7.7	Work together for local implementation of the Winterbourne View Concordat	√	√	√
7.8	Establish effective multiagency partnership working, in particular integrating statutory mental health service providers with the local VCS groups involved in the care of asylum seekers	√	√	
7.9	Work with the New Arrivals Strategy Group to ensure that the health and social care needs of asylum seekers are included in local development plans and to promote understanding of the needs of asylum seekers	√	√	
7.10	Work in partnership with the Homelessness Strategy Group to develop specialist homelessness services and ensure that health and social care needs of homeless people are a considered holistically	√	√	
Suicide				
8.1	Work with key stakeholders to develop real time surveillance of information to enable better review and response to deaths from suicide	√	√	
8.2	Raise awareness about suicide and self-harm amongst the general public and professionals	√	√	
8.3	Support those who self-harm or who are affected by acts of self-harm	√	√	
8.4	Implement NICE guidelines on self-harm should be followed so that individuals who self-harm receive an assessment of need and access to relevant support	√	√	
8.5	Support people who are bereaved by suicide	√	√	
8.6	Audit local trends in order to inform local delivery and actions	√	√	
Offenders				
9.1	Develop improved care pathways for offenders in the community and on release from prison, with particular focus upon health and social care services which relate to mental health. This should include improved access and co-ordination with Probation Services and successor organisations	√	√	√

9.2	Initiate greater monitoring of services and arrangements for offenders with mental ill-health	√	√	√
9.3	Ensure that the mental health needs of offenders are considered and addressed by the main commissioning bodies	√	√	√
9.4	Develop accessible pathways into alcohol and drug treatment for offenders in the community, building on treatment which has been undertaken in prison	√	√	√
Dual Diagnosis				
10.1	Ensure that mental health teams take the lead in cases of dual diagnosis	√	√	√
10.2	Ensure that all staff in mental health and substance misuse teams are trained and equipped to work with dual diagnosis with appropriate support and supervision	√	√	√
10.3	Develop integrated governance, roles and responsibilities of the different agencies involved are defined by clear local protocols	√	√	√

Introduction

Background

This Joint Specific Needs Assessment (JSpNA) is an overview of mental health and wellbeing in Leicester. It is based on evidence from the literature about mental health, and feedback from local statutory and voluntary and community sector organisations. The views of service users and carers are reflected in evidence from the Service User and Carer Research and Audit Network (SUCRAN).

Mental health is everybody's business. Mental ill health is a major public health problem. The local Health and Wellbeing Strategy, *Closing the Gap*, and the Leicester City Clinical Commissioning Strategy, both focus on improving mental health in Leicester. They contribute to an agenda intended to integrate health and social care for people with mental health problems and promote mental wellbeing.

Policy initiatives which are not directly related to health can also contribute to sustaining wellbeing. For instance, by enhancing the cultural life of Leicester, protecting children's health, developing the local economy, community safety, transport, housing and leisure, the City Mayor's delivery plan can have a positive impact on mental health.

Poor mental health is both a contributor to and a consequence of wider health inequalities. It is associated with increased health-risk behaviours and increased morbidity and mortality from physical illness. This is partly because people with mental ill health engage in risk taking behaviour; there are high rates of smoking, drug and alcohol misuse and poor diet among people with mental illness. It is also because people with mental illness and a long term physical health condition often receive sub-optimal treatment for their physical illness. Stigma and discrimination lie at the root of these serious public health issues; to address them there is a need for parity of esteem between mental and physical health problems.

The majority of people with mental health problems are self-caring or cared for in primary care; only a small proportion of people require secondary mental health care and a smaller number require specialist mental health care. However, currently most resources are tied up in the provision of specialist inpatient services to the detriment of a range of services, across health and social care and the voluntary sector, which provide on-going support for people with mental illness.

The economic recession, has seen an increase in mental illness against the backdrop of increased pressure on the very resources which can protect mental health. Commissioners should be aware that voluntary and community sector (VCS) organisations provide formal and informal support, often acting as a 'safety valve' for pressurised statutory services. However, VCS organisations are often hampered by short term commissioning and a lack of understanding on the part of clinicians. In some cases there is a real danger that highly skilled and trusted voluntary sector providers will disappear, leaving gaps in care and exerting greater pressure still on all resources.

Most lifelong mental illness occurs as a result of childhood experience. Therefore, it is important for health and social care commissioners in Leicester to articulate a vision which shows how protecting the mental wellbeing of children today will protect the mental health and wellbeing of the city population in the future. Promoting good mental health in this way will have other benefits, such as improving physical health, life expectancy, positive educational and economic outcomes and reducing violence and crime.

When people are ill, they should have timely access to the right treatment, be treated with respect, have their views and preferences valued. With regard to this, in 2008 local commissioning and provider organisations signed a commitment to the *Charter for Mental Health*, a clear set of statements for service users and carers about what they can expect from local mental health services in Leicester, Leicestershire and Rutland.

Table1: Charter for mental health in Leicester, Leicestershire and Rutland

Charter for Mental Health in Leicester, Leicestershire and Rutland
Every person in Leicester, Leicestershire and Rutland has the right to mental health services that:
Make a positive difference to each person they serve
Stop doing things that are not working
Are guided by the individual's views about what they need and what helps them
Treat everyone as a capable citizen who can make choices and take control of their own life
Work with respect, dignity and compassion
Recognise that mental health services are only part of a person's recovery
Recognise, respect and support the role of carers, family and friends
Communicate with each person in the way that is right for them
Understand that each person has a unique culture, life experiences and values
Give people the information they need to make their own decisions and choices
Support their workers to do their jobs well
Challenge 'us and them' attitudes both with mental health services and in the wider society

This initiative was agreed at the highest levels by health and social care organisations in Leicester and was well received by service users. SUCRAN, conducted a study of the experiences and perceptions 123 service users through direct one to one interviews about the aspirations and impact of the Charter, which gives important insight into how services are viewed. The feedback was as follows, focusing in turn on each of the 12 commitments:

<p>Make a positive difference to each person they serve: Over 80% of respondents stated that the service they had received had made a positive difference, however almost 13% (not a lot / not at all), do not feel positive changes have resulted from the service they have received.</p>
<p>Stop doing things that are not working: Only 19% of respondents were less satisfied with treatment changes when they occurred.</p>
<p>Are guided by the individual's views about what they need and what helps them: These include education, employment, relationships, finance and physical health. In particular people did not have</p>

enough support with rebuilding relationships and assistance with employment.

Treat everyone as a capable citizen who can make choices and take control of their own life: More than 75% of respondents replied positively about taking control of their own lives.

Work with respect, dignity and compassion: 91% of participants suggested they were treated with respect, dignity and compassion.

Recognise that mental health services are only part of a person's recovery: Satisfaction with this was reflected in the responses to matching services with both wants and needs, which was a positive experience for 81% of respondents.

Recognise, respect and support the role of carers, family and friends: Service recognition of the role played by family and friends in supporting recovery was mixed. 25% felt there was no recognition or respect of familial support. 27% of service users had no staff assistance in building or rebuilding positive relationships with friends and family.

Communicate with each person in the way that is right for them: Positive answers suggested that 80% of respondents were encouraged to express feelings, and that for 82%, staff ensured that information was understood.

Understand that each person has a unique culture, life experiences and values: 85% of respondents felt they were treated as a whole person and given all the necessary information to make decisions, which was endorsed by 73% who felt they were able to use life skills, capitalise on them and develop new personal challenges.

Give people the information they need to make their own decisions and choices: 84% of respondents identified that they were "allowed" to make mistakes. Although the type and range of mistakes were not described, the positive responses suggest that "positive risk taking" is a feature of planned care for the majority of those who answered this question.

Support their workers to do their jobs well: Perceptions that staff seemed "happy in their jobs" were recorded by 82% of respondents. Perceived happiness assumes that the staff member is being supported to perform their role.

Challenge "us and them" attitudes both within mental health services and in the wider society. The phenomena of being stereotyped or labelled is a real issue for people with mental health problems, suffering discrimination and prejudice reduces life opportunities in wider society.

Key messages for commissioners

As a major document contributing to the strategic approach for health and wellbeing, this JSpNA offers key messages for health and social care commissioners, who should find opportunities to deliver a joint health and social care approach to mental health and wellbeing across all areas of health care. Future commissioning should focus on:

- protecting the mental health of children and young people
- prevention of mental illness and promoting wellbeing
- population mental health

- early intervention
- personalisation and social care

The aims of a joint approach to commissioning health and social care should be to develop system wide thinking, multi-agency provision of mental ill health services and ensure that mental wellbeing underpins traditional universal services. Services should be commissioned from a wide range of organisations delivering a broad spectrum of services across the city and, where necessary, across Leicester, Leicestershire and Rutland and the East Midlands.

The key messages for commissioners concerning the priorities for mental health care in Leicester are to:

Ensure that the health and social care agenda works together to prevent mental ill health across the life course and is inclusive of the voluntary and community sector
Establish a long term vision for mental health and wellbeing which focuses on protecting the mental health of children in Leicester
Address the determinants of inequality and ill-health through mental health promotion
Support the involvement of service users and carers in the planning, development and delivery of mental health services
Ensure that there are integrated care frameworks which cover all levels of service provision and severities of mental health disorder
Ensure that there is appropriate timely access to mental health care, including personalised care
Ensure that there is equity of outcome for people with mental health disorders
Address premature mortality for people with mental health problems by delivering parity of esteem between mental illness and physical illness
Promote recovery
Renew and implement the Charter for Mental Health in Leicester, Leicestershire and Rutland to improve the experience of service users and carers.

Models of service delivery

Services for people of all ages with mental health problems are provided by a number of agencies and partner organisations, working in collaboration across statutory, voluntary and community sectors. Both adult and children’s services follow what could loosely be called a stepped care approach, in which individuals have access to appropriate treatment at certain Steps or Tiers, which should provide health gain. People should step up if treatments do not result in significant health gain. More intensive treatments are generally reserved for people who may not benefit from simpler first-line treatments.

A generic model, such as that proposed by the Royal College of Psychiatrists, suggests that commissioning for mental health and wellbeing takes place across a number of levels, covering universal and targeted services.

- Level 0: Self-caring; people who have not sought help but are attending schools, colleges, universities and their workplaces
- Level 1: universal services for people accessing primary care and lower-level advice and support. This covers a range of issues including depression, anxiety, medically unexplained symptom and interventions to promote mental health and prevent mental illness

- Level 2: services for people recovering from severe mental illness
- Level 3: services for people receiving active treatment for severe mental illness, and those using medium/long-term care services
- Level 4: services for people using specialist, intensive medical or forensic services.

The Royal College suggests that most commissioning focuses on services at levels 3 and 4, whilst most people with mental illness are treated at levels 1-2. It is vital, therefore to ensure that commissioners of mental health and social care in Leicester improve the capacity and capability of level 1 and 2 services to meet mental health care needs, as well as improving services at levels 3 and 4.

Putting JSNA recommendations in place will require partnership working at all levels of care; for instance using voluntary and community sector resources, Children's Trusts and community development. It will also include initiatives, such as the Leicester Economic Action Plan and Homelessness Strategy. A greater focus on joint commissioning between Leicester City Clinical Commissioning Group and Leicester City Council, with a focus on developing voluntary sector organisations, will ensure integration and better outcomes.

The development of some specialist services requires collaboration across the county and region. This will make the best use of resources and enhance patient pathways for acute and serious and enduring mental illness. Working in this way will maximise procurement efficiencies and strengthen contracting and performance, as long as commissioners consider the connections between services.

The formation of Leicester City Clinical Commissioning Group should be an opportunity for general practices to use their experience and proximity to patient care issues to develop local services to meet local needs. In doing this they should link with Leicester City Council and NHS England commissioners to deliver personalised care, enhance mental health in primary care and ensure integration with very specialist services. Some other commissioning organisations may also be involved, such as the Police and Crime Commissioner.

Personalisation is an important initiative for social and health care. It places individuals in the role as commissioners of their own care and support. However, effective implementation of personalisation needs a real cultural change across mental health service provision. Whilst it may be an opportunity to develop individualised care, encouraging commissioners to move away from block contracts, it may be a threat to the voluntary and community sector funding.

Recovery

The mental health recovery model describes an individual's journey through life with mental illness. It focuses on social inclusion and wellbeing rather than illness. It is about a person having hope and a meaningful and satisfying life, irrespective of whether they are experiencing ongoing or recurring problems. Under the recovery model the relationship between clinicians and patients is a partnership rather than one of expert and patient.

Recovery should encourage individuals to take responsibility for their own wellbeing, recognise the role of carers in facilitating recovery, and promote genuine partnership working between the individual and their mental health team. The recovery model fits with the current central Government approach, focusing on mental wellbeing and improvement.

Mental health across the life-course

This JSpNA takes a life-course approach to protecting mental health in Leicester. The life course approach seeks to overcome issues about transition between care pathways and services. Access to services should not be gained on the basis of age.

Half of all lifetime cases of diagnosable mental illness begin by age 14,¹ and three-quarters arise by the time a person reaches 25. However, most children and adolescents who experience clinically significant mental health problems are not offered evidence-based interventions at the earliest opportunity for maximal lifetime benefits.² Other evidence suggests that,

- 17% of the adult population experiences mental ill health at any one time
- 10% of new mothers suffer from post natal depression
- 19% of women and 13.5% of men are affected by depression or anxiety at any one time
- 50% of all women and 25% of men will be affected by depression at some time in their life
- 15% experience a disabling depression
- 4% of population has a personality disorder
- 1% of population has a severe mental illness (psychosis)

The WHO Commission on the Social Determinants of Health highlighted the importance of social circumstances in influencing health and wellbeing and the structural factors that lead to health inequalities.³ A social gradient in health exists in that better social and economic position results in better health.⁴ Each year, in England, between 1.3 million and 2.5 million years of life are lost as a result of health inequality, at an annual cost of £56–68 billion.⁵ A public health approach to mental health and wellbeing recognises the importance of addressing inequalities, and the social determinants, across the life course to prevent mental illness and promote well-being.

Perinatal maternal mental illness may be harmful for mothers, children and their families. The mental wellbeing of children is likely to have an impact on their present and future health. Commissioners will need to work closely with providers in the NHS, local authorities, schools, colleges and the third sector to ensure that services are commissioned and delivered to achieve improved outcomes for women and their families.

The risk factors for mental illness in childhood relate to child, parental and household factors. Parental factors include alcohol, tobacco and drug use. These increase the likelihood of a wide range of poor outcomes, including long-term neurological and cognitive and emotional development problems in children.

The risk of emotional or conduct disorders is associated with poor parental mental health and parental unemployment. Child abuse and adverse childhood experiences result in an increased risk of mental illness and substance misuse/dependence later in life. Looked-after children, those with intellectual disability and young offenders are at particularly high risk of poor mental health.

Adult mental health is adversely affected by factors such as unemployment, low income and debt, experience of violence, stressful life events, poor housing and fuel poverty. Poor mental health is associated with increased risk taking behaviour and poor lifestyle choices', which includes smoking, drinking and drug use, higher risk sexual behaviour, lack of exercise, poor diet and obesity. These are connected to the excess early mortality for people with mental illness.

For older people, a range of mental health issues from depression to dementia are projected to increase.

There is a need to develop appropriate mental health care for people from minority and excluded communities; there continues to be an over-representation of people from Black/Black British ethnic backgrounds in the take up of services, under-representation of people from South Asian backgrounds and a need to meet the challenges presented by new arrivals, some of whom have experienced trauma and abuse prior to their arrival.

Lesbian, gay, bisexual and transgender people experience higher rates of mental disorder than the general population.

Leicester has 2 universities, so a large student population contributes to the diversity of the city; however, many students experience mental health problems and poor access to secondary care services.

Prisoners and offenders have higher levels of mental illness than the general population

Poor mental health has wide consequences. For children and young people these include lower educational attainment, high risk of substance misuse and self-harm, antisocial behaviour and early pregnancy. In turn such factors may lead to poor health and social outcomes in adulthood, including unemployment, low income, marital problems and crime. Conduct disorder is associated with increased risk of further mental illness such as mania, schizophrenia and obsessive compulsive disorder as well as depression and anxiety.

According to Melzer et al,⁶ the increased risk of mental illness associated with relative deprivation is such that 15% of children from families in the lowest income levels experience mental health problems compared with 5% of children at the highest income levels. Higher income inequality is linked to higher rates of mental illness, decreased rates of trust and social capital, and increased hostility, violence and racism as well as lower rates of wellbeing.

People with mental illness are often excluded from areas of social life; such as being able to work, develop community relationships and or to shop. They also face some exclusion in accessing health and social care. This exclusion results in further inequality.

Discrimination and stigma experienced by people with mental illness further exacerbates this inequality, reducing employment opportunities and weakening supportive social ties. People with mental health problems are more likely to be unemployed, live in poverty, and in neighbourhoods with less social and environmental capital. People with mental illness suggest that stigma is a main source of social exclusion. Stigma may be compounded for some people as a result of their ethnic or cultural background or their sexuality.

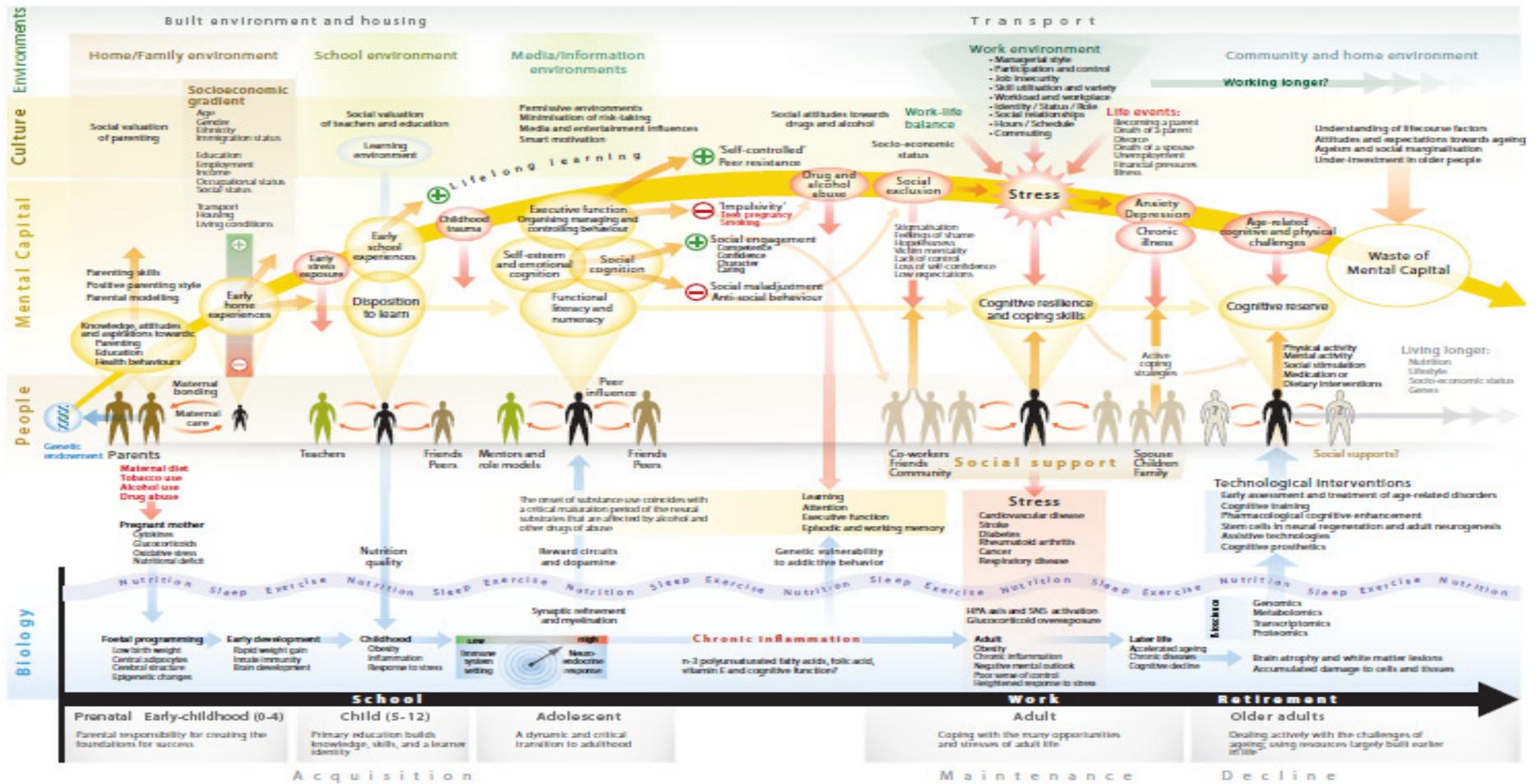


Figure 1: Synthetic view of mental capital trajectory and the factors which may act upon it (Source Government Office for Science, Foresight)⁷

Mental health promotion

The Annual Report of the Chief Medical Officer (CMO) 2013 suggests that public mental health should be framed according to the World Health Organisation model of mental health promotion, mental illness prevention and treatment and rehabilitation.⁸ These are linked to 3 ideas for improving health, namely that mental health is an integral part of health. It is more than the absence of illness and it is connected to physical health and behaviour.

Mental health promotion activities imply the creation of individual social and environmental conditions which enable optimal psychological development.⁹ One challenge of promoting mental health is to develop a cross-cutting approach; this is because of the relationship between social and economic factors and mental health. Mental illness prevention aims to reduce the incidence, prevalence and recurrence of mental disorders. Disorders have many determinants and tackling them requires a bio-psycho-social approach¹⁰.

Promoting mental health can strengthen individuals and communities and reduce the barriers to mental wellbeing. Effective mental health promotion means recognising, encouraging and implementing the role of wider stakeholders in society. This requires an approach which:

- covers the growing evidence of the link between mental health and wellbeing and the wider determinants of health
- improves prevention and early intervention for those at high risk
- improves mental health promotion for the wider community

One such way of promoting mental health is to implement the Five Ways to Wellbeing campaign. The five ways are shown in Table 1 below. They highlight the importance of social relationships, regular physical activity, taking notice, learning through life and participating in social and community life. In addition everyone should have appropriate access to universal public services which will enable them to maintain and promote their own wellbeing. These may include transport, leisure and education, housing and health services, and opportunities for employment.

Table 1: Five Ways to Wellbeing

Five ways to mental wellbeing	
1. Connect...	With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. Be active...	Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. Take notice...	Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
4. Keep learning...	Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. Learning new things will make you more confident as well as being fun.
5. Give ...	Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, as linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Public Sector Equality Duty

This JSpNA has been undertaken with regard to equalities legislation. Whilst data is not routinely available for a number of the protected characteristics, it will be seen from the body of report, and from the chapter which focuses on equalities and mental health, that this JSpNA covers issues with regard to the following: age, gender, ethnicity, disability, pregnancy and maternity, sexual orientation and gender-reassignment and highlights issues in relation to advancement and improvement in mental health and wellbeing.

The report also takes account of socio-economic deprivation, which is not a protected characteristic but is a significant factor in the health and wellbeing of the city.

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Leicester Population

Key findings:

Population	In 2010 Leicester had an estimated population of 306,600 people, with more younger and fewer older people compare with England. Projections suggest that the population will increase to 346,000 people by 2020.
Deprivation	Leicester has high levels of deprivation and is ranked 25th worse out of 326 local authority areas in England on the national Index of Deprivation 2010. Deprivation is wide cast. 41% of the Leicester population live in the most deprived areas of England. There is wide variation of deprivation among different areas of the city.
Diversity	Leicester has a diverse population compared with England. 36% of Leicester residents are from black and minority ethnic (BME) backgrounds, compared with 13% for England as a whole. The age profile of people from BME ethnic backgrounds is younger than that of people from White/White British ethnic backgrounds.
Wider determinants of health	Leicester is significantly worse than the England values in: rate of working age adults who are unemployed per 1,000 percentage of 16-18 year olds not in education, employment or training, rate of episodes of violent crime per 1,000
Risk factors for mental illness	Leicester is significantly worse than the England values in : percentage of population with a limiting long term illness first time entrants into the youth justice system of 10 - 17 year olds percentage of adults participating in recommended levels of physical activity
Mental health in Leicester	<ul style="list-style-type: none"> • 3-5% of newly delivered mothers experience moderate to severe depressive illness equating to 150-250 women in Leicester each year • 10-15% of children and adolescents will experience mental ill health in Leicester, equivalent to 3,500-5,250 a year • In Leicester 3 in every 1,000 residents under 20 years are registered with mental health services, rising to 5 in every 1,000 in the most deprived areas • Across Leicester, Leicestershire and Rutland around 250 people aged 15-19 years are admitted because of self-harm each year • 16-18% of working age adults experiences a common mental health problem at any time, equivalent to 34,358 to 38,652 people. The number registered with their GP as having depression is 30,831 suggesting that not all people with depression have health care support • The number of new cases of adult depression in Leicester is estimated to be 11,000 per year • It is estimated that there are 3,400 people in Leicester with a serious and enduring mental health condition such as schizophrenia, bipolar affective disorder and other psychoses • An estimated 3,000 people aged over 65 years have depression and a further 1,500 have severe depression • In Leicester each year approximately 32 people will take their own life, giving a rate which is the second highest in England

This chapter is a description of the Leicester population. There are various risk factors which affect mental health and wellbeing, such as deprivation, age, ethnicity, sexuality and gender and physical health and wellbeing. The picture which emerges for Leicester is one in which there is a high prevalence of the risk factors for poor mental health and wellbeing.

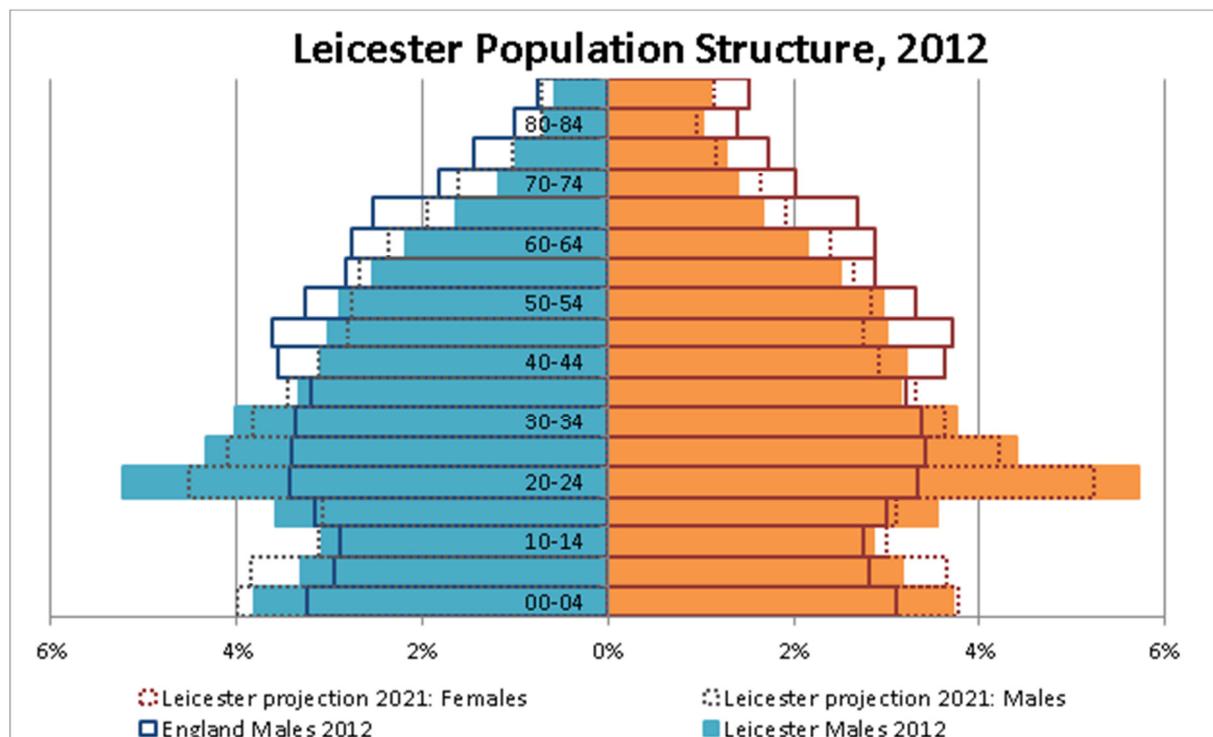
Leicester is the largest city in the East Midlands. It is a mainly urban area of 73.3 km² with a population of 306,631;¹¹ it has a high population density of 4,182 people per km². 49% of the population, 151,277 people, are male; 155,354 are female (51%). The population is predicted to increase to about 346,000 by 2020.

Average life expectancy in Leicester is lower than that for England. Male life expectancy is 75.4 years (3 years below the England average). For females it is 80.1 years (2.5 years below the England average).

Leicester has a relatively young population, with a larger proportion of people aged 40 and below, compared to the national average, although this is projected to change. Currently numbers are high for adults aged 20-34; this may be due to inward migration of new communities and the large the student population attending two universities. 11.6% of the population is aged 65 and over, equivalent to around 35,700 people, compared to 16.5% for England as a whole.

As individuals have so far not been asked to define their sexual orientation in the UK census, there are no accurate figures for the number of lesbian, gay, bisexual and transgender people in Leicester. The Department of Health briefing papers indicate that there are an estimated 3.6 million LGBT people living in the UK who make up approximately 5% of the total population, with 10% of whom are resident in London.

Figure 2: Leicester Population structure 2012



About 50% of Leicester residents are from black, minority ethnic (BME) backgrounds, compared with 14% for England. The majority of the Leicester BME population are from South Asian ethnic backgrounds; this group comprises 37% of the total population of the city. People from black or black British ethnic backgrounds make up 6%, mixed ethnic groups 4% and other ethnic groups 3%, of the population.

Leicester City Council estimates that the local Somali community comprises about 10,000 people. There are between 6,000 and 8,000 migrants of working age from Poland, Portugal, Slovakia, Latvia and Lithuania, including 1,000-2,000 people from the Slovak Roma community.

Other new communities include asylum seekers and refugees. Leicester is a National Asylum Seeker Service designated dispersal city. The official maximum number of asylum seekers in Leicester at any one time is 800, this is sometimes exceeded. Currently the number is more than 800.

It is estimated that there may be as many as 150 languages and dialects spoken in Leicester. Gujerati, Katchi, Punjabi, Urdu and Bengali are widely spoken. There are increasing numbers of people who speak Eastern European languages, such as Polish or Slovak, and East African languages such as Somali.

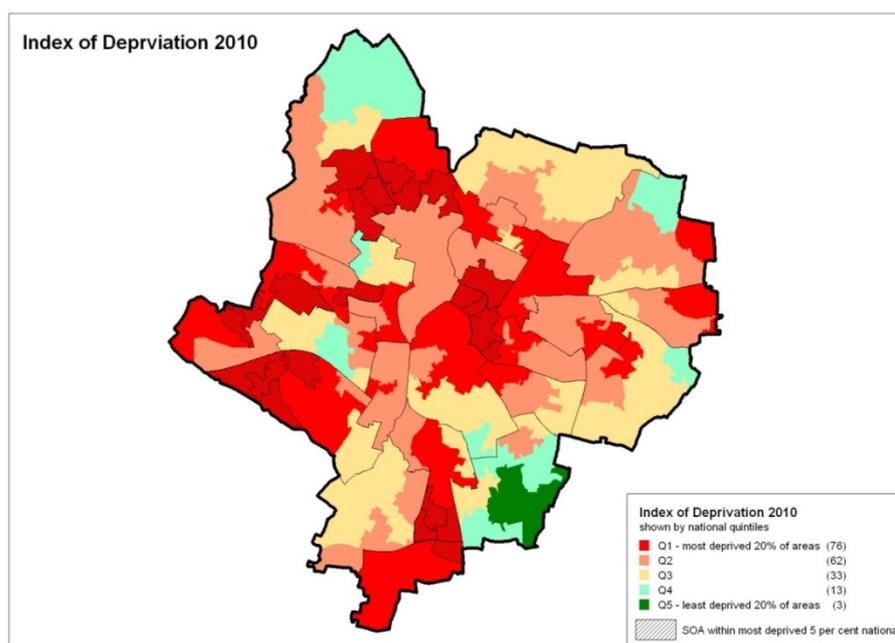
There are a number of different faith communities in Leicester. The 2001 Census showed the largest faith communities in Leicester are the Christian communities (44.7% of the population), followed by Hindu (14.7%), Muslim (11%), and Sikh (4.2%). 17.4% stated they had no religion while 7% did not indicate their religion. According to the Leicester Council of Faiths, there are approximately 240 faith groups across fourteen different faiths.

The most recent data linking ethnicity and employment in Leicester shows that the employment rate for what is classified as non-white groups, aged 16-64, was 58.4% in 2010. This is lower than that for the white population (72.1%) and the overall employment rate in Leicester during that same period (70.7%).

Patterns of residence have altered over time. The Annual Report of the Director of Public Health 2010 included a 'typologies' analysis which showed that deprivation and poorer health is not even across the city, and that there is a complex interplay between ethnicity, deprivation and health.

Although there are some wealthy areas in Leicester, most ward areas experience extreme deprivation. The Index of Deprivation 2010, a measure of poverty based on a number of criteria such as economic circumstances, health, crime, housing, educational achievement, skills and the environment, is shown in Table 2 below. Leicester ranks as the 25th most deprived of 326 Local Authority areas. 40.4% of Leicester's population live in the most deprived 20% of areas in England and a further 34% live in the 20-40% most deprived areas. Only 1.4% of Leicester's population live in the 20% least deprived areas. 22% of Leicester's residents are middle income families compared with 13% in England; 19% are lower income workers compared with only 8% nationally and 15% are families in low rise social housing whilst in England this group represents only 6% of the overall population.

Figure 3: Index of deprivation (2010) in Leicester



Leicester has two lower super output areas (an LSOA has around 1,500 people) which rank 1st and 2nd for the most deprived areas in England overall for Education, Skills and Training. There are also two LSOAs ranking 2nd and 6th for the most deprived areas for Income nationally.

The impact of deprivation can be seen most starkly in the variation in life expectancy across Leicester. For instance, for males there is a difference in life expectancy of 9.4 years and females 5.0 years between people living in the most and least deprived areas of Leicester.

Table 2: Leicester's population by quintile of deprivation

Quintile of Deprivation	Population (2012)	% Population (2012)
Q1	135783	40.40%
Q2	112404	33.90%
Q3	53859	16.20%
Q4	25016	7.50%
Q5	4544	1.40%
All Quintiles	331,606	100%

Context of mental ill health in Leicester

Mental health problems are common. Mental health is influenced by diverse biological and social risk factors, including fixed factors such as genetic and biographic characteristics (age and sex) and modifiable factors such as family and socio-economic characteristics (marital status, number of children, employment), individual circumstances (life events, social supports, immigrant status, debt), household characteristics (accommodation type, housing tenure), geography (urban/rural, region) and societal factors (crime, deprivation index).

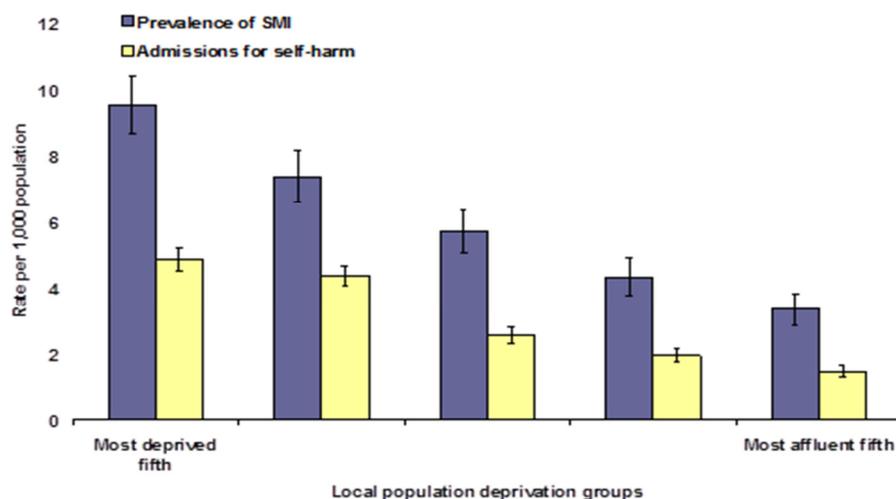
There are a number of groups within the population that are at particularly higher risk of developing mental health problems, including asylum seekers¹² and refugees, men from Black/Black British ethnic backgrounds, prisoners and offenders, looked-after children, people with physical illnesses, LGBT people, drug-users, the homeless and those experiencing fuel poverty.¹³

Mental and behavioural disorders were the cause of 4% of deaths in Leicester in the period 2008-2010. A summary of increased risks for some of these groups includes:

- up to 1 in 4 people will experience mental health problems at some point in their lives, with approximately 1 in 6 suffering from mental health problems at any one time
- unemployed adults have a 5.6-fold increased risk of developing a mental health problem
- the homeless have a 5.3-fold increased risk of developing a mental health problem
- those with a cold home or experiencing fuel poverty have a 4-fold increased risk of having depression or anxiety
- adults with two or more physical illnesses have a 6.4-fold increased risk of having mental health problems
- children who experience abuse have a 7-fold increased risk of recurrent depression and a 9.9-fold increased risk of developing post-traumatic stress disorder as an adult
- black men are 3 times more likely to be represented on a psychiatric ward and up to six times more likely to be detained under the Mental Health Act
- under 15's who use cannabis are 6.7 times more likely to develop schizophrenia
- offenders have a 5-fold increased risk of suicide (with an 18-fold increased risk amongst young offenders, a 35.8-fold increased risk amongst female offenders and an 8.3-fold increased risk for recently released offenders)
- lesbian, gay, bisexual or transgender adults have a 4-fold increased risk of suicide
- looked after children have a 4.5-fold increased risk of suicide attempt
- children experiencing 4 or more adverse childhood experiences have a 12.2-fold increased risk of attempted suicide as an adult
- Defined as child abuse, parental depression, domestic abuse, substance abuse or offending.

There are substantial gaps in mental health across the deprivation divide in Leicester, represented by up to four times higher rates of severe mental illness in the most deprived areas.

Figure 4: Inequalities in severe mental illness and self-harm in Leicester

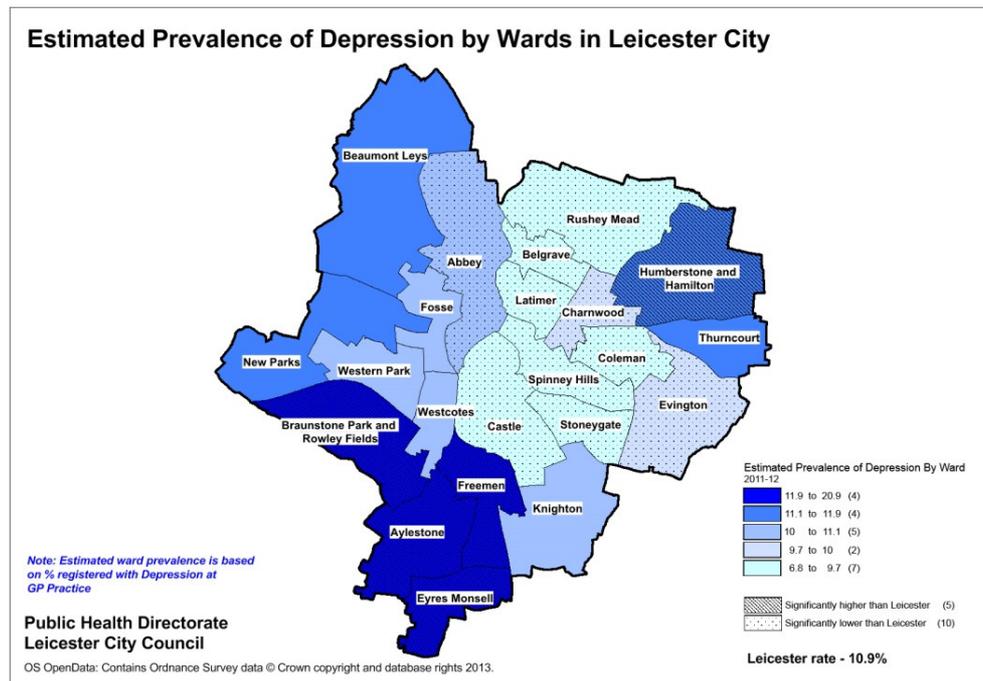


According to the map of Leicester in Figure 5 below, depression is significantly higher in Aylestone, Braunstone Park and Rowley fields, Eyres Monsell, Freeman and Humberstone and Hamilton, and lower in Belgrave, Castle, Coleman, Latimer, Rushey Mead, Spinney Hills, and Stoneygate ward areas.

Health profiles of these ward areas suggest the following:

- Aylestone: Deprivation is better here than the Leicester average. There are an estimated 415 children living in poverty. Long term unemployment is worse than the national average. Life expectancy for females is lower than the Leicester and national averages. Of the lifestyle factors which impact on health, levels of smoking and obesity are worse than Leicester overall. Mental and behavioural disorders were the cause of 9% of death in Aylestone in 2008-2010.
- Braunstone Park and Rowley Fields: Deprivation is worse than the Leicester average with an estimated 1,950 children living in poverty, long term unemployment is worse than the national average. Attainment at GCSE is lower than average. Life expectancy for males and females is lower than the Leicester and national averages. The birth rate is higher, with smoking during pregnancy and the initiation of breastfeeding worse than the England average. Of the lifestyle factors which impact on health, levels of smoking, obesity, healthy eating, drinking alcohol and physical activity are worse than Leicester overall. Mental and behavioural disorders were the cause of 6% of death in Braunstone Park and Rowley Fields in 2008-2010.
- Eyres Monsell: Deprivation is worse than the Leicester average with an estimated 1,230 children living in poverty, long term unemployment is worse than the national average and attainment at GCSE is lower than average. Life expectancy for males and females is lower than the national average. The birth rate is higher, with smoking during pregnancy and the initiation of breastfeeding worse than the England average. Of the lifestyle factors which impact on health, levels of smoking, obesity, healthy eating, drinking alcohol and physical activity are worse than Leicester overall. Mental and behavioural disorders were the cause of 2% of death in Eyres Monsell in 2008-2010.
- Freeman: Deprivation is worse than the Leicester average with an estimated 1050 children living in poverty, long term unemployment is worse than the national average. Life expectancy for males and females is lower than the national average. Teenage pregnancy is worse than the national average, smoking during pregnancy and the initiation of breastfeeding worse than the England average. Of the lifestyle factors which impact on health, levels of smoking, obesity and drinking alcohol are worse than the national average. Mental and behavioural disorders were the cause of 1% of death in the Freeman ward area in 2008-2010.
- Humberstone and Hamilton: Deprivation in Humberstone and Hamilton is better than the Leicester average with an estimated 1,045 children living in poverty. Life expectancy for males and females is lower than the national averages. The birth rate is higher than the national rate. For lifestyle factors smoking, obesity, healthy eating, drinking alcohol and physical activity are worse than average. Mental and behavioural disorders were the cause of 6% of death in Humberstone and Hamilton in 2008-2010.

Figure 5: Estimated Prevalence of depression by wards in Leicester



Apart from Castle ward, which covers the city centre, those areas where the prevalence of mental illness is lower are characterised by a high proportion of people from BME communities; otherwise they are similar to the areas where the prevalence of mental health problems is significantly higher than average.

- Belgrave: Deprivation is worse than the Leicester average with an estimated 670 children living in poverty, long term unemployment is worse than the national average. Life expectancy for males and females is lower than the national average. Mental and behavioural disorders were the cause of 2% of death in Belgrave in 2008-2010.
- Castle: An estimated 350 children living in poverty. Life expectancy for males and females is lower than the Leicester and national averages. Of the lifestyle factors which impact on health alcohol consumption is significantly worse than Leicester overall. Mental and behavioural disorders were the cause of 4% of death in Castle ward in 2008-2010.
- Coleman: An estimated 1,050 children live in poverty. Long term unemployment is worse than the national average. Life expectancy for males and females is lower than the Leicester and national averages. The birth rate is higher than the England rate. Smoking is worse than average. Mental and behavioural disorders were the cause of 4% of death in Coleman ward in 2008-2010.
- Latimer: The health of people in Latimer ward is better than the England average. Deprivation is better than the Leicester average with an estimated 500 children living in poverty. Life expectancy for males and females is better than the England averages and similar to the national averages. Mental and behavioural disorders were the cause of 2% of death in Latimer ward in 2008-2010.
- Rushey Mead: Deprivation is lower than the Leicester average, with an estimated 515 children living in poverty. Life expectancy for women (80 years) is lower than the national average but that for men is higher than the Leicester average and similar to the national average. Teenage conception rates and infant mortality rates are similar to England. Of the lifestyle factors which impact on health, levels of smoking, obesity, healthy eating, drinking

alcohol are better than average, but physical activity is worse. Mental and behavioural disorders were the cause of 2% of death in Rushey Mead in 2008-2010.

- Spinney Hills: Deprivation is worse than the Leicester average with an estimated 2,400 children living in poverty, long term unemployment is worse than the national average. Life expectancy for males and females is lower than the national average. Of the lifestyle factors which impact on health, levels of smoking and physical activity are better than average, healthy eating is significantly worse than Leicester overall, drinking alcohol is significantly better while obesity is worse than Leicester overall. Mental and behavioural disorders were the cause of 2% of death in Spinney Hills in 2008-2010.
- Stoneygate: Deprivation is lower than the Leicester average and an estimated 1,335 children live in poverty. For men, life expectancy is similar to the Leicester average (75.4 years) and 3 years lower than the England average (78.6 years). For women, life expectancy is 1.8 years higher than the Leicester average (80.0 years) and similar to the England average (82.6 years). In this ward birth rates are higher than the England rate. Teenage conception rates are lower and infant mortality rates worse. Rates of smoking during pregnancy are better, and initiation of breastfeeding better than the England average. Of lifestyle factors which impact on health, levels of obesity and physical activity are better than average, smoking is significantly better while healthy eating and drinking alcohol are worse than Leicester overall. Mental and behavioural disorders were the cause of 2% of death in Stoneygate in 2008-2010.

Further evidence of need

Mental wellbeing can be defined as “a dynamic state, in which an individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their communities.”¹⁴ In order to determine the views on positive mental health the Leicester Health and Lifestyle Survey assessed respondents against a shortened version of the Warwick-Edinburgh Mental Wellbeing Scale.¹⁵ These were presented in the Annual Report of the Director of Public Health 2010¹⁶. The results, shown in Table 3, indicated that 13% of the sample reported good mental wellbeing, 76% were in the average group and 9% reported having poor mental wellbeing. Poor mental wellbeing was reported in 1% of those living in the most deprived quartile, compared with 6% in those in more affluent areas. Data by ward shows higher rates of poor mental wellbeing in Beaumont Leys (13%), Spinney Hills (14%) and Freeman (16%) and that risk factors for poor health and unhealthy behaviour are often shared by groups or populations.

Table 3: Mental wellbeing as indicated in the Leicester Health and Lifestyle Survey 2010

	Total	Gender		Age				Ethnicity				
		Males	Females	16-24	25-34	35-54	55+	White	Asian/Asian British	Indian	Black/Black British	Ethnic Minority (net)
Unweighted Base	2377	1103	1274	316	456	848	740	1446	740	618	136	929
Weighted Base	2377	1157	1220	486	469	776	629	1394	768	640	151	980
Good Mental Wellbeing	300	150	150	50	54	95	97	154	112	98	26	145
Average Mental Wellbeing	1804	859	946	383	354	588	468	1055	601	501	103	748
Poor Mental Wellbeing	206	110	96	43	40	77	44	136	48	36	13	70
Good Mental Wellbeing (%)	13%	13%	12%	10%	12%	12%	15%	11%	15%	15%	17%	15%
Average Mental Wellbeing (%)	76%	74%	78%	79%	75%	76%	74%	76%	78%	78%	68%	76%
Poor Mental Wellbeing (%)	9%	10%	8%	9%	9%	10%	7%	10%	6%	6%	9%	7%

Impact of the recession

Mental illness increases in times of economic uncertainty. A study by Barr et al¹⁷ indicated that increases in male unemployment were associated with about two fifths of the rise in suicides among men in England during the current recession.

The pressure on welfare resources, associated with the recession and the Welfare Reform Act 2012 present major challenges to those adults of working age, and their dependants, who rely on benefits for their income. At the time of writing the reforms are partially completed and are expected to continue until 2017, with Universal Credit and Disability Living Allowance reassessment still to start in Leicester.

Most working age benefit recipients on low incomes, including disabled and vulnerable service users, will be worse off because of benefits changes to housing and disability benefits coupled with the freezing of other benefits.

As part of the welfare reform agenda, the government is moving towards the digitalisation of benefits. Claimants will be required to claim online and hold an account in which they will report changes of circumstances. Claiming online has initially been brought in for Jobseekers Allowance but will be a feature of Universal Credit when this is finally introduced. Support for claimants as part of this process is unclear, but Citizens' Advice Service anticipates 90% will need some assistance.

According to Department of Work and Pension figures there are approximately 17,000 claimants in Leicester claiming Incapacity Benefit, Severe Disablement Allowance or Income Support, because they are too ill to work. Many of these claimants are being reassessed under the Work Capability Assessment for Employment and Support Allowance (ESA). This has a higher threshold for payment, which the Court of Appeal has found to be discriminatory against claimants with mental health problems who may not be able to explain their illness at the time of assessment.

Claimants who do not return the medical questionnaire or attend the medical have their benefit stopped. Of those who do attend an estimated 40% will fail to meet the threshold, and will be considered fit to work. Although they will have the opportunity to challenge the decision, most people in this position will be required to claim Jobseekers Allowance. There are about 6,000 appeals for Leicester. Since October 2013 those appealing against a decision are not entitled to benefit, other than Jobseekers Allowance. There is a process of ongoing reassessment for those who do meet the threshold.

Case Study: Impact of benefits changes on people with mental illness

Social Worker referred claimant to Benefits Advice Service. Case was a male with schizophrenia in crisis who had no money and as a consequence his gas and electric had been disconnected.

The root cause of this issue was because he had been too ill to complete and return his ESA reassessment questionnaire to the DWP.

His benefit had been suspended and because of his condition he did nothing about it.

From 2014 onwards reassessment of approximately 10,000 claimants of Disability Living Allowance will begin. They will initially be invited to claim Personal Independence Payment, which again has a higher threshold. Some claimants will lose their entitlement. If they do not respond to the invitation

to claim for Personal Independence Payment, their benefit will be terminated leading to loss of income and potential overpayment of other benefits.

In addition to the changes in thresholds for benefits, those in receipt of Employment Support Allowance or Jobseekers Allowance are subject to further conditions, such as obligations to attend interviews. Claimants who fail to meet these obligations are subject to financial sanctions.

Local evidence from the Welfare Rights Service suggests that claimants with lower level mental health issues or learning disabilities are at risk of sanction when they are moved from old incapacity benefits onto the Jobseekers Allowance regime. The impact of changes on this group of people can be wide; there have been cases facing loss of Housing Benefit and Council Tax Reduction and subsequent eviction proceedings unless they declare no income.

Policy Background

There are a range of local and national policy initiatives which have an impact on mental health and wellbeing. This chapter discusses those documents and policies which have a more direct influence on mental health and wellbeing. They range from the cross party initiative the ‘1001 Critical Days’, through the national policies on mental health to the local focus on mental health under the banner of the Health and Wellbeing Board and Leicester City Clinical Commissioning Group.

The following table is a summary of some national and local policy initiatives which may influence the sustenance of mental wellbeing and support people with mental illness.

National	Equity and Excellence: Liberating the NHS	The NHS White Paper
National	NHS outcomes framework	Balanced set of 65 indicators, grouped around 5 domains. <ul style="list-style-type: none"> ▪ Preventing people from dying prematurely ▪ Enhancing quality of life for people with long-term conditions ▪ Helping people to recover from episodes of ill health or following injury ▪ Ensuring that people have a positive experience of care ▪ Treating and caring for people in a safe environment and protect them from avoidable harm
National	A Vision for Adult Social Care: Capable Communities and Active Citizens	Set the agenda for adult social care in England to make services more personalised
National	The Adult Social Care Outcomes Framework	Three purposes at local and national level <ul style="list-style-type: none"> ▪ Setting direction ▪ Transparency ▪ Accountability
National	Public Health Outcomes Framework	66 supporting public health indicators, split over four domains: <ul style="list-style-type: none"> ▪ Improving the wider determinants of health ▪ Health improvement ▪ Health protection ▪ Healthcare public health and preventing premature mortality
National	No Health without Mental Health: A Cross-Government	Mental Health Outcomes Strategy for People of All Ages
National	Preventing Suicide in England: A cross-government outcomes strategy to save lives	Brings together knowledge about groups at higher risk of suicide; applies evidence of effective interventions and highlights resources available
Local	Closing the Gap	Leicester’s Joint Health and Wellbeing Strategy 2013-16
Local	A Delivery Plan For Leicester	The city Mayor’s delivery plan, which includes: <ul style="list-style-type: none"> ▪ Business development ▪ Getting about in Leicester ▪ Improving the built and natural environment ▪ Developing a healthy and active city ▪ Providing care and support ▪ Children and young people ▪ Neighbourhoods and communities

Local	Joint Commissioning Strategy on mental health 2011-13	Objectives include: <ul style="list-style-type: none"> Prevention and Early Intervention Transforming Social Care Supporting the Mental Health of Older People
National	1001 Critical Days	The first 1001 days are critical in a child's life, shaping brain development, having a lifelong impact on a baby's mental and emotional health. The manifesto advocates that: <ul style="list-style-type: none"> all parents have access to antenatal education classes that address parenting and emotional needs training in child development and infant mental health to be provided as standard for health and early years workers rigorous evaluation and outcomes studies to test the effectiveness of training intervention programmes better use of Joint Strategic Needs Assessments to highlight the specific risks, such as domestic violence or substance misuse, faced by families with babies, and their needs better support for the most vulnerable families in children's centres
Local	Leicester City CCG Commissioning Strategy	Mental health element focuses on 3 core areas, <ul style="list-style-type: none"> improving dementia care expanding access to the range of services offered by IAPT Improving access to emergency and acute mental health services
National	Benefits Changes: Universal Credit	Universal Credit is a new type of financial support for people of working age who are looking for work or on a low income. It's being introduced gradually between April 2013 and 2017
National	Valuing People	Strategy on learning disabilities: rights, independence, choice and inclusion
National	Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders	Addresses: <ul style="list-style-type: none"> punishing offenders protecting the public reducing reoffending
Local	Child and Adolescent Mental Health Services Joint Strategy 2012-14	Main themes: Maintain an integrated multi-agency approach to meeting local needs Measure the impact of interventions and outcomes for children Enhance the role of universal services Ensure that children are kept safe in all services Improve access to Tier 2 and Tier 3 CAMHS Reduce waiting times for assessment and treatment Improve transition from CAMHS to Adult mental health Increase workforce capacity and capability to deliver evidence-based psychological interventions Provide services which respond to the needs of children and young people whose wellbeing is affected by the experience of stigma, discrimination and prejudice Focus on service users' and carers' best interests
Local	LLR 5-Year Strategy/Better Care Together	Planning guidance for 2014/15 requires health and social care communities to prepare 5 Year Strategic plans which outline the long-term direction for health, care and support services across each health economy. Mental health is one of 5 key workstreams for LLR, with the highest proportion of total spend (28%, £126,868,644). Priorities for mental health are:

		<ul style="list-style-type: none"> • Screening and stepped care in drug and alcohol abuse. • Early intervention with children and adolescents. • '5 a day' equivalent for mental health
National	Crisis Care Concordat	<p>The key points are:</p> <ul style="list-style-type: none"> • Key local partners should make a local crisis declaration to commit to deliver the concordat. • Some areas overlap with Police priorities. <p>Expectations include:</p> <ul style="list-style-type: none"> • Access to a 24 hour helpline staffed by MH Professionals • Services for drugs and alcohol respond flexibly to crises • The crisis response quality standard is 4 hours • There will be an audit of MH assessment rooms in EDs • NHS England will provide support MH crisis care commissioning • The CQC will review Place of Safety Assessment Units (PSAU). • Approved medic response in a PSAU should be less than 3 hours • Intoxication should not exclude people from a PSAU • Key stakeholders will develop a local protocol for Section 136 • There will be effective liaison psychiatry • There should be a local forum/MH partnership board • AMHPs know where beds are available • ED facilities for rapid tranquilisation in MH crisis • Agreed response time for transport requested under section 135/6 • Clear protocol for police assistance to manage patient behaviour in a health care setting
National	Closing the Gap (Mental Health)	Identifies 25 areas to improve mental health care and support in support of No Health Without Mental Health

National Policy

Since 2010 the Coalition Government has introduced legislation and strategic policies intended to support health and social care interventions. In summary these include:

- The Health and Social Care Bill, together with the White Paper *Equity and Excellence: Liberating the NHS*, the Command paper *Liberating the NHS: Legislative Framework and Next Steps* and the *Operating Framework for the NHS in England 2010/11*, set out the Coalition Government's plan for the NHS in England.
- *Achieving Equity and Excellence for Children: how liberating the NHS will help us meet the needs of children and young people.*
- Social care reform is covered by *A Vision for Adult Social Care: Capable Communities and Active Citizens.*
- Public Health is covered by *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, describing a greater local authority role in health and health improvement. It emphasises the importance of mental health, which is reflected in *Healthy Lives, Healthy People: Transparency in Outcomes – Proposals for a Public Health Outcomes Framework.*
- *No Health without Mental Health*, the cross-Government mental health outcomes strategy, outlines the Coalition's vision for improving population mental health through high quality mental health services, early intervention, and prevention of mental illness and promotion of population mental wellbeing.

Equity and Excellence: Liberating the NHS and the Health and Social Care Bill both described a changed NHS and local government landscape. The clinical commissioning structure has seen GP led clinical commissioning groups (CCG) replace primary care trusts (PCTs). The CCG has representation

from every GP practice. It is expected to draw on expert advice from health care professionals to deliver their commissioning responsibilities. The CCG is supported and regulated by NHS England.

NHS England is responsible for commissioning core primary medical care services provided by GP practices (including primary mental health care), and other family health services, such as pharmacy services, dental services and NHS sight tests. It also commissions some national and regional specialist services, including prison and custody health care, high security psychiatric services, and health care for the armed forces and their families.

Both NHS England and the CCG are subject to duties, from the Children Acts 1989 and 2004, to discharge their functions in ways that safeguard and promote the welfare of children, and to be members of Local Safeguarding Children Boards. These are important issues in the development of mental health care for children and adolescents.

The local authority leads the strategic co-ordination of commissioning prevention and promotion (health and wellbeing) services. It brings together NHS, social care and related children's and public health services and working with other local agencies and groups. One function of the Health and Wellbeing Board is ensure joined up commissioning across the NHS, social care, public health and other services to secure better health and wellbeing outcomes, better quality of care and better value for the Leicester population.

Closing the Gap, the Leicester joint health and wellbeing strategy (JHWS), is the overarching framework for the development of the commissioning plans agreed by the Health and Wellbeing Board for local NHS, social care, public health and other services. Leicester City Council has health scrutiny powers, through the Health Overview and Scrutiny Committee, which has recently reported on mental health and wellbeing.

The Local Involvement Network (LINK) has evolved into HealthWatch, supported and led by HealthWatch England. HealthWatch England is part of the Care Quality Commission (CQC). This part of the health and wellbeing process is intended to ensure that the views of users of services, carers and the public are represented to commissioners, and will provide local intelligence for HealthWatch. HealthWatch in Leicester is already involved in supporting local service users in various different groups.

No health without mental health

No Health without Mental Health is the government's all age strategy for mental health in England. It is underpinned by two central aims. Firstly, to improve the mental health and wellbeing of the population and to keep people well and secondly, to improve outcomes for people with mental health problems through high quality services, accessible to all.

The strategy sets out the following six objectives:

- **Objective One: More people will have good mental health**

More people of all ages and backgrounds will have better wellbeing and good mental health, and fewer people will develop mental health problems- by starting well, developing well, working well, living well and ageing well.

- **Objective Two: More people with mental health problems will recover**

More people who develop mental health problems will have a good quality of life, with a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live.

- **Objective Three: More people with mental health problems will have good physical health**

Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

- **Objective Four: More people will have a positive experience of care and support**

Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure people's human rights are protected.

- **Objective Five: Fewer people will suffer avoidable harm**

People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

- **Objective Six: Fewer people will experience stigma and discrimination**

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

Links to other policies

No Health without Mental Health points to a number of other policy initiatives which were in development at the time of its publication. Of perhaps greatest significance amongst these are plans from the Department for Work and Pensions relating to the Work Programme (the mental health strategy is clear on the importance of improving employment rates for people with mental illness).

Also of relevance, the Ministry of Justice's 2011 Green Paper, *Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders*, makes a clear case for making better use of mental health liaison and diversion services, and in particular the need to invest in mental health liaison services at police stations and courts to intervene at an early stage, diverting mentally ill offenders away from the justice system and into treatment.

In the wider context, substance misuse and mental health services have evolved separately, with few services explicitly dealing with individuals with both substance misuse and mental health problems. Broadly such clients have been either treated within one service alone or passed between services. In such cases the experience of clients has been that their problems have not been dealt with as well as they might, or there has been a loss of continuity of care.

Frameworks for practice concerning dual diagnosis include the *Dual Diagnosis Good Practice Guide*¹⁸ which summarises policy and practice with an emphasis on the provision of service and responsibility for care. The *Guide* suggests mainstream mental health services have a responsibility to address the needs of people with dual diagnosis. Where they exist, specialist teams of dual diagnosis workers should provide support to mainstream mental health services. All staff in assertive outreach and adequate numbers of staff in other areas must be trained and equipped to

work with people with dual diagnosis. Where clients have less severe mental health problems, the mental health services should provide support to substance misuse agencies.

There are a number of other policies and service frameworks which should be considered, for example the *Mental Health Act*, the *Social Exclusion Report- Mental Health and Social Exclusion*, the *National Alcohol Harm Reduction Strategy for England* and the *Updated Drug Strategy*. The Mental Health Act sets out the circumstances in which an individual may be detained in hospital for assessment and/or treatment for their mental disorder without their consent. Different strategies outline how services can work together to reduce the harm that drugs and alcohol have on individuals, families and communities.

The UK drugs misuse strategy covers all illicit drugs, giving priority to the reduction of use and harm related to Opioids, amphetamines, sedatives, hallucinogens and volatile substances. Alcohol is implicitly included in the strategy, although there is a dedicated alcohol reduction strategy.

The 1001 Critical Days

The 1001 Critical Days is a cross party parliamentary initiative which emphasises the health and wellbeing of children in the early moments of life. It suggests that pregnancy and birth offer a critical moment when parents are especially receptive to offers of advice and support. It considers the physical and mental development of a child, stressing the importance of early experiences in shaping a babies' brain development, and their mental and emotional health.

- Early stress can come from the mother suffering from symptoms of depression or anxiety, having a bad relationship with her partner, or an external trauma such as bereavement.
- Longstanding evidence show babies' social and emotional development is affected by the quality of their attachment to their parents.
- Babies are disproportionately vulnerable to abuse and neglect. In England they are seven times more likely to be killed than older children. Around 26% of babies (198,000) in the UK are estimated to be living within complex family situations, which can heighten risks for the baby's wellbeing, where there are problems such as substance misuse or mental illness.

The cross parliamentary group argues for a different approach to service provision for the 1001 Critical Days, so that babies receive sensitive and responsive care from their main caregivers, and parents feel confident to raise their children in a loving and supportive environment.

They propose a holistic approach to all antenatal, perinatal and postnatal services, including midwives, health visitors, GPs, and Children's Centres. They advocate services engaging with families as soon as possible, ideally during pregnancy.

1001 Critical Days advocates specifically that:

- At-risk families should be able to access evidence based services to promote parent-infant interaction, for example video interaction guidance and parent infant psychotherapy, delivered by qualified professionals.
- A range of services must be in place in every local area to ensure that women who are at risk or suffering from mental health problems are given appropriate support at the earliest opportunity.
- Parents should be able to access antenatal classes which address both the physical *and* emotional aspects of parenthood, and the baby's well-being (infant mental health).

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis¹⁹

The Mental Health Crisis Care Concordat²⁰ was published by HM Government in February 2014. It sets out the principles and practice that should be followed by health staff, police officers and approved mental health professionals when working together to help people in a mental health crisis. The aim of the concordat is to reduce the numbers of people in a mental health crisis being detained inappropriately in police cells and to tackle the variation in standards across the country.

The key points to note are:

- Partners are expected to make a local *crisis declaration* to commit to the delivery of the concordat.
- Several areas within this mental health concordat overlap with priorities which are being driven by the Police.

Expectations amongst others are that:

- Service users and GPs have access to a 24 hour helpline staffed by MH Professionals
- Services for drugs and alcohol respond flexibly to crisis and intoxication
- The crisis response quality standard is 4 hours
- There will be an audit of MH assessment rooms in EDs
- NHS England will provide a programme of support to improve MH crisis care commissioning
- The CQC will undertake a review of Place of Safety Assessment Units (PSAU).
- Section 12 approved medic response in a PSAU should be less than three hours
- Intoxication should not exclude people from a PSAU
- There will be a local protocol for Section 136 between LAs, MH provider, Police and CCGs
- There will be effective liaison psychiatry
- There should be a local forum/MH partnership board
- AMHPs know where beds are available
- ED should have facilities for rapid tranquilisation of people in MH crisis
- There should be an agreed response time for transport requested under section 135/6
- There is a clear protocol for police assistance to manage patient behaviour in a health care setting

Closing the Gap (Mental Health)

This focuses on 25 areas which, if prioritised could speed improvements in mental health and wellbeing

Increasing access to mental health services

- High-quality mental health services with an emphasis on recovery should be commissioned in all areas, reflecting local need
- An information revolution around mental health and wellbeing
- Establish clear waiting time limits for mental health services
- Tackle inequalities around access to mental health services

- People will benefit from psychological therapies
- There will be improved access to psychological therapies for children and young people across the whole of England
- The most effective services will get the most funding
- Adults will be given the right to make choices about the mental health care they receive
- Reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor
- Use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children’s mental health services
- Poor quality services will be identified sooner and action taken to improve care and where necessary protect patients
- Carers will be better supported and more closely involved in decisions about mental health service provision

Integrating physical and mental health care

- Mental health care and physical health care will be better integrated at every level
- Change the way frontline health services respond to self-harm
- No-one experiencing a mental health crisis should ever be turned away from services

Start early to promote mental wellbeing and prevent mental health problems

- Offer better support to new mothers to minimise the risks and impacts of postnatal depression
- Schools will be supported to identify mental health problems sooner
- End the cliff-edge of lost support as children and young people with mental health needs reach the age of 18
- More people with mental health problems will live in homes that support recovery
- Introduce a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided
- Anyone with a mental health problem who is a victim of crime will be offered enhanced support
- Support employers to help more people with mental health problems to remain in or move into work
- Develop new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work
- Stamp out discrimination around mental health

Improve the quality of life of people with mental health problems

People with mental health problems will live healthier lives and longer lives

Local strategic approach

As improving mental health in Leicester is everyone’s business, a range of initiatives will improve population mental health and increase resilience to mental ill health in our communities. This includes for instance cultural initiatives, the Economic Action Plan, community safety, transport, housing and leisure policies.

In Leicester the current model of care for people with mental health and wellbeing is set out in the Joint Commissioning Strategy for Mental Health and the LLR 5-Year Strategy. The aspirations for improving mental health in Leicester include the following:

Closing the Gap

Closing the Gap is the Joint Health and Wellbeing Strategy for Leicester, developed by the Health and Wellbeing Board. The aim of the Strategy is for key groups to work with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life.

The strategy is based on the city JSNA and feedback from local organisations, patients and the public. It considers the wider determinants of health, which it aims to tackle partly through the effective deployment of resources, partnership and community working.

One of the key strategic priorities is to improve mental health and emotional resilience in Leicester by

- Promoting emotional wellbeing of children and young people
- Addressing common mental health problems in adults and mitigating the risks of mental health problems in groups who are particularly vulnerable
- Supporting people with severe and enduring mental health needs

To protect the emotional wellbeing of children and young people, the Health and Wellbeing Board aims to focus on prevention and early intervention. This includes reducing emotional and behavioural difficulties, under-attainment at school, truancy and exclusion, criminal behaviour, drug and alcohol misuse, teenage pregnancy and the subsequent need for high cost statutory social care in later life.

Closing the Gap also aims to provide intensive support for families with multiple problems and tackling discrimination and stigma associated with mental illness.

In order to do this the Health and Wellbeing Board plans to:

- Undertake a Specific Health Needs Assessment better to understand the needs of children and young people in relation to mental health and emotional resilience
- Improve knowledge of barriers to early access including work to tackle the stigma and discrimination associated with mental health
- Work with communities to empower children and young people by ensuring services are centred on their needs and protect their rights
- Improve access to psychological therapies for children and young people
- Improve the offer, access, take-up and outcomes of health and social care services
- Reduce lifestyle risk factors for mental health
- Engage and mobilise communities to improve their own health and wellbeing

To address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable the Health and Wellbeing Board aims to:

- Focus on prevention and grass roots community work, using a community assets approach which utilises and recognises the skills and knowledge within communities
- Work in partnership to improve access to debt counselling and housing advice for people in financial crisis or at risk of homelessness
- Improve the diagnosis and treatment of mental health problems for those with long term physical conditions and the identification and treatment of anxiety or depression for those with physical health problems including medically unexplained symptoms

- Improve access for people with mental health problems to public health services that aim to increase physical activity, healthy eating, stop smoking and reduce harmful consumption of alcohol and drugs.
- Increase numbers of drug and alcohol users in treatment and increase the number of those successfully completing treatment through the commissioning of a recovery oriented treatment system.
- Ensure services are targeted and made accessible to specific groups such as substance misusers; people who experience domestic violence; newly arrived migrants; people in the criminal justice system; homeless people; people on the autistic spectrum; people with learning disabilities, and carers.
- Work in partnership with other services within the city such as cultural services, to deliver activities and environments which support good mental health

The Health and Wellbeing Board aims to support people with severe and enduring mental health needs by:

- Supporting commissioning of effective mental health services that are accessible to all, including the most disadvantaged and excluded
- Ensuring that all people with severe mental health problems receive high quality care and treatment in the least restrictive environment, in all settings
- Ensuring equity of access to high-quality, appropriate, comprehensive services for all groups, including the most disadvantaged and excluded
- Ensuring services are designed around the needs of individuals, ensuring appropriate, effective transition between services
- Continuing to work to reduce the suicide rate for Leicester city
- Promoting the public understanding of mental health and so decrease negative attitudes to people with mental health problems
- Improving access and uptake of mental health services among homeless people and ensuring that such services are designed with the particular needs of these groups in mind.

Leicester City CCG

Leicester City CCG is now the main commissioning body for local mental health services. Public consultation indicated the need to improve mental health services. Improving mental health care is a key strategic priority in the Commissioning Strategy. The section on mental health focuses on 3 core areas, improving dementia care, expanding access to the range of services offered by the local Improving Access to Psychological Therapies Service (IAPT) and improving access to emergency and acute mental health services.

With regard to dementia the CCG approved the Leicester, Leicestershire and Rutland Joint Dementia Strategy, which aims to increase awareness, early diagnosis and access to high quality dementia care. Currently the CCG is taking forward the implementation plans and working with local partners to ensure delivery.

In expanding access to and the range of services offered by IAPT the CCG aims to expand the therapies offered and access for a wider number of people, including those with more complex mental health problems.

The CCG suggests that this service will include a new pathway for those with severe and enduring mental illness, while improving access rates to 20% from 15%, offering greater access to older

people and people with long-term conditions, and will involve the development of additional local quality indicators. This new service has already started.

In improving access to emergency and acute mental health services the CCG considers that there should be better access to emergency and crisis based services. In order to achieve this CCG aims to implement:

- Re-specification of the crisis resolution home treatment service – integration with acute inpatients and development of a single point of access for urgent and crisis mental health care. The redesign will enable early discharge
- Adult Community Mental Health Team (CMHT) – redesign of this service to improve response and waiting times through the use of ‘productive community teams’
- Emergency mental healthcare – redesign of liaison psychiatry services to provide emergency mental health care from the A&E unit at UHL in order to ensure that patients with acute psychosis, or requiring emergency mental healthcare, receive are treated without unnecessary admissions, while also ensuring they receive the most appropriate services.
- Inpatient acute mental healthcare – improving inpatient care and methods for managing demand and capacity to ensure that bed occupancy levels are maintained, eliminating the use of seclusion

These actions are currently being implemented. In future the CCG aims to use its contracting processes to ensure services are meeting agreed outcomes.

LLR 5-Year Strategy

NHS England Planning guidance for 2014/15 requires health and social care communities to prepare 5 Year Strategic plans which outline the long-term direction for health, care and support services across the local health economy. Of the 5 main workstreams chosen for Leicester, Leicestershire and Rutland, dementia, mental health, respiratory disease, cancer and CVD, 28% of spend, or £126,868,644, is used on mental health care.

Workshops for the 5-year strategy suggest that there are at least 6 problems related to mental health. These are low levels of screening and prevention, lack of systematic detection and risk assessment in primary care, poor information sharing and communication, including sharing of best practices, misinformation regarding care pathways, lack of enhanced recovery pathways/early discharge and anticipatory care and lack of stratified risk pathways for patient-led post treatment care.

The root causes of these problems are considered to be lack of targeted, demographically appropriate and coordinated prevention approaches-education, lifestyle, screening; lack of knowledge/training in some parts of primary care to support detection and diagnosis; limited multi-disciplinary training; capacity issues; limited IT systems-not linked; uncoordinated and fragmented service pathways, and not enough coordination with voluntary sector and social care; lack of consistent identified key worker, access to information and wider support to help patients manage and lead their own care, recovery and follow up.

The priorities highlighted for improving mental health are

- Screening and stepped care in drug and alcohol abuse.
- Early intervention with children and adolescents.
- ‘5 a day’ equivalent for mental health

Some of the problems and solutions which have been discussed include improving the skills of people in primary care, increase staff capability to manage mental health conditions. Improving data sharing, better coordination between services, tackling the stigma associated with mental illness, and targeting particular groups and risk identification of the most vulnerable.

Thus far the strategy advocates using the JSNA to underpin service developments. It recommends changes at all levels of service provision including at the bottom of the pyramid with a citizen based approach and recovery model running through the whole of the pathway. This would also include easier referrals, co-location of teams (e.g. crisis teams in the emergency department), more provision for psychological therapies and voluntary and community sector organisations incorporated into care structures.

Joint Commissioning Strategy on mental health 2011-13

The Joint Commissioning Strategy for Mental Health 2011-13 set out the commissioning intentions of NHS Leicester City and Leicester City Council in respect of mental health services. At the time Leicester City PCT was the key NHS partner responsible for commissioning local health services. Leicester City Council continues to be responsible for commissioning social care services.

The aim of the strategy was to improve the wellbeing of the people of Leicester by strengthening resilience, reducing health and social barriers to good mental health and wellbeing and improving local communities. It set out 3 broad aims:

Prevention and Early Intervention

- Improving access to psychological therapies (this includes specialist CBT, Personality Disorder and Psychodynamic Therapy) steps 1-5 including early intervention with people who have long-term health conditions (diabetes/COPD).
- Supported Living – supporting people with mental health conditions to move from residential homes into independent housing and maintaining people to continue to live in their own home with support
- Strengthening crisis intervention within health and social care in order to prevent people from requiring admission to hospital and maintain and support them safely within the community

Transforming Social Care

- Personalisation – providing individuals with greater choice and control over the support/services they need
- Personalised Budgets

Supporting the Mental Health of Older People

With regard to the mental health of older people, there is a focus on developing an integrated dementia care pathway, covering the spectrum of need for people with dementia from early diagnosis and intervention to end of life care.

The strategy looked to follow key principles and values in delivering services:

- Delivering Race Equality in Mainstream Services
- Implementing the Mental Health Charter

- Value User/Carer experience and use this to inform service design/redesign
- Strengthen partnership working with all key stakeholders including voluntary sector and partners

In order to achieve this vision the strategy aimed to:

- Promote good mental health and well-being
- Improve services for people who have mental health problems
- Help people to look after their mental health and prevent them from becoming ill
- Tackle the stigma that's associated with mental ill health by focussing on whole population mental health
- Recognise that mental health and well-being is everybody's business
- Work in partnership with service users and their carers throughout the commissioning process
- Commission services of a high quality that will meet the needs of the service users
- Ensure Mental Health services are closely integrated with general health services
- Develop services closer to home, where ever possible
- Develop well planned care which will aim to support people in achieving recovery
- Implement personalised care plans for people assessed as needing services.

Policy context on Learning disabilities

The policy direction for meeting the health care needs of people with learning disabilities is underpinned by a commitment to social justice and inclusion. It focuses on increased community based care and equitable outcomes.

In 2001, the Department of Health published *Valuing People*²¹ a national strategy for learning disabilities. It offered guidance on service organisation and development. It emphasised four key principles for the future delivery of health care for people with learning disabilities; **rights, independence, choice and inclusion**. Despite the development of this strategy, significant service development is still required to ensure that people with learning disabilities have access to high quality comprehensive health and social care.

The policy initiatives suggest a *modus operandi* to address the disadvantages and to meet the additional and complex needs of this population. *Valuing People* accepted that there are some key outstanding issues which need to be considered such as poorly co-ordinated services, insufficient carer support, unmet health care need and limited service choice. It also suggests that people with learning disabilities lack control over their own lives.

Despite the strategic changes earlier in the decade, in 2008, Michael reported there were still shortcomings in services, and that people with learning disabilities are not a priority. One of the recommendations of the *Michael's Report (Healthcare for all)*²² was that the Department of Health should amend the *Core Standards for Better Health*, to include the need for reasonable adjustments to the delivery of services for people with learning disabilities. The report also emphasised that Primary Care Trusts should commission direct enhanced services to provide regular health checks and to improve data, communication and integration, in a bid to reduce the risk of premature avoidable death for people with learning disabilities.

This has been added to by the Report into Winterbourne View which highlighted a widespread failure to design, commission and provide services which give people the support they need close to home. There was also a failure to assess the quality of care or outcomes being delivered for the very

high cost of places at Winterbourne View and other hospitals.²³

For many people however, even the best hospital care will not be appropriate care. People with learning disabilities or autism may sometimes need hospital care but hospitals are not where people should live. Too many people with learning disabilities or autism are doing just that.

Clearly, with the development of CCGs, it is necessary to ensure that commissioners are cognisant of the high levels of unmet need and receive less effective treatment experienced by people with learning disabilities. In addition, new commissioning bodies should also be aware that the Disability Discrimination Act and the Mental Capacity Act provide a legal framework for the delivery of equal treatment.²⁴

Locally there has been a Leicestershire Learning Disability Register, a joint initiative between the University of Leicester and local health care trusts. It was established in 1987, in response to carer and client demands for better coordination and continuity of care. The Register facilitates the planning, evaluation and monitoring of services for people with learning disabilities by generating evidence-based public health intelligence.²⁵ Each registered person has been visited every 5 to 7 years, and information is collected through interview.

Measuring Outcomes

The NHS and Adult Social Care and Public Health Outcomes Frameworks all contain indicators related to the objectives set out in *No Health Without Mental Health* and provide a useful starting point for future development. Importantly, all three frameworks accord importance to mental and physical health outcomes as a measure of effectiveness. Commissioners' performance will be judged against these outcomes by the national NHS Commissioning Board, and potentially at local level by health and wellbeing boards and local HealthWatch.

The NHS Outcomes Framework: The purpose of the NHS Outcomes Framework is to set priorities for the service. It measures outcomes across five domains: preventing people from dying prematurely; enhancing quality of life for people with long-term conditions; helping people recover from episodes of ill health or following injury; ensuring people have a positive experience of care; treating and caring for people in a safe environment and protecting them from avoidable harm. There are a number of measures included in the NHS Outcomes Framework that directly relate to the objectives of the mental health strategy. For example, measures of the under 75s mortality rate in people with serious mental illness, employment for people with mental illness, and patient experience of community mental health services are all included in the framework for 2011/12.

The Public Health Outcomes Framework: The Public Health Outcomes Framework suggests a number of national and local level indicators to help government, local Health and Wellbeing Boards and local communities to track progress. A large number of the indicators have a clear relevance to the objectives in the mental health strategy, for example, the proportion of people with mental illness and or disability in settled accommodation, the number of first time entrants to the youth justice system, and measures of the smoking rate of people with serious mental illness.

The Adult Social Care Outcomes Framework: *Transparency in Outcomes: a framework for adult social care*²⁶ was published in parallel with the vision for adult social care in November 2010. It set out a number of proposed outcomes relevant to mental health. The document does not focus on top-down performance management of local authorities but rather one of transparency through an enabling framework. Some of the indicators correlate appropriately with the aspirations of *No Health without Mental Health*.

Mental health promotion

This chapter sets out some of the links between mental health and wellbeing, productivity and the wider environment. A key message for commissioners to consider is that, given the scale of mental ill health, promoting mental wellbeing is crucial. There are many initiatives which could inform commissioning for mental wellbeing, including guidance on wellbeing at work, mindful commissioning, encouraging self-help, exercise and creativity. Among the recommendations at the end of the chapter is the need to ensure that mental health and wellbeing is everyone’s business and the use of health promotion initiatives such as the 5 Ways to Wellbeing.

The following table is a list of the kind of resources which may be used to improve local resilience to mental illness through mental health promotion.

Leicester, Leicestershire and Rutland Mental Health Promotion Network	<ul style="list-style-type: none"> ▪ Strengthening individuals ▪ Strengthening communities ▪ Reducing structural barriers to mental health
NICE Public Health Guidance	<ul style="list-style-type: none"> ▪ Promoting Mental Wellbeing at work ▪ Community engagement to improve health ▪ Physical activity and the environment ▪ Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation ▪ Promoting physical activity for children and young people
Foresight Report	Creating resilience to mental illness across the life course
Five Ways to wellbeing	<p>Evidence-based actions which promote people’s wellbeing. They are:</p> <ul style="list-style-type: none"> ▪ Connect ▪ Be Active ▪ Take Notice ▪ Keep Learning ▪ Give
Libraries	Libraries in Leicester offer Books on Prescription, which are free to loan, as a self-help tool for people with mental health problems. They are also a valuable resource for community resilience, offering meeting spaces, use of IT equipment for job applications etc. and opportunities to improve literacy skills
Creativity and co-production	Local examples include BrightSparks, Fosse Arts and even the Comedy Festival.
Annual Report of the Chief Medical Officer 2013	Epidemiology of public mental health, quality of evidence, the economic case for good mental health; outlines the importance of parity of esteem

Promoting positive mental health

Mental health is more than just an absence of mental illness.²⁷ It influences how people think about themselves and others, their ability to learn and communicate, to form and sustain relationships and to interpret and cope with change and life events.

Mental health promotion considers individual and collective action to enhance mental wellbeing. It can be aimed at the general population or targeted at individuals at greater risk, vulnerable groups and those with mental health problems.

Promoting mental health carries significant social, economic and health benefits. These include preventing mental ill health and improving the health and wellbeing of individuals with mental health problems. It has wider benefits such as improved physical health, increased emotional resilience, increased social inclusion and improved productivity.²⁸ It supports action to challenge the stigma of mental illness and ways of tackling the prevention of suicide and self-harm.²⁹

There is no discrete budget for mental health promotion in Leicester. Whilst health care has the main burden of improving health and wellbeing, protecting mental health may rely on the resources which are available in systems which are adjacent to health, such as housing, employment and education. However, given the societal impact of mental illness commissioners should consider that direct investment in mental health promotion will represent a good use of resources.

Obesity and nutrition

The brain requires energy and a range of nutrients to function well. Good nutrition is vital for both physical and mental health. Obesity disproportionately affects people with mental illness, learning disability and physical disability.^{30 31} Antipsychotic medication can cause significant weight gain, dyslipidaemia and diabetes.³² Obesity is more common in people with major depression, bipolar disorder, and panic. People with mental illness may often have less healthy diets and make poorer dietary choices than people without mental illness.³³ They may eat less fresh fruit and vegetables, and are less likely to have breakfast.

Physical activity

People with serious mental illness are less likely to exercise.³⁴ Regular physical activity is associated with improved mental health and wellbeing and lower rates of depression and anxiety across all age groups.³⁵ There is a positive relationship between physical activity and mental capacity in older people.³⁶ Physical activity brings a range of benefits beyond direct health outcomes, in particular promoting community cohesion and addressing health inequalities. UK household surveys conducted in 2002 and 2004 found increased levels of physical activity to be associated with measurable improvements in mental health and well-being.³⁷ NICE guidance on depression cites 17 RCTs showing physical activity can reduce symptoms of depression. NICE concluded that evidence supports physical activity as an effective treatment for sub-threshold depressive symptoms and mild to moderate depression. It found that group physical activity also benefits mental health.³⁸

NICE Public Health Guidance³⁹

NICE Public Health guidance makes recommendations for populations and individuals on activities, policies and strategies to prevent disease or improve health. Guidance may focus on topics (such as smoking), populations (such as schoolchildren) or settings (such as the workplace). Much of the guidance has links to protecting mental health and wellbeing. Some examples are as follows:

Promoting Mental Wellbeing at work

Promoting mental wellbeing at work (PH22) focuses on promoting mental wellbeing through productive and healthy working conditions. It covers 5 areas (strategy, assessing opportunities for promoting mental wellbeing and managing risk, flexible working, the role of line managers, and supporting micro, small and medium-sized businesses). It offers interventions to promote mental wellbeing through productive and healthy working conditions, suggesting that mental wellbeing at work is determined by the interaction between work, the working environment and individuals.

Community engagement to improve health⁴⁰

Formal evaluations of initiatives such as health action zones, New Deal for Communities and Sure Start schemes pointed to implementation difficulties. Community engagement (PH 9) guidance looks at how communities can be effectively involved in the planning (including priority setting and resource allocation), design, delivery and governance of health promotion activities and activities and initiatives to address the wider social determinants of health. It offers a variety of methods, such as neighbourhood committees, forums and community champions.

Physical activity and the environment⁴¹

Public health guidance on environments that support increased physical activity (PH 8), <http://publications.nice.org.uk/physical-activity-and-the-environment-ph8>, demonstrates the importance of environmental improvements and the need to evaluate how they impact on the public's health.

Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation⁴²

Physical activity is essential for good health. It promotes mental wellbeing, can help reduce the risk of coronary heart disease, stroke, cancer, obesity and type 2 diabetes. Physical activities, such as walking and cycling offer pleasure, independence and exposure to outdoor environments. Guidance PH 41 (<http://publications.nice.org.uk/walking-and-cycling-local-measures-to-promote-walking-and-cycling-as-forms-of-travel-or-recreation-ph41>) aims to set out how people can be encouraged to increase the amount they walk or cycle for travel or recreation purposes.

Promoting physical activity for children and young people⁴³

Public Health guidance 17 (<http://publications.nice.org.uk/promoting-physical-activity-for-children-and-young-people-ph17>) is for all those who have a direct or indirect role in – and responsibility for – promoting physical activity for children and young people. It includes recommendations for schools, but does not make recommendations for the national curriculum. It complements other national health campaigns and strategies to increase participation in play and sport and reduce obesity (such as 'Change4Life').

Foresight Report

The aim of the Foresight report on Mental Capital and Wellbeing (2008) was to use the best available evidence to develop a vision for future mental health and wellbeing. It considers the concepts such as “mental capital” and “mental wellbeing”. It makes recommendations on how to meet future challenges, so that everyone can realise their potential and flourish. The project outlined priority actions and how available resources could be better allocated.

The Foresight Report highlights the following signposts for action:

- **Improve diagnosis and treatment**
- **Address stigma and discrimination**
- **Target risk factors and very high risk groups**
- **Strengthen protective factors**
- **Integrate primary, social and occupational care**
- **Harness wider policies in government**
- **Monitor impact of new policies on mental health and wellbeing**
- **Improve access to work for people with mental health problems**
- **New ways of getting government to work together**

Future Challenges:

Children: Many factors may impact on children’s mental health and wellbeing needs. The report suggests that up to 10% of children have a learning difficulty, that dyslexia and dyscalculia can reduce lifetime earnings and that the developing brain leaves children vulnerable to mental health problems. In order to meet the challenge of children’s mental health, the Foresight Report advocates focusing on: Early detection; teacher training; coaching for parents and Looked After Children.

Wellbeing at work: Sustaining mental health in the workplace is vital. According to the Foresight Report 10 to 14 million days per year are lost through absenteeism, at a cost of £750 million. ‘Presenteeism’, attending work when one is not really well enough is estimated to cost about £900 million per year. Meeting the challenge of wellbeing at work requires: Training and retraining throughout our working lives, flexible working and improved line management and better integration of primary care and occupational health services.

Mental ill health: The Foresight Report suggests that although one in six adults in the UK currently suffer a common mental disorder at any one time, mental disorders are set to grow in the future. This means that meeting the challenge of mental illness should include: Scope for improving early diagnosis and treatment, addressing social risk factors – e.g. debt and addressing stigma and discrimination.

The ageing population: The report suggests that by 2071, over 65s could nearly double to 21m, over 80s more than treble to 9.5m and that by 2038, dementia could double to 1.4m, and costs treble from £17 to more than £50b per year. Meeting the challenge of the ageing population will require: Protecting mental capital through exercise, lifelong learning, promoting social networking, improved technologies for assisted living and early detection of cognitive decline.

Mental Health and Employment: People with mental health problems frequently suffer discrimination in the workplace. This forms one of the greatest barriers to social inclusion – the lack of a job is an obstacle to independence generally. Unemployment affects those with long term mental disorders more than any other groups of people with disabilities.

*Mental Health and Employment in the NHS*⁴⁴ suggested that a key Government objective is to enable all disabled people, including those with mental health problems, to make the most of their abilities at work and in the wider society, by:

- Providing active help for people to move into work;

- Taking the obstacles out of the benefits system;
- Promoting equality and opportunity in the workplace.

It suggested that the NHS should be making a significant contribution to delivering these objectives, setting an example to show that discrimination against people with mental illness is taken seriously, that mental health should not be the cause of ridicule and that people with a mental health problem have the same right to be treated fairly and with respect as everyone else.

Employers' Organisations and the Department of Work and Pensions suggest that the most common cause of long term (>6 weeks) sickness absence in the UK is stress. A systematic review⁴⁵ found that the evidence supported the principle of a co-ordinated return to work plan, the need to identify people at risk of long term sickness absence from primary care and de-medicalising the reasons for absence.

The Kings Fund recommends case management as an effective way to integrate health and social care towards successful outcomes. This approach is successful in guiding people with common mental health problems towards employment. NICE guideline (PH19) on the management of sickness absence also supports de-medicalisation and a case management approach.

It was in the light of this evidence that **Fit for Work Pilots** were developed. In Leicester the importance of employment to mental health is shown in the partnership between Open Mind IAPT and the **Fit for Work Team**. The philosophy of the Fit for Work Team is that human interventions, rather than therapy, can help people with mild to moderate anxiety and depression return to work.

It uses case management to deliver these interventions. Case management is a tool used to integrate services around the needs of individuals with long-term conditions. It works best as part of a wider programme, such as good access to primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation and re-ablement.

Headline data from the Fit for Work Team's employment support for Leicester Open Mind IAPT for the period January to November 2013 is that there were:

- 251 people accepted for employment support
- 166 completed cases.
- 56% employed, 44% unemployed, 55% from BME community
- 74% improved EQ5D score (improved health status used for financial modelling of health outcomes)
- 74% improved GAD7 score (reduction in anxiety)
- 55% below IAPT score for active symptoms (caseness)
- 83% improved PHQ9 score (reduced depression)
- 64% below IAPT score for active symptoms (caseness)

Vocational outcomes:

- Employed - 84% workforce retention
- Unemployed - 41% into workforce

Annual Report of the Chief Medical Officer (CMO) 2013⁴⁶

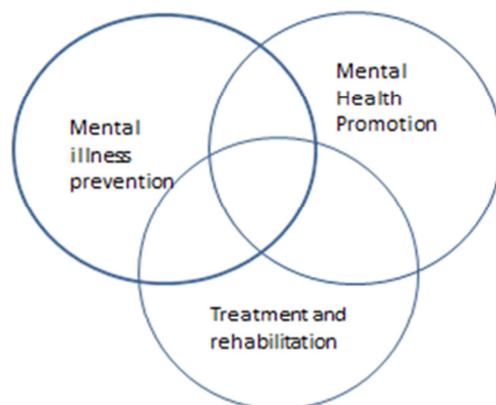
The 2013 CMO Annual Report suggests that mental illness and wellbeing are not ends of the same continuum, and that it is possible to have a subjective sense of wellbeing despite having a mental illness. When this is not understood there is sometimes a blurring of the boundaries between

wellbeing promotion, prevention of mental illness, and treatment of mental illness. The report argues that there is no robust evidence that a population approach to improving wellbeing will have any impact on the prevalence of mental illness.

In this context it is important to give priority to public mental health interventions which have a strong evidence base of effectiveness. Wellbeing approaches based on evidence, such as the NICE Public Health Guidelines about social and emotional wellbeing in children, should form part of a wide approach to public mental health.

The CMO refers to the model proposed by the World Health Organization, which illustrates the opportunities for mental health promotion, mental illness prevention and treatment of and recovery from mental illness. This is shown in the figure below.

Figure: Relationship between mental health promotion, mental illness prevention and treatment and rehabilitation



Leicester, Leicestershire and Rutland Mental Health Promotion Network⁴⁷

An important local resource is the Leicester, Leicestershire and Rutland Mental Health Promotion Network. This group seeks to promote mental health and reduce the discrimination and social exclusion associated with mental health problems. To achieve this, the Network uses the Mental Health Promotion Quality Framework produced by the Health Education Authority. This has three strands:

- Strengthening individuals - or increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
- Strengthening communities - this involves increasing social inclusion and participation, improving neighbourhood environments, developing health and social services, which support mental health, anti-bullying strategies at school, tackling violence and abuse of children and adults, workplace health, community safety, childcare and self-help networks
- Reducing structural barriers to mental health - through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable

Five Ways to Wellbeing

One way in which commissioners may improve wellbeing for the whole population is through the Five Ways to Wellbeing.⁴⁸ These are a set of actions which promote people's wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give. These activities are simple things individuals can do in their everyday lives.

The Five Ways have been used by health organisations, schools and community projects across the UK and around the world to help people take action to improve their wellbeing. They've been used to get people to start thinking about wellbeing, to develop organisational strategy, to measure impact, to assess need, for staff development, and to help people to incorporate promotion of wellbeing activities into their lives.

Libraries: books on prescription

Leicester Libraries offer a network of non-stigmatised, safe and trusted community spaces with digital access, which especially reaches out to meet the needs of disadvantaged communities. They offer information about health and wellbeing, social care and health signposting and cultural activities to keep people active and engaged.

As part of the health promotion activity of the modern reading service and learning resources local libraries offer Books on Prescription. Such schemes are a form of bibliotherapy, an alternative way of making psychotherapy available to people with mild to moderate mental health problems. Leicester Libraries is a key supporter and partner of choice for the health and social care sectors, offering health and wellbeing information and support at local libraries, including the Reading Well Books on Prescription scheme. The scheme uses high-quality cognitive behavioural therapy self-help books, which have been endorsed by health care professionals. These provide help and treatment for a range of common emotional and mental health problems such as depression, anxiety, phobias, low self-esteem, insomnia, panic and agoraphobia, obsessive compulsive disorder and eating disorders. It offers a core list of books.

Creativity and mental health and wellbeing

There is evidence that creativity can have a beneficial impact on health and wellbeing⁴⁹. Some initiatives derive their benefits partly from increased physical activity, for example in dance or singing. However, the main benefits in all arts and health initiatives relate to emotional health and wellbeing, improving self-esteem, reducing the symptoms of anxiety and depression, and providing opportunities for supportive social contact. In Leicester, such initiatives may include BrightSparks, Fosse Arts and even the Comedy Festival.

BrightSparks arts in mental health group aims to use the arts to promote positive images of mental health, social inclusion and service user and carer involvement. It acknowledges supports and showcases the creative talent that exists within the mental health community through an expanding portfolio of creative projects, such as the BrightSparks Annual Showcase, The Brighter Side and Artspace.

Fosse Arts provides creative activities for both individuals and groups, with two studios, one for ceramics and pottery and one for general arts activities.

Some of the feedback from Fosse Arts suggested that

- “This place changes people’s lives, without this a lot of the most vulnerable people would be left isolated”
- “I love to come here I learn so much here, it brings me alive. I don’t go out anywhere else, it’s very important to me to come, like watching the sunrise in the morning”
- “I love coming to pottery its stimulating and I have met so many new friends, I don’t feel disabled because everyone accepts me for who I am”
- “(Fosse Arts) it gets me out of the home into a safe environment it has encouraged me to engage with society again. I applied successfully for University course for 1st Time in my life as a result.”

The Yellow Book from the Rethink Your Mind project seems to combine elements of bibliotherapy and creativity. Endorsed by the NHS Confederation Mental Health Network, the Institute of Psychiatry and the Royal College of Psychiatrists, it is a self-help guide for people who require mental health support, their families, friends and anyone who wants to find out more about mental ill health. It also signposts readers to a range of organisations and contains pieces of artwork and poetry from a nationwide competition.

The Six priority areas for promoting wellbeing in children and young people

The factors that contribute to positive and negative emotional health amongst children and young people are explored under six priority area headings, developed by the Children’s Society.

The conditions to learn and develop: Children need to be given the conditions to learn and develop, starting early, with support during pregnancy and birth and continuing on to high quality education in school. Factors that can be explored include; Perinatal health, Good level of development at age 5, GCSEs, School absenteeism.

- **A positive view of themselves and an identity that is respected:** Children need to see themselves in a positive light, deserving to feel and be respected by all adults and other children. Factors that can be explored include; Children with disabilities; Young people who smoke and drink; Children not in education, employment, or training (NEET); Pregnant teenagers; Asylum Seekers, Refugees and Immigrants; Gypsy, Roma and Traveller children and Ethnic minorities.
- **Have enough of what matters:** Children who live in poorer households are twice as likely to have low wellbeing compared to children in more economically stable households (Children’s Society, 2012). ‘Having enough’ and ‘fitting in’ are more important than being very well off. Factors that can be considered under this heading include; Child poverty and Children Living in Single Parent Households.
- **Positive relationships with family and friends:** The strongest driver of low subjective wellbeing is when children experience weak and uncaring relationships with their family or carer. Stable positive relationships with family and friends are of great importance. Factors that can be explored here include; Children looked after; Missing children and Children whose parents have mental health and other problems.
- **Safe and suitable home environment and local area:** Children need safe and suitable environments at home and in their local area. Feeling safe, privacy, and good local facilities are important to wellbeing, Factors such as poor quality or overcrowded housing or moving house a lot are risk factors to wellbeing, homelessness and aggression and violence.
- **Opportunity to take part in positive activities to thrive:** A healthy balance of time, involving choice and autonomy, is important to wellbeing. This would include opportunity to spend time with friends and family, time to oneself and the opportunity to be active. Children and

adolescents at risk in this respect include: Teenage parents; Young carers and participation in physical activity and other positive activities.

Gaps, Findings and Recommendations

Promoting mental health carries significant social, economic and health benefits, including preventing mental illness and improving mental and physical health and wellbeing. Signposts for action include improving diagnosis and treatment, addressing stigma and discrimination in workplaces, targeting health inequalities, high risk groups and strengthening protective factors.

The main gap in Leicester is that there is no specific funding for mental health promotion, though specific projects are undertaken on an *ad hoc* basis. The Mental Health Promotion Network aims to ensure that resources available in systems adjacent to health, such as housing, employment and education, are used to protect mental wellbeing. However, investment in the promotion of mental health, developing community projects might represent a good use of resources, given the wide impact on health.

It is recommended that commissioners support the development of the mental health promotion agenda by

- Ensuring that mental health and wellbeing is everybody's business
- Linking mental health promotion activity to all health and leisure activities
- Making a commitment to mindful commissioning of services
- Commissioning
- Using mental health promotion impact assessment tools to ensure strategies and initiatives do not produce unintended negative outcomes for mental health
- Influencing employers in Leicester to develop robust mental health in the workplace programmes and implement strategies to promote employment of people with mental health problems
- Promoting anti stigma messages and support action to reduce discrimination
- Ensuring that mental health and wellbeing cuts across all local strategies, such as economic development, libraries, transport, arts and culture and the environment.
- Funding specific mental health promotion topics

Perinatal maternal mental health

This chapter builds on the evidence from the policy background, such as 1001 Critical Days, to show the impact of perinatal maternal mental health on the health and wellbeing of women, children, families and communities. The importance of this period on child and family life means that commissioners should take advantage of the full range of available resources, such as Children’s Centres, midwives and health visitors, and develop frameworks to integrate those resources with mental health services.

The PAWS and PoNDER research trials indicate that training community midwives and health visitors in psychological approaches can have a protective effect on women in the antenatal and postnatal periods. PoNDER shows that this training is cost effective.

There was a well-liked and effective Perinatal Psychiatric Service for Leicester, Leicestershire and Rutland. However, Leicestershire Partnership Trust (LPT) ceased to deliver the inpatient element of this service in 2014, because it was not compliant with Royal College of Psychiatry guidance. This closure will present significant challenges, especially given higher than average rates of mental ill health in Leicester.

Women in Leicester with significant perinatal maternal mental illness, which requires inpatient care, will receive that care in either Nottingham or Derby. It will be important for commissioners to ensure the provision of high quality community support for women in the perinatal period.

Headline findings for perinatal mental health in Leicester

Estimated incidence in Leicester based on 5,000 births/year	<ul style="list-style-type: none"> • Post-partum psychosis 10 cases/year • Chronic serious mental illness 10 cases/year • Severe depressive mental illness 150 cases/year • Mild-moderate depressive illness/anxiety 500-750 cases/year • Post-traumatic stress disorder 150 cases/year • Adjustment disorders and distress 750-1,500 cases/year
NICE Guidance for best practice CG45	<p>Prediction and detection questions</p> <p>Psychological treatments</p> <p>Management of depression</p> <p>Clinical Networks</p>
Service Provision for Leicester	<p>Universal services: GPs, midwives, health visitors</p> <p>Specialist Services: Leicestershire Perinatal mental health service due to close in April 2014</p>
Research	<p>PAWS and PoNDER: Effective perinatal mental health care may be delivered by midwives and health visitors who have training in cognitive behavioural therapy techniques</p>

Perinatal Maternal Mental Illnesses

Perinatal maternal mental illness refers to the range of mental health problems which can affect women during pregnancy and after birth; these include anxiety, depression and postnatal psychotic disorders. The incidence of some common mental health disorders does not change in the perinatal period; pregnant women and new mothers have the same level of risk as other adults. However, their occurrence during the perinatal period can have a significant impact on women, children and families.

Severe mental illness is often experienced for the first time by women during pregnancy and childbirth. Those with a history of severe mental illness find that it may persist, deteriorate or recur during the perinatal period because of the social, psychological and physical changes associated with childbirth. The risk of developing or experiencing a recurrence of severe mental illness, such as postpartum psychosis, severe depression, schizophrenia or bipolar conditions increases after childbirth.⁵⁰

Depression is the most prevalent mental illness in the perinatal period; 10-14% of mothers are affected during pregnancy or after the birth of a baby.^{51 52} Most cases are mild to moderate, but some women experience severe depressive illness.⁵³ Depression is more likely to be experienced in late pregnancy than after birth,⁵⁴ and often occurs at the same time as feelings of anxiety.⁵⁵ Many women with postnatal depression experience similar symptoms during pregnancy, and could have been identified in the antenatal period.⁵⁶ Better antenatal detection of depression therefore offers an opportunity for earlier intervention.

Perinatal obsessive compulsive disorder (OCD) can occur at any time, but the onset of OCD, or the worsening of symptoms, has been associated with pregnancy and childbirth.⁵⁷ This may be explained by hormonal changes, and the psychological distress of pregnancy and infant care. Some studies suggest that perinatal OCD is experienced by 3% of new mothers.⁵⁸

Perinatal OCD is similar to other forms of OCD, but the focus of a woman's obsessions and compulsions are more likely to focus on the baby. For example, women might experience extreme fears of harming their baby, leading to excessive checking of the baby and seeking reassurance.⁵⁹ These thoughts, and consequent behaviours, may hamper women's wellbeing, their experience of pregnancy and parenting.

Postpartum, or puerperal, psychosis is a severe mental illness that affects around 2 in 1000 new mothers.⁶⁰ It causes symptoms such as confusion, delusions, paranoia, hallucinations and symptoms of mania and depression. Unlike milder forms of depression and anxiety, this severe mental illness is more likely to occur after childbirth. Most cases occur during the first few weeks of a child's life.⁶¹ Women are 20 times more likely to be admitted to a psychiatric hospital in the 2 weeks after delivery, than at any other time in the two years before or afterwards.

Post-traumatic stress disorder (PTSD), and mental health problems which result from childhood trauma, can recur or worsen both during pregnancy and after childbirth. Rates of PTSD are higher in pregnant women than in adult female population as a whole.⁶² It is thought that the experience of being pregnant triggers the symptoms of these disorders, particularly for women who have experienced childhood abuse or sexual abuse, as they may experience complex feelings as a result of becoming a parent, and the physical care experienced in pregnancy.⁶³ PTSD can also be triggered by childbirth, and is estimated to occur in approximately 3% of women after birth. Women are particularly at risk if they have an emergency caesarean, are admitted to high dependency care units, or if their baby dies.⁶⁴

Many fathers can experience mental health problems in the perinatal period. Between a quarter and half of new fathers with depressed partners are depressed themselves.⁶⁵ Paternal depression in the perinatal period has been shown to affect couple relationships and the developing infant.^{66 67}

Women who have a history of severe perinatal mental illness, such as postpartum psychosis or severe depression, have about a 50% chance of it recurring in a subsequent pregnancy.⁶⁸ Women who have had a previous episode of bipolar disorder (which may or may not have been related to the birth of a child), are also at increased risk of having a severe episode in the perinatal period, even if they have been well during pregnancy and for many years previously.⁶⁹ Having a first-degree relative affected by mental illness is also an added risk factor for perinatal mental illness.⁷⁰

Socio-economic factors can also increase the risk of mental illness or exacerbate its effects. Rates of perinatal depression are higher amongst women experiencing poverty or social exclusion.⁷¹ However, whilst there is an increased risk of mental illness amongst some disadvantaged groups; perinatal mental illness can affect women from all sections of society. More than 50% of women who committed suicide during pregnancy or shortly after birth in the UK between 2006 and 2008 were white, married, employed, living in comfortable circumstances and aged 30 years or older.⁷² The risk of depression is twice as high amongst teenage mothers.⁷³ In addition the stress caused by issues such as poor housing, domestic violence and poverty can exacerbate symptoms of anxiety and depression.

Non-psychotic conditions, such as depression, are common during pregnancy and following delivery. There is an increased incidence of serious mental illness following delivery, but not during pregnancy. Recurrences and relapses of affective disorder (bipolar disorder/depression) are common in pregnancy, especially if a person's medication has been stopped.

According to the Royal College of Psychiatrists⁷⁴ evidence suggests that between 3% and 5% of delivered women will meet the criteria for moderate to severe depressive illness. Those who are at increased risk include the young, those who experience conflict in their family life, those who have been anxious or depressed before and those who have little or no social support. As there are about 5,000 births in Leicester every year, this means that between 150 and 250 moderate to severe cases of depression in Leicester. Evidence also suggests that in Leicester there will 10 cases of postpartum psychosis.

Table 4: Rates of Perinatal Psychiatric Mental illness applied to Leicester

Rates of Perinatal Psychiatric Disorder per 1000 maternities	Rates based on evidence	Evidence applied to Leicester based on 5000 births/year
Postpartum psychosis	2/1000	10 cases
Chronic serious mental illness	2/1000	10 cases
Severe depressive illness	30/1000	150 cases
Mild-moderate depressive illness and anxiety	100-150/1000	500-750 cases
Post-traumatic stress disorder	30/1000	150 cases
Adjustment disorders and distress	150-300/1000	750-1,500 cases

Universal Services

Universal and obstetric services are involved in the prediction and detection of mental health problems for women who are in the perinatal period. At a woman's first contact with services in both the antenatal and the postnatal periods, healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask questions about:

- Past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression
- Previous treatment by a psychiatrist/specialist mental health team including inpatient care and family history of perinatal mental illness.
- Self-reported measures such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire 9 (PHQ9).

Specialised services

Women with serious mental illness complicating childbirth require specialised expertise. This includes knowledge of care available for new mothers, the risks and benefits of medication, helping mothers to meet the physical and emotional needs of their babies and the skills to care for women with a serious mental illness. The complexity of this care means that perinatal maternal mental health services are organised differently to other mental health services. There are, for instance, connections with maternity services, links to children's social care services, and special thresholds and response times to meet the needs of mother and infant.

Care of mothers who are suffering with a psychotic condition will require inpatient care, in a mother and baby unit, to meet the physical health needs of mother and child as well as resolving the mental health need. Women who have a non-psychotic mental illness may not require inpatient mental health care, but will require support in primary care to mitigate the risk of the subsequent development of a more serious mental health problem.

Adult mental health services are not always familiar with perinatal mental health needs, a time in which psychosis can rapidly develop. This means that there is an important role for specialist perinatal services.

NICE Guidance: Antenatal and postnatal Mental Health (ICD-10; F53)

Antenatal and Postnatal Mental Health (CG45) (2007) covers all mental disorders, including perinatal mental disorders with the aim of helping clinicians to balance the risks of treating a mental disorder with the risks to the mother, her infant and other family members.

Prediction and detection: At a woman's first contact with services in both the antenatal and the postnatal periods, healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask questions about past or present severe mental illness, family history of perinatal mental illness and previous psychiatric treatment.

At a woman's first contact with primary care, the booking-in visit and post-natal (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

A third question should be considered if the woman answers 'yes' to either of the initial questions

- Is this something you feel you need or want help with?

Psychological treatments: Women requiring psychological treatment should be seen normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of lower threshold for access to psychological therapies during pregnancy and the postnatal period.

Before treatment decisions are made, healthcare professionals should discuss with the woman the absolute and relative risks associated with treating and not treating the mental disorder during pregnancy and the postnatal period. They should acknowledge the uncertainty surrounding the risks and describe risks using natural frequencies rather than percentages (for example, 1 in 10 rather than 10%) and common denominators (for example, 1 in 100 and 25 in 100, rather than 1 in 100 and 1 in 4).

Management of depression: The guidance suggests that for a woman who develops mild or moderate depression during pregnancy or the postnatal period, self-help strategies and non-directive counselling delivered at home and brief cognitive behavioural therapy or interpersonal psychotherapy should be considered.

The guidance also gives information about the best antidepressant to choose for pregnant or breastfeeding women.

Organisation of care: A regional clinical network exists for perinatal mental health services to provide:

- A specialist multidisciplinary perinatal service in each locality, offering direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams
- Access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- Clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental disorders, to ensure effective transfer of information and continuity of care
- Pathways of care for service users, with defined roles and competencies for all professional groups involved.

PAWS and PoNDER

PAWS and PoNDER are 2 studies which respectively looked at training midwives and health visitors in therapy techniques as a way of developing therapeutic relationships with their clients.

PAWS looked at evidence of antenatal depression as the main predictor of postnatal depression, focusing especially on the later stages of pregnancy. Before PAWS there had been few trials of antenatal interventions aimed at preventing postnatal depression, and none to prevent depression assessed before childbirth.⁷⁵

The purpose of PAWS was to evaluate the feasibility, and effectiveness of training community midwives (CMWs) in psychological approaches, to prevent perinatal depression. The study randomly selected CMWs, who received training on a psychological approach and then subsequently delivered enhanced care to consenting women on their caseload.

305 women from Leicestershire and Rutland were involved in the 2 year pilot study, funded by NIHR-CLAHRC, Leicestershire, Rutland and Northamptonshire. This demonstrated that training CMWs in a psychological approach to prevent perinatal depression in the antenatal period is feasible and potentially effective. Whilst CMWs felt that the training was an added burden, the pilot study provided an indication that the training and the delivery of enhanced care, could help prevent antenatal depression and improve the mental health of pregnant women.

The PoNDER study focused on identifying postnatal depression (PND), using the Edinburgh Postnatal Depression Scale (EPDS), with a clinical interview, to help assess postnatal women's mood and identify depressive symptoms and suicidal thoughts. In the EPDS, women who score ≥ 12 are at risk of PND.

The PoNDER study focused on psychologically informed interventions as a practical alternative to medication, utilising especially the role of health visitors (HVs) in alleviating PND. HVs in 101 clusters in 29 primary care trusts collaborated in the 3 year study. Some were trained in psychological therapy techniques. From 7,649 eligible women 4,084 (53.4%) consented to take part: 17.3% (595/3,449) of women who returned a 6-week questionnaire had a 6-week EPDS score ≥ 12 and were at-risk women; 70.3% (418/595) of at-risk women had a 6-month EPDS score available. The study showed a statistically significant protective factor for those women cared for by health visitors who had been trained in psychological therapy techniques.⁷⁶

The economic analysis showed a consistent pattern in which psychological approaches were cost effective at funding levels used by the National Institute for Health and Clinical Excellence. This effect was produced by lower mean costs and higher means quality-adjusted life-years gained in those women who were cared for by health visitors with psychological training.

PoNDER concluded that the package of HV training was effective compared with usual care in reducing the proportion of at risk women with a 6-month EPDS score ≥ 12 . The effect remained for 1 year. The economic evaluation found that the HV intervention was highly likely to be cost-effective compared with the control.

Services in Leicester

In Leicester women see obstetricians and midwives regularly throughout their pregnancy, and most deliver their babies in hospital. During the period after the birth women are seen by GPs and HVs. The CMO Report 2012 gives support to the drive to increase health visitor numbers.⁷⁷ Effective health visiting can improve the quality of life for new mothers and have a positive impact on reducing post-natal depression. Public health should be the catalyst for the use of health visiting resources to strengthen perinatal maternal mental health in Leicester.

The local Perinatal Psychiatry Service, provided by Leicestershire Partnership Trust, covered Leicester, Leicestershire and Rutland. It was established in 2003 because of the complicated clinical challenges associated with mental illness during pregnancy. It had both an outreach and an inpatient focus. LPT ceased to provide the inpatient component of this service in April 2014 because it was not compliant with NICE and Royal College of Psychiatry guidance and there was evidence of only a few women requiring inpatient care.

The service comprised a half time equivalent of a consultant liaison psychiatrist and a whole time community psychiatric nurse. The regional commissioning network suggested that this is below the basic staff requirement. The service held outpatient clinics at Leicester Royal Infirmary and at Leicestershire Partnership Trust. Patient satisfaction surveys showed that when the clinics were held

in the maternity unit patients experienced reduced levels of stigma associated with mental illness and higher levels of acceptance.

The service also had a 3 bedded mother and baby unit and conducted community follow up in association with local community health care teams. Perinatal Psychiatry staff liaised closely with obstetric services, offered second opinions, advised on medication and child protection, and trained other clinicians.

Given the high level of mental health need in Leicester, and the importance of the perinatal period in protecting mental wellbeing health, local and regional commissioners should that women in Leicester with significant perinatal maternal mental illness requiring inpatient care, will receive that care in either Nottingham or Derby. It will be important for commissioners to ensure the provision of high quality community support for women in the perinatal period.

A mother and baby inpatient unit should manage acutely mentally ill women and their babies where there are no viable alternatives to admission. The aim is therapeutic and ensures that no woman is separated from her baby because of admission to a psychiatric unit. The perinatal mental health inpatient unit at the Bradgate Unit recently closed as it did not meet the appropriate quality standards.

Community based psychiatric activity provides intensive home support for childbearing women with serious mental illness, working closely with the inpatient unit. It provides a service for assessing and managing significant mental illnesses that complicate pregnancy and the postpartum period which cannot be managed effectively and safely by primary care services and assists in the detection and proactive management of those at risk of becoming seriously ill and provide assistance to primary care, maternity and psychiatric services.

Referrals to the service are often urgent and complicated by child protection issues. Service users are accepted from GPs, midwives, obstetricians, psychiatrists and health visitors. According to Ali⁷⁸ the majority of referrals come from primary care practitioners.

Table 5: Patient diagnosis for referral to Leicester Perinatal Psychiatry Service 2006⁷⁹

Diagnosis	% of Patients
Depressive episode	43
Neurotic disorders	22
Past history of severe illness	21
Somatoform disorders	9
Personality disorders	2
Psychoses	2
Eating Disorders	1

Table 5 shows that depression was the frequently diagnosed condition for referral to the service in 2006, with neurotic disorders and past history of severe illness also figuring strongly.

Gaps, findings and Recommendations

Perinatal maternal mental illness may be harmful for mothers, children and their families. There should be an integrated approach to perinatal health care, which utilises the range of resources from universal services in primary care through to specialist mental health service. Training health visitors

and midwives in cognitive behavioural techniques will enable them to develop therapeutic relationships, along the PAWS and PoNDER models. Public health is well placed to influence this with the drive to increase health visitor numbers.

The closure of the Leicestershire Perinatal Mental Health inpatient facility presents a significant challenge to local mental health care, especially when the care of children and families is so important to the future mental health and wellbeing of Leicester.

There needs to be more capacity for women to have timely access to specialised therapy and to enable those professionals who regularly see women during and after pregnancy to build therapeutic relationships with women as part of their preventative work. This service should meet the relevant criteria. This work should not just cover Leicester, but it should include Leicestershire and Rutland and other parts of the region.

It is recommended that commissioners consider:

- Developing a strategic response to perinatal maternal mental health across Leicester, Leicestershire and Rutland and the region which ensures capacity for perinatal maternal mental health services in Leicester
- Ensuring that there is an integrated pathway for perinatal mental health in Leicester which covers all levels of service provision and severities of disorder
- Ensuring that local perinatal maternal mental health service offers timely access to compliant with NICE Guidance which offers equitable access to the right treatment at the right time by the right service
- That mother and baby units should be accredited by the Royal College of Psychiatrists' quality network for perinatal services
- That all women requiring admission in late pregnancy or after delivery are admitted with their infant to a mother and baby unit not an adult mental health admission ward
- That adult mental health services should counsel women with serious affective disorder about the effects of pregnancy on their condition and the possible effects of their medication on pregnancy
- That Health visitors and midwives should receive receiving additional training in perinatal mental health and the detection of at-risk patients
- Creating capacity in primary care to ensure that mental health promotion can be delivered effectively.
- Developing a Perinatal Mental Health Outreach Team, including obstetricians, midwives, community, primary care staff, and voluntary sector, to work across primary and secondary care to allow early identification and prevention of serious problems; plan care for antenatal period, labour, birth and the postnatal period.

Child and adolescent mental health

Most lifelong mental illness is acquired before the age of 14. Resilience to future mental illness in Leicester largely depends on commissioners and policy makers planning to protect the health and wellbeing of children and families. Early intervention when the early signs of emotional or psychological problems are identified can help to prevent the development of more serious and costly difficulties in later life.

The age limit for child health care has usually been set at 16 or 18 years. However, the Annual Report of the Chief Medical Officer (CMO) 2012, *Our Children deserve better: Prevention Pays*⁸⁰ uses the United Nations definition of young people, which includes all those aged under 25 years. This is because key areas of human development, including emotional development, continue until one's early 20s. Furthermore, many adult services are difficult for young people to access.

Common mental health disorders and difficulties encountered during childhood and the teenage years include: Attention deficit hyperactivity disorder (ADHD); anxiety disorders ranging from simple phobias to social anxiety; Post-traumatic stress disorder (PTSD); autism and Asperger syndrome (the Autism Spectrum Disorders, or ASD); behavioural problems; bullying; depression; eating disorders (including anorexia nervosa and bulimia); obsessive compulsive disorder (OCD); psychotic disorders, in particular schizophrenia; and substance abuse.

Good childhood mental health depends on many factors, such as developing psychologically, emotionally, intellectually and spiritually. It is also associated with good physical health, having access to appropriate play and learning opportunities, eating a balanced diet and regular exercise. Children need time for indoor and outdoor play. They need to be part of a family that gets along well most of the time, to attend a school aware of and concerned with pupil wellbeing and to take part in activities for young people.

Mental health and psychological wellbeing is affected positively and negatively by a child's own make up, the influence of their parents, carers, families and wider communities; and by the everyday services available to them such as schools and community resources. Unless a person is feeling mentally healthy it is difficult for them to have optimum physical health and wellbeing and to realise their learning potential.

Resilience to mental illness is partly concerned with being able to solve problems and to cope when things go wrong, and to learn from those experiences. This requires children to have a sense of belonging, to feel loved, trusted, understood and valued. They should also be interested in life, have opportunities to succeed, learn, and be hopeful and optimistic. High levels of social capital, such as child friendships, parental approval of friendships, the child's social support networks, their views on their neighbourhoods and their participation in clubs and groups, can have a positive effect on health.

There are a variety of statutory education, health and social care services and a number of voluntary and community services offering general and specialist support to children and families. Commissioners and providers should recognise the lifelong impact of poor childhood mental health. Whilst there is an imperative to develop more effective services to treat mental illness in Leicester, an improved focus on the mental health and wellbeing of children and adolescents could have a major long-term beneficial impact on mental health and wellbeing in Leicester.

Headline findings for child and adolescent mental health in Leicester

<p>Evidence of mental health problems in children and adolescents</p>	<ul style="list-style-type: none"> • Good emotional, psychological and social health can protect young people • 10% of children aged 5 -15 years had a mental disorder: 5% had clinically significant conduct disorders; 4% were assessed as having emotional disorders (anxiety and depression), and 1% was rated as hyperactive • Between 3,500 and 5,250 children in Leicester have a mental health problem • There are higher rates of mental illness among children with Special Educational Needs (SEN) and Disability. Children with a special educational need are 16 times more likely to have a mental disorder than those without SEN. • There are higher risks of poor mental health in Looked After Children – there are about 520 Looked After Children in Leicester • 9-10% women and 5-6% of men will be parents with a mental health problem, equivalent to 9,700 women and 6,400 men in Leicester • 25% of children aged 5-16 years have mothers at risk of common mental health problems equivalent to 12,000 children in Leicester • 25% of adults in mental health care is likely to be a parent
<p>Some key Statistics for children in the UK and England⁸¹</p>	<ul style="list-style-type: none"> • Death rates in England for injury and poisoning have fallen for all social groups except the poorest; these children are 13 times more likely to die • UK ranks 24 of 27 European countries in a measure on family pressure • UK has highest proportion of children living in a family where no adult is working compared with other European countries • Social disadvantage has a strong hereditary component in the UK • The weight of children on leaving primary school is increasing • Young men living in the poorest 10% of postcodes area almost 5 times more likely to attend Emergency Departments than those in the wealthiest 10%
<p>Leicester Child Health Profile</p>	<ul style="list-style-type: none"> • 66.4% of Leicester school children are from BME backgrounds • Infant mortality and child mortality rates are worse than the England average • The level of child poverty is worse than the England average with 30% living in poverty • Children in Leicester have worse than average levels of obesity and participate in less physical activity than the England average • In 2011/12 children were admitted for mental health problems and self-harm at a lower rate than the

	national average
Service Provision for Leicester	<p>4 tier model of CAMHS : 1,350 children seen by these services in 2012-13</p> <p>Tier 4 Service: Children and Families Support Team: 257 children</p> <p>Tier 2/3 Service: Young People's Team: 302 children</p> <p>Tier 2/3 service: Centre for Fun and Families IAPT</p> <p>Tier 2 service: Primary Mental Health Services: 423 children</p> <p>There are 23 Sure Start Children's Centres across the city, all providing a full range of information and support to parents and carers</p> <p>Leicester City Council has a comprehensive CAMHS service following the LLR CAMHS Strategy. This includes dedicated time from Educational Psychology and Assistant Psychologists from the City Early Intervention Psychology Support Team. CEIPS is a CCG funded, LCC managed service for those moving to tier 3 or moving DOWN from tier 3 to tier 3.</p> <p>The newly constituted Early help model (working through Children Centres in the city) includes dedicated time for Educational Psychology – direct to families and children in need of early psychological help.</p>
Six Priority Areas for Promoting Wellbeing in Children	<p>It is important to promote children's wellbeing, using the Six Priority Areas:</p> <p>The conditions to learn and develop;</p> <p>A positive view of themselves</p> <p>Have enough of what matters</p> <p>Positive relationships with family and friends</p> <p>Safe and suitable home environment and local area</p> <p>Opportunity to take part in positive activities to thrive</p>

Evidence from the literature

Good emotional, psychological and social health can protect young people from emotional and behavioural problems, violence and crime, teenage pregnancy and substance misuse. Poor mental health may affect childhood development, a young person's capacity to establish long-term relationships and the adequacy of parenting their own children. It may also affect their chances of gaining employment. Therefore there is a strong economic argument for early intervention to promote emotional wellbeing and mental health.

Early intervention may be facilitated by the availability of a comprehensive Child and Adolescent Mental Health Service (CAMHS) to support universal services, in addition to specialist services. Leicester City was a pathfinder for the targeted Mental Health in Schools project and has developed nationally recognised methods of joint working as well as providing early intervention in schools through the educational psychology Service, school nurses and Primary Mental Health Workers.⁸²

Interaction with caregivers is the most important element of a child's early experience, and lays the foundations for social and emotional development. It is through these early interactions that young children learn how to recognise and regulate their own emotions, and build the foundations for later relationships.⁸³ During the first year of life, children should develop their first attachment relationship which may predict a number of physical, social, emotional and cognitive outcomes.⁸⁴ Secure attachment enables children to feel safe and protected, and is likely to result in them developing social competence and resilience.

In serious cases of parental mental illness there is an increased risk that children will be abused or neglected. Children are particularly at risk if parents experience psychotic beliefs about the child; if mental health problems result in parental conflict or isolation; or if mental health problems significantly impair parents' ability to function.⁸⁵

Most parental mental illness will be depression or anxiety however 0.5% will have a psychotic disorder such as schizophrenia. According to SCIE Guide 30⁸⁶ it is probable that, among the working age adult population 9 -10% of women and 5-6% of men in Britain will be parents with mental health problems. It is possible that up to 25% of children aged between 5 and 16 years have mothers who would be classed as at risk for common mental health problems. There are large differences between lone parents and those who are in couples. Both lone mothers and lone fathers are more likely to have mental health problems than are mothers or fathers who live in couples. It is also possible that younger mothers are more likely to have a mental health problem than older ones.

In a survey of children and adolescents aged 5 to 15 years Meltzer et al⁸⁷ found that:

- 10% of children aged 5 -15 years had a mental disorder: 5% had clinically significant conduct disorders; 4% were assessed as having emotional disorders (anxiety and depression), and 1% was rated as hyperactive.
- Less common disorders (such as autistic disorders, tics and eating disorders) were attributed to half of one per-cent of the sampled population.
- Among 5-10 year olds, 10% of boys and 6% of girls had a mental disorder. In the older age group, the 11-15 year olds, the proportions of children with any mental disorder were 13% for boys and 10% for girls.

The prevalence rates of mental disorders were greater among children:

- In lone parent compared with two parent families (16% compared with 8%)
- In reconstituted families rather than those with no step-children (15% compared with 9%)
- In families with five or more children compared with two-children (18% compared with 8%)
- If interviewed parent had no educational qualifications compared with a degree level or equivalent qualification (15% compared with 6%)
- In families with neither parent working compared with both parents at work (20% compared with 8%)
- In families with a gross weekly household income of less than £200 compared with £500 or more (16% compared with 6%)
- In families of social class V compared with social class I (14% compared with 5%) whose parents are social sector tenants compared with owner occupiers (17% compared with 6%)
- In household with a *striving* rather than a *thriving* geo-demographic classification (13% compared with 5%)

Mental health problems are also be associated with issues such as education, crime, hyperactivity disorders and whether a child is looked after. Count Us In cites a 40% prevalence of mental health problems amongst those diagnosed as having a learning disability. Children with special educational needs are 16 times more likely to have a mental disorder than those children without SEN.⁸⁸ Research from Manchester University⁸⁹ found that 25% of juvenile offenders aged 10 to 17 appearing before the Manchester Youth Court had recent contact with psychology or psychiatric services. If applied to the same age range on the Youth Offending Team caseload, this equates to 500 individuals who may have had recent contact with CAMHS.

Some specific severe mental health problems are common among young people. Worries about weight, shape and eating are common, especially among young girls. Being very overweight or obese can cause a lot of problems, particularly with health. Some young people, many of whom are not overweight in the first place, want to be thinner; this can evolve into a serious eating disorder, such as anorexia nervosa and bulimia nervosa. Both of these eating disorders are more common in girls, but do occur in boys. They can happen in young people of all backgrounds and cultures.

Those with anorexia nervosa are pre-occupied with being fat, even if they are not overweight, and eat very little. It is a syndrome in which the individual's weight is at least 15 per cent below that expected. Children and younger adolescents with anorexia may present with delayed puberty or stunted growth as well as weight loss. Concerns are often raised by parents or teachers, and it is common for the young person to resist medical attention. The prognosis for children and adolescents with anorexia nervosa is variable. Some, such as those reacting to a life event, will make a full recovery from a first episode. For these cases the physical consequences of anorexia, such as stunted growth and pubertal delay are usually reversible. Others with a more insidious onset, with earlier social difficulties or abnormal personality development, may go on to have a more chronic course into adult life.

Someone with bulimia nervosa also worries a lot about weight. They alternate between eating next to nothing, and then having binges when they gorge themselves. They vomit or take laxatives to control their weight. The ICD10 criteria⁹⁰ stress the importance of purging behaviour on the grounds that vomiting and laxative misuse is considered pathological behaviours in our society in comparison to dieting and exercise. The condition usually develops at a slightly older age than anorexia nervosa (the mean age of onset is 18 to 19, compared to 16 to 17 for anorexia nervosa). Bulimia nervosa sometimes arises from a pre-existing anorexic illness.

Other eating disorders include binge eating episodes, which are associated with three or more of, eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not physically hungry, eating alone through embarrassment at the amount one is eating or feeling disgust or extreme guilt after overeating. Distress regarding binge eating is present and social avoidance is common.

The incidence of anorexia nervosa in the general population has been calculated from 12 cumulative studies at 19 per 100,000 per year in females and two per 100,000 per year in males.⁹¹ In community-based studies, the prevalence of bulimia nervosa has been estimated as 0.5-1.0% in young women with an even social class distribution. About 90% of people diagnosed with bulimia nervosa are female.⁹²

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder characterised by poor concentration, which includes a combination of additional symptoms including impulsiveness and over activity. Another medical term for ADHD is hyperkinetic disorder. ADHD affects 2-5% of UK school-aged children, with rates being higher in boys than in girls.⁹³

Meltzer found that the rate of mental ill health disorder amongst looked after children to be significantly higher than that in the general population. Looked after children⁹⁴ are those who are looked after by the state, where the Children Act 1989 applies, including those who are subject to care order or temporarily classed as looked after on a planned basis for short breaks or respite care. Looked after children are vulnerable to mental illness because they may not have access to stable education and they may experience a difficult transition to adulthood, being disproportionately associated with crime, homelessness and unemployment. Some looked after children may have particular needs, such as those from black and minority ethnic backgrounds, unaccompanied asylum

seekers or those who are gay or lesbian, who have particular needs. There are about 520 looked after children in Leicester, and services should be sufficiently diverse and sensitive to meet their needs.

Children with learning disability have psychiatric disorder prevalence rates of 36% compared with 8% in children without. They comprise 14% of all British children with a diagnosable psychiatric disorder.⁹⁵ Children with learning disability are 6.5 times more likely to have a psychiatric disorder, 3.5 times more likely to have an emotional disorder, 3.9 times more likely to have an anxiety disorder, 8.4 times more likely to have ADHD and 5.7 times more likely to have a conduct disorder than children in the general population.⁹⁶

*Research reviews on prevalence, detection and interventions in parental mental health and child welfare: summary report*⁹⁷ identifies factors which inhibit good outcomes for parents and children where parental mental health issues are a feature of family life. It found that 25% of children aged 5 to 16 has a mother who is at risk of a common mental health problem such as depression or anxiety.

In an average primary school class this might mean six or seven children living with a mother with a mental health problem. In classes where there are a high proportion of children living with lone mothers, the numbers are likely to be even higher. Given the evidence about the impact of parental mental health problems on children, this has implications for people working with children, particularly schools and general health services regarding detection and access to support.

At least one in four adults in contact with mental health services is likely to be a parent. The proportion may be even higher, particularly among younger women. Parental status is not routinely recorded when adults are in contact with these specialist services, with the obvious result that parents are not offered the most appropriate support. Services working with adults seem less likely to address parenting and mental health issues than those that work with children.

The review found an association between poor socio-economic circumstances and mental health problems which apparently explained the higher proportions of lone parents with mental health problems. Those who work with parents and families in poor socio-economic conditions should be aware that they are likely to be dealing with a higher than average proportion of parents with mental health problems. Dealing with parents' financial or housing problems may be necessary before or alongside intervention aimed at managing their mental health problems clinically.

Best practice for children and adolescents with mental health problems

A range of NICE Guidance is presented in the following table as best practice for young people with mental health problems. Some of the guidance which presented in later chapters may be useful to commissioners. For instance depression is more common in adults, but is common among adolescents.

NICE Guidance⁹⁸ on promoting young people's social and emotional wellbeing in secondary schools has a wide approach to mental health, indicating that secondary education should have access to specialist skills, advice and support from local authority advisory services, educational psychology and child and adolescent mental health services.

Self-harm is a common problem among young people. Some people find it helps them manage intense emotional pain if they harm themselves, through cutting or burning. Children and young people with generalised anxiety disorder (GAD) become very worried, this may occur when a child changes school or experiences separation anxiety.

Post-traumatic stress disorder can follow physical or sexual abuse, witnessing something extremely frightening or traumatising, being the victim of violence or severe bullying or surviving a disaster.

Children who are consistently overactive ('hyperactive'), behave impulsively and have difficulty paying attention may have Attention Deficit Hyperactivity Disorder (ADHD) Many more boys than girls are affected, but the cause of ADHD isn't fully understood.

Eating disorders usually start in the teenage years and are more common in girls than boys. The number of young people who develop an eating disorder is small, but eating disorders such as anorexia nervosa and bulimia nervosa can have serious consequences for their physical health and development.

<p>Eating Disorders (F50) NICE Guidance (CG9) (2004)</p>	<p>Covers: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders, such as binge eating disorder. The NICE eating disorders clinical guideline covers physical and psychological treatments, treatment with medicines, and what kinds of services best help people with eating disorders.</p> <p>Recommendations include</p> <p>Anorexia nervosa</p> <p>Most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service which is recognised as being competent in the assessment of the physical risk of people with eating disorders and in giving the necessary treatment.</p> <p>When admitted people with anorexia nervosa require skilled implementation of re-feeding with careful physical monitoring combined with psychosocial interventions.</p> <p>Family interventions to address the eating disorder should be offered to children and adolescents with anorexia nervosa.</p> <p>Bulimia nervosa</p> <p>As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme.</p> <p>Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with bulimia nervosa. Adolescents with bulimia nervosa may be treated with CBT-BN, adapted as needed to suit their age, circumstances and level of development, and including the family as</p>
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	<p>appropriate.</p> <p>Atypical eating disorders</p> <p>In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, CG9 recommends that clinicians consider following the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder.</p> <p>For all eating disorders</p> <p>Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management and facilitating communication.</p>
<p>Generalised anxiety disorder (ICD10 F41.1) <u>Anxiety</u> (NICE Clinical Guidance CG22) (2007)</p>	<p>Covers: Identification, assessment and issues such as co-morbidity</p>
<p>ADHD Guidance CG 72 http://publications.nice.org.uk/attention-deficit-hyperactivity-disorder-cg72</p>	<p>Covers:</p> <ul style="list-style-type: none"> •the care, treatment and support that children, young people and adults with ADHD should be offered •how families and carers can support people with ADHD
<p>Post-traumatic stress disorder (F43.1) <u>Post-traumatic Stress Disorder</u> (CG26) (2005)</p>	<p>Covers: Initial response to trauma Trauma-focused psychological treatment Screening for PTSD Children and young people: Trauma-focused CBT should be offered to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.</p> <p>Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused CBT adapted appropriately to suit their age, circumstances and level of development.</p>
<p>Obsessive Compulsive Disorder (F42) <u>Obsessive Compulsive Disorder (OCD)</u> and <u>Body Dysmorphic Disorder (BDD)</u> (CG31) (2005)</p>	<p>Initial treatment of adults with OCD includes low intensity psychological treatments; Brief individual cognitive behavioural therapy (CBT), the use of structured self-help materials; Brief individual CBT by telephone and Group CBT</p> <p>Children and young people with OCD or BDD</p> <p>Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT that involves the family or carers and is adapted to suit the developmental age of the child.</p>

	<p>Following multidisciplinary review, for a child or young person with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT then SSRI to ongoing psychological treatment may be considered. Careful monitoring should be undertaken, particularly at the beginning of treatment.</p> <p>All children and young people with BDD should be offered CBT that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment.</p>
<p>Promoting young people’s social and emotional well-being in secondary schools (PH20) (http://guidance.nice.org.uk/PH20)</p>	<p>It focuses on support for young people aged 11-19 who attend any education establishment.</p> <p>Social and emotional wellbeing includes being happy, confident and in control, with the ability to solve and cope with problems and have good relationships with other people.</p> <p>The six recommendations cover: strategy, the key principles and conditions, working in partnership with parents, families and young people, the curriculum, and training and professional development. They include:</p> <ul style="list-style-type: none"> •Secondary education establishments should have access to the specialist skills, advice and support they require. •Practitioners should have the knowledge, understanding and skills they need to develop young people’s social and emotional wellbeing. •Secondary education establishments should provide a safe environment which nurtures and encourages young people’s sense of self-worth, reduces the threat of bullying and violence and promotes positive behaviour. •Social and emotional skills education should be tailored to the developmental needs of young people

Child and adolescent mental health in Leicester

Improved emotional wellbeing cuts across different issues, such as the 5 *Every Child Matters* outcomes; keep safe, be healthy, make a positive contribution, enjoy and achieve and economic wellbeing.

27% of the population of Leicester is aged below 20 years. 66.4% of school children in Leicester are from a BME group. The health and wellbeing of children in Leicester is mixed compared with the England average. The infant mortality rate is worse and the child mortality rate is worse than the England average. The level of child poverty in Leicester is worse than the England average, with 30% of children aged below 16 years live in poverty.⁹⁹ Ward areas with high rates of children in poverty are Spinney Hills, New Parks, Braunstone Park and Rowley Fields, Stoneygate and Charnwood.¹⁰⁰ However the distribution of poverty in Leicester is wide.

Childhood educational attainment is correlated to socio-economic circumstances in adult life. Given the distribution of poverty and deprivation in Leicester, education provides an opportunity to tackle

disadvantage. The Child Health Profile suggests that Leicester has the worst value for the level of child development at the end of reception year at school. It also indicates that Leicester has a significantly worse proportion of attainment at GCSE than the national average.¹⁰¹

In terms of wider activity, the 2009-10 *Tell Us Survey* found that young people in Leicester were less likely than to participate in a group activity outside school. The rates of obesity in children aged 4-5 and 10-11 are significantly higher in Leicester than the national average.¹⁰²

Young people's mental health is affected by safeguarding issues, such as domestic violence and bullying. Children are more likely than adults to be a victim of sexual violence, robbery and violence. Bullying is related to attendance at school. *Tell Us Surveys* showed that bullying in Leicester was slightly higher than the national average. Leicester City Council has guidance on anti-bullying¹⁰³, including cyberbullying, the use of Information and Communications Technology (ICT), particularly mobile phones and the internet, deliberately to upset someone else.

Domestic violence includes physical violence, sexual violence, psychological and emotional abuse, force marriage, female genital mutilation and honour based violence. It is strongly related to risk of harm to children. Police records of domestic violence related offences and incidents suggest that there were 8,935 incidents in 2012/13 and 8,342 in 2013/14. 2012/13 Data from SAFE (Stop Abuse for Everyone) suggests that from 942 cases of domestic violence accessing a specialist support service), 65% had reported domestic violence to police in last 12 months, 67% had children who lived in or regularly visited the household, 32% reported mental health issues, 23% reported having previously threatened or attempted suicide and 13% reported having self-harmed.

If 9-10% women and 5-6% of men are likely to be parents with a mental health problem,, then this is equivalent to 9,700 women and 6,400 men in Leicester. If 25% of children aged 5-16 years have mothers at risk of common mental health problems then this is equivalent to 12,000 children in Leicester.

10-15% of children and adolescents in the general population suffer from mental ill health¹⁰⁴, equivalent to a range of approximately 3,500 to 5,250 for a city the size of Leicester. The prevalence of particular disorders varies according to age and to some extent gender; with higher rates among boys. Meltzer¹⁰⁵ found that 10% of boys aged 5-10 years, and 6% of girls in the same age group had a mental disorder. Amongst 11-15 year olds the proportions were 13% for boys and 10% for girls. The spectrum of mental illness from which they may be suffering is wide.

Estimates of the prevalence of specific disorders suggest that diagnosable anxiety disorders affect around 12% of those aged 4 to 20, disruptive disorders around 10%, attention deficit disorder 5%, specific developmental disorders, enuresis and substance abuse up to 6% depending on age group. In Leicester 3 in every 1,000 residents under the age of 20 are registered with mental health services, a figure which reaches 5 in every 1,000 in the most deprived areas.¹⁰⁶

The impact of attention deficit and hyperkinetic disorders on a child's mental health is also great. Attention deficit hyperactivity disorder (ADHD) has an estimated prevalence of 5% in those aged 4-16,¹⁰⁷ or 2,300 children in Leicester; whilst the prevalence of hyperkinetic disorder is accepted as approximately 1.5% of the UK school aged population,¹⁰⁸ 700 children in Leicester. Although it is important that people in this group continue to get appropriate care in their adult years, currently there is inconsistency in availability of services as adolescents reach the maximum age which is treated by Child and Adolescent Mental Health Services (CAMHS).

Self-harm is a particular mental ill health issue among adolescents. Approximately 7% of adolescents will harm themselves at some point whilst 20% will think seriously about it.¹⁰⁹ Between 2% and 4% of adolescents will attempt suicide,¹¹⁰ and 40% of those who survive a first attempt will repeat it.¹¹¹ Although the risks factors for poor mental health for children and adolescents in Leicester are high, in 2011/12 the rate of children admitted for mental health conditions was lower than England as a whole. In Leicester cases of suicides registered amongst people aged 18 or under are rare. The self-harm admissions for 15-19 years olds vary roughly between 200 and 300 per year (based on 2004/5-2006/7 data) for the Leicester, Leicestershire and Rutland area. In 2011/12 the Leicester rate of inpatient admissions for children because of self-harm was lower than the England average.

Service provision for children and adolescents with mental ill health

The integrated approach between mental health services, social services, education, offender management services and adult mental health is crucial to enable children and adolescents to reach their full potential. Only a small proportion of the mental health needs of children will be met by specialist mental health services. In Leicester there are 4 interdependent tiers promoting psychological health and wellbeing and providing targeted support for children and their families. These are shown in Figure 6, below.

According to the tiered model of care, children and their carers are supported on the first level by schools, primary care professionals, Local Authority care workers, Children and Family Centre workers. These services are essential in the promotion of mental and emotional health resilience. Services become more specialised and targeted with each tier.

All tiers are expected to promote social inclusion and child protection. They provide information and advice, assess and manage the care of children and young people across the sectors, agencies and departments according to their assessed needs. These services are meant to liaise with each other, and cascade education, training and teaching to other services.

Tier 1 describes primary or direct contact services. Services provided at Tiers 2 to 4 are focused on increasingly specialised service interventions for children with complex mental health problems. The majority of services are provided by Leicestershire Partnership Trust and Leicester City Council.

Tier 1 services include GPs and other primary health carers including, for example, health visitors, school nurses and staff in social care and education. Tier 1 services also include non-statutory and voluntary sector organisations. The core functions of Tier 1 are:

- Identification of mental health problems and mental disorders early in their development
- General advice and treatment for less severe problems
- Ensuring that children, young people and families are referred to other agencies within Tier 1 or to other tiers as appropriate
- Providing the primary care component of care programmes for individual children and their families that are shared with other services
- Pursuing opportunities for mental health promotion and promoting the resilience of vulnerable children, young people and families.

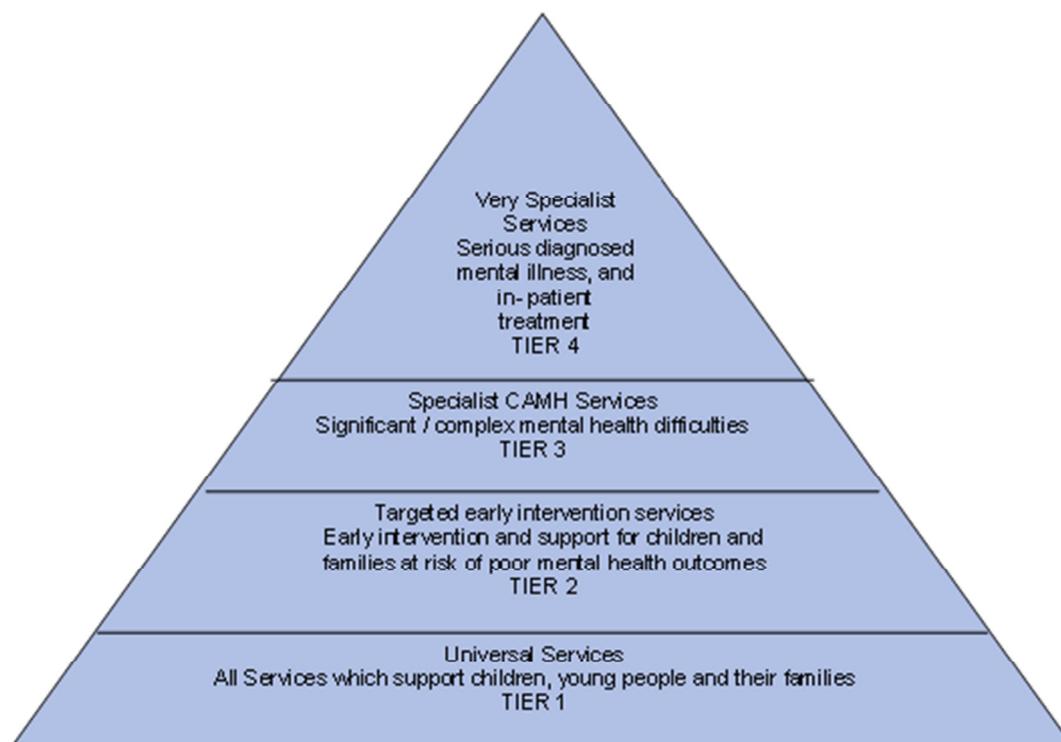
Leicester City Council has 23 Children and Family Centres, which provide services to support families where a child is assessed as being in need as defined by the Children Act 1989. These services include care for children below five years of age on a daily or sessional basis, support for parents on behaviour management, child development and help to build self-esteem.

These, Early Help services are currently being redesigned and will focus on areas which are organised in clusters. In addition there is an intention to provide psychologists support to tier 1 workers so that assessment at the earliest stage is enhanced. These educational psychologists and primary mental health Workers will support Family Support Workers in a “team around the professional” model.

The organisation of children’s services links to the principle of proportionate universalism, advocated by the CMO,¹¹² in which the lives of all are improved by targeting proportionately greater resources at the more disadvantaged. The improvement of childhood mental health relates to system wide thinking, in which all available resources are utilised to protect childhood mental wellbeing.

There is an opportunity to ensure that universal and specialist services are more joined up, with shared frameworks to enable integrated working. The resources available, in addition to Children’s Centres, include Health visitors, School Nurses, GPs, Educational Psychologists, Schools, Community Paediatricians, as well as the range of specialist mental health services for children and young people. Better use of universal services, escalating to the more specialist CAMHS tiers when appropriate, may contribute to more effective prevention of mental health problems and better treatment. This improvement should be underpinned by prevention and earlier intervention, developing the workforce and tackling stigma.

Figure 6: Four tiered model of service provision for CAMHS



Organising services differently, should also include a move towards commissioning services for young people up to 25 years. One service model which the way in which commissioners may The PIER Team is a specialised service providing assessment, support and treatment to young people, aged 14-35 years who are experiencing psychosis for the first time

In addition to universal services available at Tier 1, Leicestershire Partnership Trust provides a CAMHS telephone service, called the CAMHS Professional Advisory Service, staffed by the Primary Mental Health Service. It offers advice and guidance for all practitioners working with children and young people who are concerned about mental health issues and is often the first point of contact for advice and support about accessing more specialist child and mental health services. The City (Educational) Psychology Service provides a telephone advice line for parents and carers who are concerned about the behaviour of their children. The advice given often either reassures parents or signposts them to other sources of support and guidance.

Tier 2 comprises targeted early intervention services and training for carers and other groups. These manage symptoms of mental distress and provide brief targeted interventions aimed at preventing escalation of symptoms. Tier 2 services provide health promotion, early recognition and education through:

- Advising other agencies about the design, delivery and evaluation of universal and selective health promotion and education programmes
- Designing, delivering and evaluating some selective and indicated health promotion and early intervention programmes
- Provision of support to other specific services in delivering care to Looked after Children
- Provision of first-line specialist assessments and interventions directly with referred young people delivered by staff who have been specifically trained for the purpose
- Ensuring that children and young people who require services at Tiers 1 and 3 receive them in timely and co-ordinated ways.

The first-line clinical services provided at Tier 2 include:

- Generic CAMHS assessments (including triage, and risk assessments)
- Short to medium term interventions delivered by staff in locally accessible settings.

Leicester City Child Behaviour Intervention Initiative (CBII) is a Tier 2 Service which works with City children, aged up to 11 years, and their families to enhance parenting skills and capacity in managing common emotional and behavioural concerns. It is based on a multi-agency approach, comprising Family Support Workers; Educational Psychologists and Primary Mental health Workers (CAMHS). The service promotes emotional well-being and positive mental health. Requests for involvement are made and signed by parents, although professionals may refer children to the service with parental consent. CBII works directly with children, families and with groups of families. Parents report an increase in parental confidence in managing their children's behaviour and satisfaction in their skills in behaviour management. Children report enjoyment, engagement and improvements in their self-esteem.

Tier 2 services also include the City (Educational) Psychology Service. This service provides direct assessment and intervention on a group as well as an individual basis for children and young people (0-25) presenting with social, emotional and mental health challenges. The team works with other professionals and provides training and advice to schools, settings and parents/carers regarding the needs of children and young people. Every school both primary and secondary, every city academy and special school (including early year's settings and colleges of further education) have their own named link educational psychologist.

Psychology Service works with approximately 6,000 open cases. The psychologists work with children and young people with a wide range of presenting difficulties, including, ADHD, Special Educational Needs and Disabilities, self-harm, autism spectrum disorder, conduct disorder, family/parenting problems, bereavement and loss, speech, language and communication difficulties, attachment problems and bullying issues.

Educational Psychologists offer individual assessment and intervention for these difficulties and work closely with colleagues in specialist CAMHS and in paediatric services around diagnosis and intervention for these difficulties. Educational Psychologists also run group interventions to support children and young people with a wide range of challenges and problems that if left could develop into more entrenched and complicated (severe) difficulties and disorders. This work, often delivered in group settings, is with young people who have difficulty with their body image, self-esteem and challenges at times of transition (e.g. primary to secondary school), bullying, bereavement, anger management, self-harm, assertiveness and family issues.

The City Psychology Service works closely with universal service providers and with specialist CAMHS at tiers 3 and 4. The service helps to deliver the multi-agency training on childhood mental health. It also delivers in-service training for teachers and other school staff (INSET). INSET training covers topics such as ASD and ADHD, self-esteem and supporting staff in building their own resilience as well as that of their students.

The CCG commissions the City Early Intervention Psychology Support (CEIPS) a team of assistant psychologists, employed by Leicester City Council within the City Psychology Service. These psychologists take referrals from specialist CAMHS and from Educational Psychology. They work with young people aged 0- 18 who may not meet the specialist CAMHS threshold for tier 3 involvement but do require some ongoing intervention and support; and those youngsters who may have been seen at tier 3 but are being stepped-down and still require support to ensure the interventions received have a better chance of success.

Leicester City Council has a Children and Family Support Team which provides therapeutic interventions for young people aged 3-18 years and their families, to provide improved resilience and coping strategies. The client group for this service have experienced traumatic situations which have detrimentally impacted on the emotional wellbeing of children and families, such as safeguarding issues, being a Looked after Child, domestic violence or bereavement. The service aims to increase emotional capacity, improve parenting skills, give stability to youngest children and help older children to manage their problems. In the 2012/13 period the Children and Family Support Team had 257 clients, an increase in demand of 30% on the previous year.

Tier 3 services target children and young people with significant mental health problems. They contribute to the provision of health promotion, early recognition and education services with advice, specialised peripatetic forensic mental health outpatient services and the provision of out of office hours, emergency, rapid response and on-call services.

Interventions at this level are instigated by a referral from services in Tiers 1 or 2, or by a transition from Tier 4 as the acute phase of illness eases. They work with the other tiers and may facilitate the delivery of services at Tier 2 through training, advice and consultation.

In Leicester services at this level are provided by LPT and the Local Authority, and include the CAMHS community teams, the Young Persons Team, the Learning Disability Outpatients Team, the Joint Therapeutic Social Work Team and the Family Welfare Association. They cover the whole of Leicester, Leicestershire and Rutland and comprise different professionals such as consultant psychiatrists and psychologists, social workers, community psychiatric nurses, and occupational therapists.

The CAMHS Community Teams are multi-disciplinary, providing specialist assessment and interventions for children and young people with significant mental health difficulties. Illnesses

covered include depression, anxiety, psychosis, eating disorders and neuro-developmental disorders such as Autism and Attention Deficit Hyperactivity Disorder.

The Young People's Team within LPT is a Tier 3 service with a remit to work with vulnerable children and young people with mental health difficulties, including Looked after Children, adopted children, Young Offenders and homeless young people. The Team provides individual case work, consultation and liaison with other services and training for other services on mental health issues.

The LPT Learning Disability Team is a specialist team focused at Tier 3 care, working with young people up to the age of 18 years who have a moderate, severe or profound learning disability and mental health needs. The client group for this service is generally young people who are functioning at a level below half their chronological age. The team works with young people and their families in a variety of settings including outpatient clinics, home, and school and community placements. Referrals are accepted from GPs, health visitors, educational psychologists, community paediatricians, social workers and other CAMHS teams.

The Paediatric Psychology Service is a Tier 3 clinical psychology service for children and young people with medical conditions. The service provides psychological assessment and treatments primarily in community-based settings. The service receives referrals directly from community and hospital paediatricians.

The Child Psychotherapy Department within specialist CAMHS offers psychoanalytic treatment for children, young people and families. Child and Adolescent Psychotherapists treat a range of behavioural and emotional problems not easily addressed by other methods of treatment. Therapists are trained to observe a child or young person and respond to what they might be communicating through their behaviour and play. Child Psychotherapists offer consultation and teaching, brief work with families, and children, parent work as well as longer term psychotherapy.

A recent audit of Child Psychotherapy patients showed that the average of age was 13.25 years. Most of the children aged below 12 were boys, and most of those aged 13-18 years were girls. 80% were from a White/White British ethnic background and 20% from BME backgrounds. The conditions experienced by the children included anxiety and mood, autism spectrum and eating disorders. Approximately half of all cases evaluated had a history of or experience of current domestic violence, half of all had a parent with a diagnosed physical illness, half disclosed that they had self-harmed, 58% had a parent or carer with a diagnosed mental illness and half had a history of early abuse and neglect.

Tier 4 provides specialist services for children whose complex needs interfere with their social functioning. Local services operating at this level include Tanglewood, the Psychosis Intervention and Early Recovery (PIER) team, Oakham House and the CAMHS Assessment and Intervention Treatment Service. These teams offer expertise from consultant psychiatrists, psychiatric nurses, psychologists and a care co-ordinator.

The CAMHS Assessment and Intervention Treatment Service offers nurse led intensive behaviour intervention in the educational and social care settings; PIER is a service for young people aged 14-35 during the first three years of a psychotic illness, which offers a low-stigma approach focusing on psychological adjustment and the prevention of relapse; Tanglewood is a service for children up to 12 years old and their families, offering intensive interventions aimed at boosting children's self-esteem, managing behaviour and caring for children with specific problems, such as ADHD and autism. Oakham House is an 8 bedded psychiatric inpatient unit offering assessment and treatment for children and adolescents aged between 12 and 16. Referral to this service is for children whose

clinical needs are too severe, complex or unresponsive to be managed appropriately at out-patient level. Table 5 shows the activity of CAMHS in 2013.

Table 5: CAMHS Service Activity 2013 compared to estimate of prevalence of mental illness in Leicester

Tier	Service	Number of Cases
1	Universal Services (Schools, GPs, health visitors, school nurses, Children's Centres)	
1/2	Primary Mental Health Services	423
2	Children and Families Support Team	257
2/3	Young People's Team	302
2/3	Centre for Fun and Families IAPT	250
2/3	Child Behaviour Intervention Initiative	781 families
4	Specialist CAMHS (Oakham House, PIER)	
3/4	Child and adolescent psychotherapy	24
	Other services which cover mental health issues	
	The Laura Centre	132
	Post Sexual Abuse Project	15
	CAMHS Learning Disability Team	220
	Total Number of Cases 2012-13	2,154
	Estimated of children and adolescents with mental illness in Leicester based on 10-15% prevalence	3,500-5,250
	Estimated number of parents in Leicester with a mental health problems	9,700 women 6,400 men

Early Help and Prevention Offer

The Early Help and Prevention Offer aims to improve outcomes for children and young people at all stages of their development; from pre-birth, through early years, school lives and transition to adulthood. The Offer is about improving parental capacity and ensuring that universal and targeted services are coordinated. It represents an opportunity for different agencies to work together to help children, young people and their families; preventing problems occurring or worsening. It reflects the understanding that it is better to identify and deal with problems early rather than to respond to them when difficulties have become acute and require intensive action. The objectives of the programme are to:

- Build the capacity of vulnerable families to support their children effectively in achieving positive outcomes.
- Reduce the number of children requiring intervention from statutory services.
- Address the impact of child poverty and worklessness on vulnerable families.
- Target resources effectively so they assist children, young people and their families who require extra help and support at the right time.

Early Help and Prevention Offer activities, shown in the table below, cover universal, targeted and specialist care which will have an impact on those factors which are linked to emotional health and

wellbeing, such as poverty, relationship problems, depression, drug and alcohol use and social isolation.

Leicester City's Thresholds level	1	2 & 3	4
	Universal	Targeted & Targeted/Specialist	
	Types of Activities	Types of Activities	Types of Activities
0-12	<p>Midwifery Health Visiting Services Services promoting learning, development and well-being through children's centres and others School Nursing Parenting Advice Information on activities and services</p>	<p>Welfare rights Promoting children's early learning Parenting and family support Supporting parents into work and training Specialist midwifery Targeted health visiting Early support for disabled children Support for young parents through the Family Nurse Partnership School Nursing health checks Improving school attendance Emotional and mental health support Educational Psychology advice and guidance Every Children's Centre has a link to an educational psychologist</p>	<p>Parenting and family support Short breaks provision Prevention of entry to care system Emotional and mental health support</p>
Co-ordination Points	<p>Children centre liaison meetings</p>	<p>Common Assessment Framework/ Team Around the Child processes Youth CC Panel Think Family Panel Think Family Allocation Panel Ill Children Education Panel MARAC Duty & Assessment in Children's Social Care (Child in need) Educational Psychology advice and guidance</p>	<p>Duty & Assessment in Children's Social Care and Safeguarding (child protection, LAC) Leicester Access to Resources Panel Police Comprehensive Referral Desk</p>
13-19	<p>Positive activities for young people Drug and alcohol advice Relationships and Sex Education School Nursing Information, advice and guidance Bullying prevention</p>	<p>Improving school attendance School Nursing health checks Support to young carers Targeted youth support Mentoring/counselling School Nursing Accommodation advice and support Parenting and family support Emotional and mental health support Educational Psychology advice and guidance</p>	<p>Parenting and family support Prevention of entry to care system Emotional and mental health support</p>

These activities offer an opportunity to co-ordinate services for children and families who are at risk of poor emotional health and wellbeing. The Targeted and Specialist Services already have a defined role in supporting people with poor mental health, universal services could be developed to enhance their role in:

- Raising awareness of mental health problems, ensuring that children and families know how to enhance their mental health and observing for signs of emerging mental health problems and what to do when they occur
- Supporting families by being sensitive to the negative effects of poor mental health and taking actions to mitigate those effects
- Tackling Stigma, reducing the stigma and discrimination associated with poor mental health through being open and knowledgeable in their routine care of children and families
- Strengthening emotional wellbeing, providing sensitive and supportive care to increase emotional wellbeing and reduce anxiety
- Promoting emotional wellbeing
- Building trusting relationships to help children and families feel confident to say they are feeling unwell
- Securing appropriate care, signposting for additional care

The THINK Family programme

The THINK Family programme in Leicester aims to improve outcomes for families with multiple and complex needs. Eligible families meet at least two of three criteria; children that are absent or excluded from school; families who are involved in Crime and/or Anti-Social Behaviour; families who are in receipt of out of work benefit. Thus, the initiative is clearly likely to have an impact on short term mental health need and the long term mental health needs of children in Leicester. With regard to evidence collected so far by the programme, there are 61 households matching all 3 criteria, 627 which match least 2 and 8,943 matching at least 1.

THINK Family does not offer a new service, but aims to make it easier for agencies working with families to work together in a complimentary way. This involves, for instance better sharing of information and co-ordination between agencies, tracking families' progress so to highlight good practice and inform future service delivery and training for the workforce to enable them to 'think family' and a move to a 'key working' approach with families.

The essence of THINK Family therefore is to organise services so that they ensure continuity of care. Individual services are not sufficient on their own, to ensure the best outcomes for families with complex needs. Families with the greatest need, require well-co-ordinated expert care to ensure that there are no gaps in service provision.

Voluntary sector support for children with mental health problems

There are a variety of voluntary sector organisations with a focus on supporting children and families in Leicester. These use a variety of methods. Some of the services offer vital expert support which would be not available elsewhere.

ADHD Solutions is an independent initiative set up to support children young people and adults who have ADHD, their families, and professionals. They offer a behaviour management programmes to empower parents; they work with a child's school to prevent exclusion thereby enabling them to reach their full potential. They support adolescents to understand ADHD, offering them life, social and studying skills, anger management, and preparation for transition to adulthood.

This needs assessment has shown the importance of creativity and productivity in creating resilience to mental ill health. In 2001 Oakham House and Soft Touch Arts conducted a Samba Drumming Project, funded by Youth music; 12 young people took part and the project culminated in a performance by some of them in Leicester city centre. The staff at Oakham House reported that the

sessions focused on the healthy side of the young people, and that the project created a sense of normality in an abnormal environment. One resident felt that the project helped to stop negative thoughts. The evaluation of the project showed that there was progress in the participants' concentration, their ability to articulate feelings about the project and help in coping with being part of a group.

Opened by the bereavement charity COPE, The Laura Centre offers specialist bereavement counselling to parents whose child has died and to children or young people who have been bereaved, a source of different mental health problems, such as post-traumatic stress disorder, depression and anxiety. The Laura Centre is one of only a few places in the UK to specialise in counselling children who have lost a parent or other significant person in their lives. It offers one on one sessions and group work. The latter is of particular value in helping children understand that they are not in a unique position.

The Centre for Fun and Families, which was established to reduce parent and carer difficulties in managing the behaviour of children and young people, assist and support teenagers who are experiencing difficulties in relationships with adults. Since November 2011 the Centre for Fun and Families has developed Improving Access to Psychological Therapies (IAPT) service for children and adolescents. IAPT offers NICE compliant interventions for treating people with depression and anxiety disorders. The Children and Young People's (CYP) IAPT Project is a service transformation project for CAMHS across the UK. It aims to create change by involving children, young people and parents through participation, embedding evidence-based practice across services and creating local strategies to improve access.

The 'Positive Minds' Ground Group was developed for young people aged 11 to 16 years, where mental health issues are affecting family relationships (either due to their own, or other family members, mental ill-health) and who are also experiencing difficulties in managing emotions, for example anger and communication with adults and peers at home or at school.

Case Study

A teenage girl was referred to the Grounded Group by The Duty and Assessment Team. Her parents had split up some time ago and her father had become estranged. Her relationships at home, with her mother and sister, were becoming aggressive and had broken down. She was angry, felt rejected and suffered with low self-esteem. She started truanting from school and getting into trouble with the police for anti-social behaviour, drinking and possibly drugs. She had an older boyfriend who had a record for prostitution and drug dealing.

Group workers recommended a one to one mentor, because they believed that she was a young person at risk because of her low self-esteem. She was referred to New Futures (Sexual Exploitation Project), and her mentor liaised with her Youth Offending Worker.

She wanted to work on improving her relationship with her mum and sisters and staying out of trouble at school. She requested some of the sessions to take place at her home address and the mentor and parent agreed to do a baking session. By the 4th session she reported a change regarding school attendance and staying out of trouble.

She had started to come to terms with her poor relationship with her dad and accepted that the estrangement was not her fault. A few months after mentoring had stopped, she reported continued improvements, such as getting on well with her family, feeling happier and had a relationship with someone her own age.

Barnardo's services work with children and young people who have mental health difficulties, running centres for children and young people to discuss problems, build their confidence and to address the root of their difficulties. For instance, locally they support young carers, many of whom experience emotional difficulties. A case study of a 14 year old girl from an Asian/Asian British Background was presented by Barnardo's.

Barnardo's Case Study

Young carer had regular and substantial practical, emotional and personal care role:

- Emotional distress due to the pressures of caring
- Tiredness impacting on physical health due to waking up early to provide support
- Need for respite from care role and time out to have fun
- Some practical needs e.g. Clothing

Outcomes achieved for the young carer and her parent:

- Due to the level of need, the parent received an immediate Adult Social Services assessment, which assessment identified the need for support with personal care.
- Focus on reducing practical chores for young carer
- Reduced caring role significantly improved young carer's emotional well-being. She was no longer required to wake up extra early to support her mother with personal care.
- Carer reported improved rest and improved physical health.
- Carer attends the Young Carers' Group, which enables her to have respite from her care role and the opportunity to have fun and meet with other young carers who understand her home circumstances and the pressures of being a young carer.
- A successful grant application meant the carer was able to buy clothing, improving her confidence and self-esteem.
- A successful DLA application for the family

The Y in Leicester provides supported housing for young people and homeless services in the city. It has a project worker for young people with complex needs and dual diagnosis. In the period September 2013 to April 2014 the service saw 42 young people, of whom 35 had poor mental health. The service liaises with a number of different services including Francis Dixon Lodge, Inclusion Health Care and CAMHS. The extent of the problem encountered by this service can be seen in the following case studies:

The Y Housing Project: Young People with complex needs and dual diagnosis

- Medication – Person moved from foster care into supported housing. Prior to the move client's foster carer issued medication for clinical depression, but the support housing provider could not. Therefore YPOD project workers made an agreement with inclusion health, CAMHS and boots that the medication be dispensed on a daily basis.
- Transitions CAMHS and secure estate – Case open to CAMHS team, and then sentenced to a period within the secure estate. Assessment and medication given within secure estate and talking therapy started. On release from custody a lapse in talking therapy and prescription of medication meant case self-medicated with substances and then committed further crimes on licence so then returned to the secure estate.
- Deliberate self-harm – Client presented at emergency Department with self-inflicted

wounds, following consuming alcohol and other drugs. The client was discharged. Although the client was open to CAMHS however they were unaware of the Emergency Department admission, so YPOD set up a follow up appointment

Gaps, Findings and Recommendations

Most lifelong mental illness results from childhood experiences. Childhood mental illness may result, for instance, from an event, abuse, trauma, parental mental illness. Mental illness disproportionately affects children and young people from disadvantaged areas. CAMHS are organised in tiers, with children accessing more specialist services according to need, and stepping down if a condition eases. Universal services have a vital role in protecting mental wellbeing and ensuring timely access to specialist care.

The main gaps for commissioners to address are:

- Improving wider mental health means targeting commissioned resources at the areas of greatest need, and ensuring that health promotion activity, such as that which focuses on creativity, diet and exercise, highlights its relevance to mental health
- Developing a whole system approach, in which services that are adjacent to health care, such as education and community groups, contribute to protecting childhood mental health, including voluntary organisations
- Improving access and outcomes from CAMHS services

It is recommended that commissioners consider:

- Adopting system wide thinking to ensure that key resources are identified and properly used to improve the health and wellbeing of children (including schools and voluntary sector organisations)
- Recognising that support for young people extends beyond teenage years, and should include people up to age 25
- That there are benefits in commissioning a range of services to meet the needs of children and young people, including more integrated work at Tier 1 and improved timely access to specialised services
- That all professionals involved in the identification of mental and emotional health require development to improve the mental health care of children and young people.
- Working with schools and relevant services to increase child participation in physical activity and to promote healthy lifestyles
- Targeting prevention resources at ward areas with greater disadvantage

Student mental health and wellbeing

As a city with 2 universities, student mental health and wellbeing is crucial to Leicester. Both De Montfort University (DMU) and University of Leicester are committed to the promotion of the positive mental health and wellbeing of the student communities. They provide information both on the variety of support available to all students with any emotional or mental health difficulties and procedures available to support staff when managing situations where students are presenting with such difficulties. Local general practices offer expertise in supporting students with mental health problems.

This chapter describes the evidence concerning student mental health, some of the services available to students and the difficulties of access that students experience. Above all, it is crucial, given the role played by the universities in Leicester, that the wider community acknowledges the importance of sustaining student mental health and wellbeing.

<p>Some key Statistics DMU and University of Leicester</p>	<ul style="list-style-type: none"> • There are 19,702 registered at DMU with 17,634 (89.5%) Home/EU nationals and 2,068 (10.5%) from overseas • There are 15,261 students are registered at University of Leicester , of these 11,061 (72.5%) are Home/EU nationals and 4,200 (27.5%) are from overseas • 2 universities in Leicester have diverse populations which contribute to raising productivity and contribute to the economic and cultural growth of the city • Total revenue of East Midlands higher education sector was £1.7 billion in 2011/12 • Universities provide jobs across a range of occupations and skill levels • Universities generate local jobs • Annual economic benefit of the University of Leicester on Leicester and the Leicestershire region adds up to £729¹¹³
<p>Student mental health</p>	<ul style="list-style-type: none"> • Education can be an important part of a person’s recovery from mental ill health but it can also precipitate distress and relapse • Mental ill health will have a negative impact on the ability to study, reach full potential and graduate • Underachievement or failure at this stage can have long-term effects on self-esteem, employment, debt and progression through life • Universities offer student counselling and support • Local services used by students include, GPs (Victoria Park Health Centre and Mill Lane Surgery); Open Mind IAPT; Crisis team; Emergency Department; PIER team • 13% undergraduates suffer mental health symptoms related to stress and anxiety • Eating disorders and alcohol and substance misuse problems are highlighted

Student mental health

Education can be an important part of a person's recovery from mental ill health but it can also precipitate distress and relapse. The effects of student mental ill health can be felt not only by the students themselves but by their peers, family and friends, and of course it has an impact on their education. In some areas academic and pastoral support may be difficult to obtain, so both the University of Leicester and DMU have developed services to sustain student wellbeing.

Commissioners should be aware that the impact of student mental health on peers is of vital importance. There are cases in which a student has attended the Emergency Department with a mental health problem, only to be discharged into the care of residential support advisors in Halls of Residence who have no mental health expertise or duty of care. NHS service commissioners and providers have to work with university support services to understand the role that they play.

National evidence shows that there are increasing numbers of students presenting with mental health problems. This reflects both the growing rates of mental health problems among young people generally, the rapidly increasing access of young people to higher education and the concomitant growth in student numbers.

The factors which contribute mental ill health in the student population can include moving away from home, family and childhood friends to an unfamiliar place and culture. There is also a temporal aspect to the problem, as these changes occur at a time when students are experiencing developmental changes. Students with mental illness are often reluctant to discuss a mental health problem, because of the potential impact on their academic studies. International students can feel particular pressures from the costs of studying abroad and feelings of loneliness and isolation. Tutors, supervisors and peers are often not equipped to discuss mental health issues in a therapeutic way.

Evidence suggests that some factors affect different student groups; mature students face the challenge of attending institutions at a time when they have domestic responsibilities; students from overseas face cultural and language problems. Other barriers are faced by the increasing numbers of students from socio-economically disadvantaged populations and from ethnic minority communities. As with the general population, most students with mental illness have anxiety or depression; a smaller number present with schizophrenia.

The Student Psychological Health Project at Leicester University¹¹⁴ surveyed more than a thousand second-year students in 1998 and 2001 using the Brief Symptom Inventory (BSI) and found in both years that 13% of undergraduates recorded scores suggesting they were moderately distressed by feelings of depression. Women scored significantly higher than men. This study also showed that 12–14% of the undergraduate population recording BSI sub-scale scores suggestive of moderate obsessive–compulsive distress (trouble remembering things, trouble concentrating, difficulty making decisions, checking). Eating disorders were also a problem, with 4% of undergraduates reporting self-induced vomiting and 2% the use of diuretics and laxatives.

Alcohol and substance misuse increases the risk of mental illness and mental ill health increases the risk of increased intake of alcohol and substance misuse. In Leicester¹¹⁵, 14% male and 31% female undergraduates admitted harmful levels of alcohol consumption; but 50% and 25% respectively also admitted binge drinking at least once per week.

Females are more likely to show increased evidence of emotional problems during the course of higher education with female students demonstrating increased levels of depression, anxiety and

phobias compared with their male counterparts. With regard to homesickness, there was no significant difference between males and females. In the UK and elsewhere, female students have been found to be more likely to demonstrate increased levels of psychological symptoms. The University of Leicester study¹¹⁶ showed that students from ethnic minorities scored significantly higher on all six sub-scales of the BSI.

University mental health services for students

Services differ between universities. Often there is no need for counselling support, because many students resolve their problems by talking to friends, family or perhaps someone in their department. Others find looking on-line for information about their concerns helpful and we have a large selection of self-help information available.

Student Counselling Services are available when a student needs to talk to someone from outside their everyday life. Support services aim to help students to focus on and understand more clearly those issues which concern them, such as the transition to higher education and job applications.¹¹⁷ The focus of Student Counselling Services is to support students in their work, and not necessarily to promote recovery. Student counselling initiatives may be supported by NHS employees, but there is a need for strategic engagement to understand if they fit into the step care approach to mental health and to ensure the success of different projects.

<p>Student welfare services at DMU</p>	<p>Services offered :</p> <p>a) Short term counselling: initial contract of up to 6 sessions that can be extended to a maximum of 12 sessions if therapeutic</p> <p>b) Life coaching for skills enhancement</p> <p>c) Self-help resources</p> <p>d) Contributions to the wider university such as workshops and training.</p> <p>Students per year:</p> <p>Around 800 for a full 12 months June academic year period. This number has increased significantly the academic year 2013/14. The majority of new referrals (approx. 750) would be in the October to June</p> <p>Who refers to DMU:</p> <p>Self-referral is the largest number, followed by GP referral, academic, friends and family.</p> <p>Referrals GP's:</p> <p>In the period October –March 2013/14 there were 102 health service referrals (around 1 in 6 of all referral referrals). 84 from De Montfort Surgery, 8 other doctor, 3 other NHS service and 3 from psychiatrists). This represents an increase in referrals from the NHS of almost 100% from the 2012/13 academic year.</p>										
<p>Student mental health at University of Leicester</p>	<p>Services offered :</p> <ul style="list-style-type: none"> • Short term counselling up to 6 sessions • Self-help resources • Limited group sessions currently with intention to expand <p>Students per year:</p> <table border="0"> <tr> <td>Academic Year</td> <td>Number of clients</td> </tr> <tr> <td>2010 – 2011:</td> <td>768</td> </tr> <tr> <td>2011 – 2012:</td> <td>882</td> </tr> <tr> <td>2012 – 2013:</td> <td>935</td> </tr> <tr> <td>Current to Dec 2013</td> <td>1,231</td> </tr> </table>	Academic Year	Number of clients	2010 – 2011:	768	2011 – 2012:	882	2012 – 2013:	935	Current to Dec 2013	1,231
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De Montfort University

DMU has almost 20,000 registered students, with 10.5% from overseas. The student population is more likely to be from the Leicester area, when compared to the University of Leicester.

DMU has a Mental Health Inclusion team consisting of a Mental Health Inclusion Manager and two Mental Health Inclusion Officers. These team members will have qualifications in relevant areas, such as psychiatric nursing, social work, or occupational therapy. The team works in partnership with both the Counselling service and the Disability Support Team. The approach to supporting students with mental health conditions can be split broadly into 3 areas. Some of this work will be done by the Mental Health Inclusion team alone, some in partnership with other team, and some by other parts of the university.

The DMU Mental Health Inclusion Team provides students with on-going support aimed at assisting them to manage their mental health and enabling them to continue their studies. Where appropriate such services will help students to apply for benefits and work with academic members of staff where 'reasonable adjustments' can assist the student to make the most of their learning opportunities. The model of support at DMU ensures that students with mental health conditions are supported throughout their studies and on towards employment.

The options which available to students concerning their future employability include volunteering, 1 to 1 support from the Careers and Employability team, Frontrunners scheme (which gives students the chance for paid work experience in a graduate level job during their studies), in-course placement opportunities, DMU Global (which gives student the chance of an International experience as part of their studies), and the DMU student Internship scheme.

Counselling is available to any student who feels they would benefit from the support. Some of these students will have diagnosed mental health conditions. The NHS is the second largest source of referral. Many students will not have formally diagnosed conditions, but may either be at risk of developing them, or have chosen not to access support through the NHS. Students are offered 6 sessions initially, and this can be extended to 12 where necessary. Students can re-present for counselling at a later point, but the service does not offer any long term provision.

DMU is developing health promotion strategies, which will create resilience to student mental illness. For instance structure access to the DMU gym facilities, and other schemes such as the Saffron Lane Green Gym / Allotment project. These will give students the opportunity to exercise and improve mental wellbeing through social connections, around exercise and growing (and potentially selling) fruit and vegetables. A scheme for promoting resilience among young men aims to equip male students to understand the importance of resilience and to have the skills to enhance their own resilience. It is provided on an outreach basis, and aims to engage students who would not present to services.

DMU is developing a 'Coaching Academy' to publicise the availability of Coaching, and facilitate students to develop their own skills without identifying themselves as having a 'problem' they need to address.

Other projects to be developed will include initiatives to engage students who may be more reluctant to engage with university and NHS support services (and may fall into higher suicide risk groups), for example some BME groups, LGBT students and young men.

University of Leicester

University of Leicester offers a free, confidential, face to face service to all current undergraduate and postgraduate students. The majority of students find that just one session, with perhaps a follow up, is sufficient. When appropriate the service offers brief counselling for up to 6 sessions; this is an active, collaborative process with follow ups or on-going sessions scheduled at weekly, fortnightly or longer intervals. Sessions are usually 50 minutes long. The service also offers a selection of workshops throughout the year and, from January 2014, counselling groups, some of which will be able to offer longer term support.

Leicester University Counselling Department also has two part time Mental Wellbeing Advisers who provide support and guidance to students experiencing mental health difficulties and when appropriate, can liaise with departments and advise staff about student concerns.

The experience of a General Practice with high numbers of students

De Montfort surgery on Mill Lane is a general practice with 17,000 patients, providing primary health care to the local population, including many of the students from DMU. The practice has a range of specialist skills and experience which enables them to provide care for patients with gynaecological, sexual health, musculo-skeletal or mental health problems which exceed those usually available at a general practice.

Anecdotal evidence suggests that the practice has a higher than average mental health work load. Students who register with the surgery are likely to be those who regularly consult GPs about their physical or mental health, whereas those who do not register, or register late in their university career, tend to be those who do not regularly seek medical advice and may not have on going physical or mental health problems.

It is practice policy to follow up patients who have presented to the emergency department with self-harm. An audit of recent cases shows that GPs at De Montfort Surgery have managed to make contact with the majority of these patients, with 5 of 29 patients failing to take up support from the surgery. Experience suggests that these patients are often new to the practice and Leicester, but have had previous issues with self-harm. GPs at the practice feel that it is good practice to try to establish contact with these patients to minimise the risk of suicide and self-harm.

A local consultant psychiatrist provides fortnightly secondary care clinics from the surgery. This is beneficial both in terms of improving the contact between secondary care and primary care clinicians but also provides an excellent service for any of our psychiatric patients who find it difficult to travel to Glenfield hospital. This contact enables clinicians to liaise more easily over individual patients care in order to reduce referrals and admissions.

There is a high level of mental health expertise at the practice; De Montfort Surgery generally refers fewer patients at a later stage than other city practices. The surgery offers various specialist clinics in order to provide easy access for their patients. These include a smoking cessation clinic, substance misuse clinic, and a clinic run by the community alcohol team. IAPT workers are based at the surgery, enabling timely access to both low and high intensity workers.

Over the last year De Montfort Surgery has improved links with DMU welfare services as well as the students' union welfare officer. Both of these links have raised the profile of the surgery within the university and increased awareness of the services which the practice offers.

There is an agreement about how to refer students in crisis to the surgery and an agreed procedure for liaising over students who are giving cause for concern within the university, while continuing to always respect patient confidentiality.

Case Study

Case Study: Leicester University

A Chinese student presented to Student Welfare as an emergency, because her visa had expired. Two days later University Security staff informed Student Welfare that the police had arrived with the student who has been discharged from UHL, Emergency Department.

The police reported that Emergency Department had contacted them because of concerns about the mental health of the patient. She appeared muddled and disorientated, and for the first time spoke about being on medication for schizophrenia.

As the student appeared to need medical attention, and given that she had just been discharged from hospital, Freeman's Common Health Centre (FCHC) was contacted. FCHC is the main surgery for students at Leicester University.

The student agreed to see a GP and the earliest appointment was booked for late afternoon. As the student was resident in University halls the Head of Student Support contacted the Senior Residential Advisor in halls who agreed to arrange for a member of staff to call at the student's room to remind her about the appointment. However, when a member of staff called the student was neither in her room nor at the health centre.

The student actually presented at the Student Welfare Office in a confused state. She explained that she suffers from schizophrenia and has not taken medication. As there was no one else, and as the student could not be left alone, the Senior Residential Advisor stayed with the student at the health centre.

The student requested that the advisor stayed with her during the consultation with the GP. Following the consultation the doctor decided to refer the student to the Crisis Resolution Team, telling the advisor that the student is extremely ill and likely to be sectioned under the Mental Health Act.

Even though it was not the role of the advisor, the expectation of the services used by the student was that the advisor would remain with the student.

The student became even more disorientated, leaving the advisor, who was concerned not to leave the student alone, so followed her and contacted University Security and police. The Advisor was asked to continue to follow student by the police and was contacted by the Crisis Resolution Team. The police arrived after approximately 15 minutes and the student tried to enter police car. Officers tried to speak to student who becomes increasingly confused and distressed. Police have forcibly to remove the student and take her into custody.

This case study has a number of points to consider:

- Welfare provide advice in relation to student finance, immigration and visa issues
- Welfare is not equipped to deal with emergency health related issues, although this is the

perception among students and some statutory services

- The University has a mental wellbeing service which sees students on an appointment basis, but this service would not be equipped or qualified to respond to emergency situations
- International students are particularly vulnerable because they usually studying without the support of local family
- Although this international students lived in University halls of residence, many others a living in potentially vulnerable situations in which even this support would not be available
- There is often a perception that University staff can act as 'carers' in this type of situation
- There is often a perception that house mates can act as 'carers' in this type of situation
- International students are required by law to have an up to date visa to remain in the country
- To maintain an up to date visa, students (and the University) must demonstrate that the student is attending academic lectures etc. and are actively studying
- If the University is in breach of the conditions it could potentially lose its licence to sponsor/employ international students and staff
- The student welfare service is not designed for staff to leave the department
- In leaving the department the member of staff from student welfare missed appointments which had been made for other students.
- The member of staff involved felt vulnerable and not equipped to deal with the situation
- The student was sectioned after being collected by the police
- The student did not inform or visit the health centre in relation to her Schizophrenia at any stage prior to this situation

This case study shows that young people, especially those coming to university and living independently for the first time, are subject to increased stress and pressure which can frequently affect their mental health adversely. The provision of mental health support in primary care for students is effective, but when there are episodes of crisis statutory sector services inappropriately rely on the support of student support services and even the peers of those students who are unwell.

Gaps, Findings and Recommendations

There are 2 universities in Leicester which contribute to the economic and cultural life of the city. There are 20,000 students at DMU, 10.5% from outside the EU and 15,000 from University of Leicester, 27% are non-EU residents.

Whilst education is generally protective against mental illness the stresses associated with attending a university can precipitate mental distress and often cause a relapse into poor mental health. This occurs at a time of challenge as young people progress from adolescence into adulthood, when there is a high risk of developing serious mental illness. Students needing mental health support may be fearful of the impact of having a mental illness on their academic studies. Support networks, such as tutors or residential offers may not have the capability of giving advice.

Both universities offer student counselling and support. There are links with primary care and Open Mind IAPT, but secondary mental health care is problematic, because of the impact on the students' academic work and because some students are transient, living between their university address and their parental home address. University counselling services aim to support students in their studies, however, there is some evidence, such as sources of referral, to suggest that they are used for more generic mental health support. Therefore there is probably a hidden mental health need amongst the student population.

There is a requirement for a flexible service to meet the mental health needs of students. This should be based on a strategic overview of the services which includes support for the main general practices involved in student health care and a review of how student counselling services fit into an integrated student mental health care framework.

Commissioners are recommended to

- Develop strategic level contact with student welfare services to develop an integrated approach to student mental health in Leicester
- Recognise and develop the role of primary care mental health for students in Leicester, focusing on provision interested clinicians, social support and good liaison with secondary care services.
- Develop strategies to enable students to gain appropriate access to mental health services
- Investigate whether student counselling services have any role to play in the stepped model of care for mental health

Mental health of working age adults

For working age adults mental illness is common and disabling. The spectrum of illness ranges from depression and anxiety with a prevalence of about 14% in the UK as a whole, to less common psychotic illnesses, such as schizophrenia, with a prevalence of 0.5%. One person in 4 will experience mental illness during their lives, and whilst most recover some will experience varying degrees of disability and distress for long periods.

The audit commission estimates that in the course of a year for a population of 1,000 people, 300 will suffer from mental health problems, of which 230 will go to their GP, 102 will be diagnosed with mental illness, 24 will be referred to specialist outpatients and 6 will require hospital care.¹¹⁸

This chapter considers the evidence concerning the impact of risk factors for mental illness in Leicester and the services available to treat people. Relevant NICE guidance is reviewed, and linked to the descriptions of disorders which are described in the International Classification of Diseases.

In the development of integrated care, commissioners of mental health services in Leicester should recognise the valuable role played by the Voluntary and Community Sector (VCS) in delivering non-stigmatising support for people with mental disorder. Often these organisations are not adequately commissioned, although they provide therapeutic services which are widely valued.

The stepped care approach to mental health is described in this chapter. According to this approach most people with mental disorder are treated in primary care and have timely access to services from which they will experience health gain. However, evidence suggests that when people experience a mental health crisis in Leicester they often experience sub-optimal care.

<p>Wider determinants of health affecting mental health in Leicester</p>	<ul style="list-style-type: none"> • Crime levels are associated with both illness and poverty, increasing the burden of ill health on those communities least able to cope. Leicester has significantly worse levels of crime than England • Any increase in inequalities in deprivation is likely to result in widening inequalities in health. Leicester has significantly more people living in the 20% most deprived areas than the England average • Long term worklessness is associated with poorer physical and mental health. Leicester has more long term unemployment than the national average • Poor quality of life through physical illness is closely related to mental health problems. People with mental health problems are twice as likely as the general population to experience a long term illness or disability, the percentage of the Leicester population with a limiting illness is significantly higher in Leicester
<p>Leicester Adult Mental Health Profile</p>	<ul style="list-style-type: none"> • There is a lower rate of depression diagnosed in Leicester than England as a whole • Hospital admissions for mental health are significantly worse than the England average
<p>Service Provision for Leicester</p>	<p>Stepped care model of service provision Significantly higher number of total contacts with mental health</p>

	services, rate per 1,000 population Significantly lower number of contacts with Community Psychiatric Nurse, rate per 1,000 population than England Significantly worse recovery rate for Improving Access to Psychological Therapies 2011/12
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Evidence

One way of defining mental illness is to review the disorders described in the tenth revision of the International Classification of Diseases (ICD-10), which may be listed as (See Appendices):

- F2, schizophrenic and delusional disorders
- F3, mood (affective) disorders, including severe depressive, manic and bipolar forms, and a range of severe, moderate and mild depressive disorders
- F4, neuroses, including phobic, panic and obsessive–compulsive disorders
- F5, behavioural disorders, including eating, sleep and stress disorders
- F6, personality disorders of eight different kinds.

ICD-10 F disorders are defined in terms of patterns of symptoms. Severity is assessed at the time of diagnosis and appraised throughout the course of the disorder.

Another key concept is ‘severe mental illness’ (SMI), which places ICD diagnosis within the context of a wider range of problems, such as severity, persistence and potential vulnerability. For example:

- Active self-injury, food refusal, possibility of suicide
- Threatening or injurious behaviours towards others
- Embarrassing, overactive or bizarre behaviours
- Active delusions, depression, phobias, obsessions
- Long-term ‘negative’ symptoms, such as slowness, self-neglect, social withdrawal

The prevalence of ‘neurosis’

Neurotic disorders can negatively affect a person's ability to function effectively in the activities of daily living, such as going to work and school, caring for family, and taking care of basic needs. They include post-traumatic stress disorder, somatization disorders, anxiety disorder, panic disorder, phobias, dissociation disorder, obsessive compulsive disorder and adjustment disorder. People with disorders that are considered a neurosis or neurotic disorder do not have delusions or hallucination, which are symptoms of psychotic disorders.

According to the National Psychiatric Morbidity Survey (NPMS)¹¹⁹ the most commonly reported neurotic symptoms among both men and women were sleep problems, fatigue, irritability and worry. The proportion of all adults experiencing these symptoms ranged from 29% for sleep problems to 19% for worry. The next most frequently occurring symptoms were depression, anxiety, poor concentration and forgetfulness.

The survey showed 1 in 6 adults assessed as having a neurotic disorder (164 cases per 1,000). The most prevalent disorder among the population was mixed anxiety and depressive disorder (88 cases per 1,000). Generalised anxiety disorder affected 44 cases per 1,000. The remaining disorders, which included depressive episode, phobias, obsessive compulsive disorder and panic, were less prevalent, ranging from 26 to 7 cases per 1,000 adults.

Prevalence rates were usually higher among women than men for neurotic disorders. The prevalence rates of 'any neurotic disorder' showed variation by age, with the highest prevalence rates (nearly 200 per 1,000) in people aged between 40 and 54 years; for males the rate peaked in the 45 to 49 age group (204 cases per 1,000) whereas for women the rate peaked between 50 and 54 years.

The prevalence of personality disorders

Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others. Changes in how a person feels and distorted beliefs about other people can lead to odd behaviour, which can be distressing and may upset others.

The main symptoms, which worsen with stress, include being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger; avoiding other people and feeling empty and emotionally disconnected; having difficulty managing negative feelings without self-harming (for example, abusing drugs and alcohol, or taking overdoses) or, in rare cases, threatening other people and sometimes losing contact with reality.

The prevalence rate for any personality disorder in the NPMS was 54 per 1,000 for men and 34 per 1,000 for women. Obsessive compulsive disorder had the highest prevalence of any category of personality disorder, and was more common among men.

Psychotic and severe affective disorders

Affective disorders are characterised by dramatic changes or extremes of mood; they include manic (elevated, expansive, or irritable mood with hyperactivity, pressured speech, and inflated self-esteem) or depressive (dejected mood with disinterest in life, sleep disturbance, agitation, and feelings of worthlessness or guilt) episodes, and often combinations of the two. In manic-depressive disorders, periods of mania and depression may alternate with abrupt onsets and recoveries.

The prevalence rate for a probable psychotic disorder in the NPMS was 5 per 1,000 for women and 6 per 1,000 among men. The survey appeared to show a concentration of cases among people aged 30 to 54 years, although the difference in prevalence was not statistically significant. The highest rate among women was observed in the 40 to 44 year group (12 per 1,000). For men it was in the 30 to 34 age group (13 per 1,000).

Mental and physical health and wellbeing

One impact of the stigma associated with mental illness is that people with mental health problems are less likely to have effective physical health treatment. This is despite a strong link between mental illness and increased early mortality and morbidity.¹²⁰ Life expectancy for people with schizophrenia is on average 25 years shorter than the general population.¹²¹ More premature deaths in people with mental illness are due to treatable cardiovascular, pulmonary and infectious diseases than from suicide and undetermined injury.¹²²

This increased cardiovascular mortality reflects in part increased health-risk behaviours. People with common mental health disorders are more likely to engage in behaviours that are detrimental to health. They are more likely to have a poor diet, exercise less, smoke and misuse drugs and alcohol.

Conversely good mental health and wellbeing are associated with reduced mortality rates, both in healthy people and in those with illness.

Evidence suggests that depression is associated with poor physical health:

- Analysis of a large population survey found that depression was associated with increased mortality.¹²³
- Multiple causes for increased mortality: depression was associated with increased mortality for cardiovascular disease 1.67 (95% CI 1.38-2.01), cancer 1.50 (1.19-1.89), respiratory disease 2.06 (1.26-3.38), metabolic disease 3.03 (1.46-6.28), nervous system diseases 4.66 (2.44-8.92), accidental death 2.09 (1.07-4.08), and mental disorders 6.75 (2.09-21.78).¹²⁴
- Systematic reviews of 11 prospective cohort studies in healthy populations show that depression predicts later development of Coronary Heart Disease.^{125 126}
- Increased psychological distress was associated with 11% increased risk of stroke after adjusting for a range of possible confounders in an analysis of a cohort study of 20,267 participants followed up over 8.5 years.¹²⁷
- Prospective population-based cohort studies show that depression predicts later colorectal cancer,¹²⁸ back pain,¹²⁹ irritable bowel syndrome¹³⁰ and multiple sclerosis.¹³¹
- Meta-analysis of factors related to non-compliance found that depressed patients were three times as likely to be non-compliant with treatment recommendations as non-depressed patients.¹³²

Many physical health conditions also increase the chances of poor mental health, for example:

- Physical illness showed increased risk of developing depressive disorder in a large population-based cohort.¹³³ The risk was similar for a range of physical illnesses including hypertension, asthma, arthritis and rheumatism, back pain, diabetes, heart disease and chronic bronchitis.
- Up to 70% of all new cases of depression in older adults are caused by poor physical health.¹³⁴
- Physical illness and two or more recent adverse life events increases risk of mental illness by six times compared to without physical illness.¹³⁵
- Long-term conditions increase the risk of mental illness; those with diabetes have 2-3 times increased risk of depression which is associated with increased health care consumption by 50-75% and increased symptoms¹³⁶ Those with chronic obstructive pulmonary disease (COPD) have 40-50% rates of depression and anxiety.

Mental ill health of working age adults in Leicester

Prevalence rates from national surveys¹³⁷ suggest that 16-18% of working age adults might be expected to experience a common mental health problem at any time. Applied to the 2011 Census population of Leicester aged 18-64 years, which was 214,736 people, this equates to somewhere between 34,358 and 38,652 people. Half of adults with these problems have symptoms severe enough to require treatment.¹³⁸ Common mental health problems are more frequent among females than males (19.7% and 12.5%).

The estimated number of people in Leicester with serious and enduring mental illnesses, such as schizophrenia, bipolar affective disorder and other psychosis, is about 3,400 people. Although the figures vary slightly, the Projecting Adult Needs and Service Information System (PANSI), shows similar projections of working age adults with mental health problems in Leicester, in Table 6 below.

The Sainsbury Centre for Mental Health suggested that the annual incidence of adult depression is 6.4% in Leicester; this means about 14,000 working-age adults developing a common mental health

problem every year. In terms of the incidence of severe and enduring mental disorders it is estimated that about 2,000 people of working age in Leicester will experience psychosis in a year.

Table 6: Projections of working age adults with a range of mental ill health problems in Leicester 2011 – 2030

	2011	2015	2020	2030	Leicester	East Midlands	England
People aged 18-64 predicted to have a common mental disorder	33,501	34,789	35,773	38,071	16%	10%	10%
People aged 18-64 predicted to have a borderline personality disorder	937	973	1,001	1,065	0.50%	0.30%	0.30%
People aged 18-64 predicted to have an antisocial personality disorder	723	751	773	824	0.40%	0.20%	0.20%
People aged 18-64 predicted to have psychotic disorder	833	865	889	946	0.40%	0.30%	0.30%
People aged 18-64 predicted to have two or more psychiatric disorders	14,960	15,536	15,981	17,010	7%	4.50%	4.50%

There are important differences in the recorded burden of mental illness between different ethnic groups. People from BME backgrounds are, on average, three times more likely to experience psychosis than their White/White British counterparts.¹³⁹ Risk of psychosis in people from Black/Black British ethnic backgrounds is nearly seven times higher than in the White/White British population.¹⁴⁰ Higher rates of common mental disorders have been found in South Asian subgroups than in the White/White British population;¹⁴¹ South Asian women are at more than two-fold higher risk.¹⁴²

People from Black/Black British communities are over-represented in social care assessments and reviews, and mental health advocacy. The *Count Me In Census* reports for 2006-10 showed that Black/Black British groups were over represented among in-patients in local secondary care facilities. People from BME communities who were admitted to psychiatric wards were significantly less likely to have a diagnosis of personality disorder compared to people from White/White British communities but were more likely to have a diagnosis of schizophrenia compared to White inpatients.

Measures of deprivation and disadvantage, such as unemployment, overcrowding, low educational attainment, lone parents and adults who are divorced or separated are associated with poor mental health. Adults in the lowest quintile of household income are more likely to have a common mental health problem than adults in the highest quintile. Leicester has high rates of such risk factors, with unemployment above the national average and high rates of people aged 16-18 years not in employment, education or training. Nearly half of the population of Leicester can be described as highly disadvantaged, with pockets of very high deprivation, more violent crime, poor quality housing and a higher proportion of children living in poverty.

Despite these high risks, Table 7 shows that the proportion of those people aged over 18 years who are registered with depression at General Practices in Leicester is lower than the regional and national averages. This suggests that, whilst many people with depression may not be seeking help from their GP, there may be an under diagnosis of depression in Leicester. Furthermore, whilst there is a lower than expected rate of diagnosis for depression in Leicester, the Community Mental

Health Profile also suggests that Leicester has high rates of admissions to hospital for serious mental illness, and high rates of admission for hospital admission for unipolar depressive disorders.

Taken together, this suggests that there are fewer cases of diagnosed depression than expected, higher rates of hospital admission for mental illness and worse than average outcomes.

Table 7: Adults >18 years with depression (QOF data) 2011-12

	List size	>18 years	>18 years with depression	%
EAST MIDLANDS	4,661,646	3,693,916	462,084	12.5
ENGLAND	55,525,732	43,855,136	5,123,948	11.7
LEICESTER CITY PCT	373,376	283,806	30,831	10.9

Evidence of best practice

The following table is a summary of NICE Guidance which covers a range of mental health problems

<p>Generalised anxiety disorder (ICD10 F41.1) <u>Anxiety</u> (NICE Clinical Guidance CG22) (2007)</p>	<p>Covers: Identification, assessment and issues such as co-morbidity</p> <p>Step 2: Low intensity psychological interventions e.g. self-help</p> <p>Step 3 treatments for GAD with marked functional impairment, e.g. High-intensity psychological interventions, such as cognitive behavioural therapy (CBT) or applied relaxation. Drug treatment, such as selective serotonin reuptake inhibitor (SSRI)</p> <p>Step 4 treatment for GAD with severe anxiety with marked functional impairment in conjunction with either a risk of self-harm or suicide or significant comorbidity, such as substance misuse, personality disorder or complex physical health problems</p>
<p><u>Post-traumatic Stress Disorder</u> (F43.1) (CG26) (2005)</p>	<p>Covers: Initial response to trauma Trauma-focused psychological treatment Drug treatments for adults Screening for PTSD</p>
<p><u>Obsessive Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD)</u> (F42) (CG31) (2005)</p>	<p>Initial treatment of adults with OCD includes low intensity psychological treatments; Brief individual cognitive behavioural therapy (CBT), the use of structured self-help materials; Brief individual CBT by telephone and Group CBT</p> <p>Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT should be offered the choice of either a course of SSRI or more intensive CBT</p> <p>Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of a selective serotonin re-uptake inhibitor (SSRI) or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.</p> <ul style="list-style-type: none"> • Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these

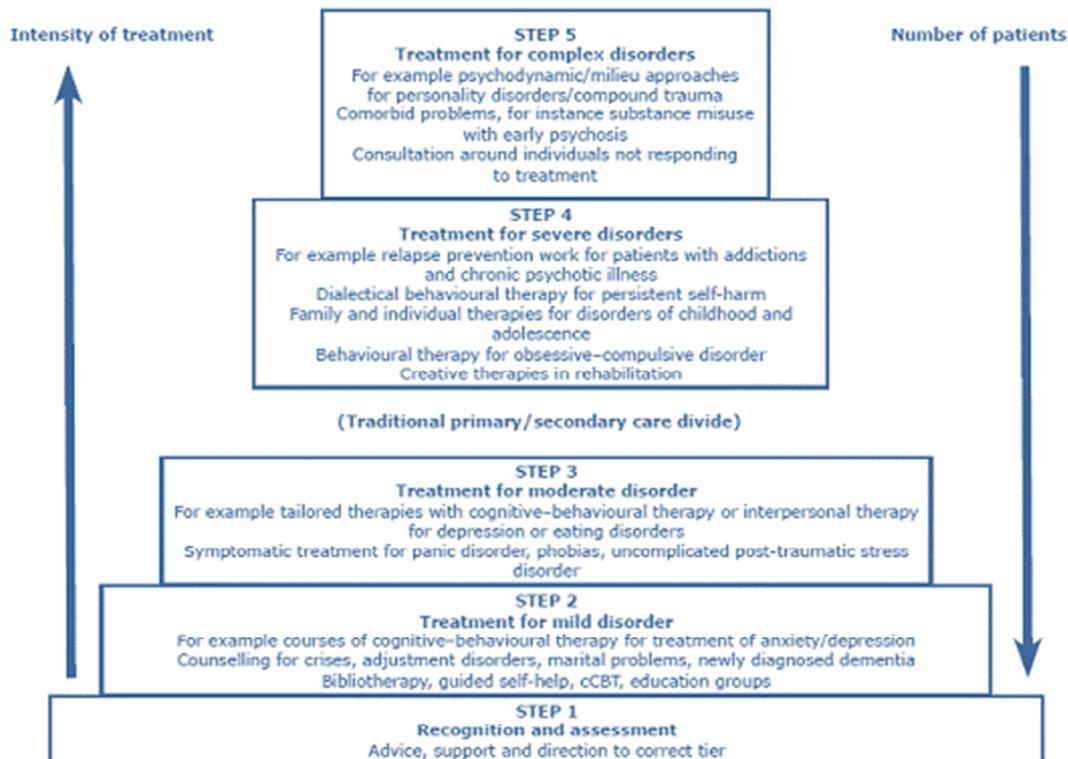
	<p>treatments appear to be comparably efficacious.</p> <ul style="list-style-type: none"> • Adults with BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive individual CBT (including ERP) that addresses key features of BDD.
<u>Bipolar disorder (F31) (CG38) (2006)</u>	<p>Covers the range of treatment people with bipolar disorder can expect to be offered, including medication and psychological therapies, advice on self-help, the services that may help people with bipolar disorder, including psychiatric or specialist mental health services and how families and carers may be able to support people with bipolar disorder, and get support for themselves.</p> <p>Key priorities for implementation include: Treating bipolar disorder with drugs</p> <ul style="list-style-type: none"> • Valproate should not be prescribed routinely for women of child-bearing potential. If no effective alternative to valproate can be identified, adequate contraception should be used, and the risks of taking valproate during pregnancy should be explained. • Lithium, olanzapine or valproate should be considered for long-term treatment of bipolar disorder.
<u>Antisocial Personality Disorder (F60.2)(CG77) (2009)</u>	<p>Makes recommendations for the treatment, management and prevention of antisocial personality disorder in all levels of healthcare and across a wide range of other services.</p> <p>Developing an optimistic and trusting relationship Cognitive behavioural interventions for children aged 8 years and older with conduct problems</p> <ul style="list-style-type: none"> • Cognitive problem-solving skills training should be considered for children aged 8 years and older with conduct problems if: Assessment in forensic/specialist personality disorder services • Healthcare professionals in forensic or specialist personality disorder services should consider, as part of a structured clinical assessment, routinely using: Treatment of comorbid disorders • People with antisocial personality disorder should be offered treatment for any comorbid disorders in line with recommendations in the relevant NICE clinical guideline, where available. This should happen regardless of whether the person is receiving treatment for antisocial personality disorder. <p>The role of psychological interventions</p>
<u>Borderline Personality Disorder (F6) (CG78) (2009)</u>	<p>Make recommendations for the treatment and management of borderline personality disorder in adults and young people in primary, secondary and tertiary care.</p>
<u>Schizophrenia (F2) (CG82) (2009)</u>	<p>Covers the care, treatment and support that adults (aged 18 and older) with schizophrenia should be offered, including people who develop schizophrenia before they are 60 and continue to require treatment after this age including:</p> <p>Primary care and physical health Psychological interventions Pharmacological interventions Interventions for people with schizophrenia whose illness has not responded adequately to treatment</p>
<u>Depression in adults (F31.3 F31.4)(CG90) (2009)</u>	<p>Effective delivery of interventions for depression Case identification and recognition Low-intensity psychosocial interventions Drug Treatment</p>

	Treatment for moderate or severe depression
<u>Depression with a chronic physical health problem</u> (CG91) (2009)	Makes recommendations on the identification, treatment and management of depression in adults aged 18 years and older who also have a chronic physical health problem Effective delivery of interventions for depression Low intensity psychosocial interventions Treatment for moderate depression Antidepressant drugs Collaborative care

Stepped Care Approach

Services for people in Leicester with mental health problems are provided by a number of agencies working in close collaboration across the statutory and community and voluntary sectors. Stepped care (see Figure 7) is a model of healthcare delivery which focuses on: Delivering recommended treatment to provide significant health gain; stepping up if treatments are not achieving significant health gain; reserving complex treatments for people who do not benefit from simpler first-line treatments, or for those who can be accurately predicted not to benefit from such treatments. Treatment of common mental health problems is provided by GP practices and CVS organisations at Step 1, and Open Mind IAPT (Improving Access to Psychological Therapies) at Steps 2 and 3. Secondary mental health is provided by Leicestershire Partnership Healthcare Trust, in 3 distinct areas, Community Services, Complex Care Services and Access Services- Crisis & Inpatients.

Figure 7: Stepped care model for mental health



Source: Royal College of Psychiatrists (2008): *Psychological therapies in psychiatry and primary care*
Voluntary sector organisations caring for people with mental health problems

The provision of care for people with mental health disorders in Leicester benefits from a voluntary sector which offers a range of services. There is a list of voluntary and community sector (VCS) organisations attached as in the appendices. Many of these groups offer support which benefit people at risk of poor mental health, including carers, parents, faith communities, lesbian, gay, bisexual and transgender people, people from BME backgrounds, offenders, and people with problems such as debt or addiction.

These services empower and respect service users, supporting recovery and social inclusion and tackling stigma, marginalisation and harassment. They generally focus on Step 0 (enabling self-care through community support) or Step 1 care, offering advice, support and direction. However, it is important that commissioners recognise that some organisations offer expert support within a particular area, which may cut across different steps, as shown in the summary table below.

CCG Commissioned services: Step 1	<ul style="list-style-type: none"> • LAMP information and advocacy service • Alzheimer’s Advocacy Project • CLASP carers information and advice service
CCG Commissioned services: Step 2	<ul style="list-style-type: none"> • Community Advice and Law Service • Crossroads carers support service • Foundation Housing Support service • RETHINK Homeless outreach service • YMCA Welfare Rights Service • Genesis LAMP
CCG Commissioned services: Step 3	<ul style="list-style-type: none"> • Network for Change support services • Advance Housing and Support Ltd (Glengarry House) • LHA Compass Project • RETHINK Focus line
CCG Commissioned services: Step 4	<ul style="list-style-type: none"> • Bradgate Unit Assertive In reach Service • Welfare Rights MH inpatient service • Quetzal Specialist counselling service • Bernard’s & Jupiter Lodge psyche- social support for victims of sexual assault
Leicester City Council Voluntary and Community Sector	<ul style="list-style-type: none"> • Supported employment & community/social activities • Advocacy, peer advocacy, • Carer Support • Housing related Support • Drug and Alcohol care • Independent Sector • Residential care • Supported living • Domiciliary care • Housing related support

A recent report to the Leicester City Council Health and Community Involvement Scrutiny Commission found that voluntary sector organisations have a role to play in building community

capacity and resilience to mental illness, and that they can deliver effective mental health services. However, it found that their role or budgets had not been specifically defined and noted that VCS organisations suggested they had limited opportunities to engage with health and social care commissioners.

One of the important factors in developing VCS is Personalisation. This concerns the allocation of personal social and health care budgets so that individuals can arrange and pay for their own support and care. Personalisation means that individuals are assessed and allocated funds according to need. This allocation is known as a Personal Budget. The process requires health and social care workers to encourage and enable service users to exercise more informed choices and control over their own lives, and explore different approaches to their care.

However, Personalisation represents a challenge to the capacity of the voluntary and community sector, because it means that VCS services are expected to develop new ways of working, measuring effectiveness and delivering governance. The prevailing view amongst VCS organisations is that whilst there is a high level of mental health need, the voluntary sector is underfunded but it is expected to act as a safety valve for the statutory sector. Network for Change, an organisation which aims to meet the needs of adults whose mental health problems have impacted significantly on their quality of life, suggests of all the people registered with a severe and enduring mental illness in Leicester, the majority are unlikely to qualify for a budget.

The range of services offered by VCS organisations in Leicester can be seen in the LAMP Directory (<http://www.lampdirect.org.uk/lamp-directory#sthash.lhFZ1FJ5.dpuf>). LAMP has the ethos that those who seek or use mental health services and their families and friends, should have a voice in how those services are provided and planned. In addition to the Directory LAMP provides generic Mental Health Advocacy for people of working age experiencing mental distress and Independent Mental Health Advocacy (IMHA) for people who are legally entitled to specialist advocacy under the Mental Health Act.

Between April 2012 and March 2013, most LAMP service users were unemployed and in receipt of benefits. There was an association between LAMP service user clients and geographical areas of deprivation. Most of the service users (49%) were from a White/White British ethnic background, with the next most frequent group being those from an Asian/Asian British background (20.8%). In terms of gender, LAMP clients in the same period were evenly divided. Most of the clients were aged between 45 – 64 years.¹⁴³

Network for Change provides services to more than 200 people from hard to reach groups, including BME populations and new communities, people with dual diagnosis (for instance mental health and alcohol and drug related issues or learning difficulties), people who have become disengaged from mainstream or statutory services, the homeless and offenders with mental health problems. Most Network for Change service users are Leicester residents. There are roughly equal numbers of men and women, the majority (over 95%) are long-term unemployed, are single and live alone. Network for Change service users have often experienced social isolation, stigma and discrimination. They have difficulty in sustaining good relationships and have found that statutory services lack understanding of their needs.

Another area of expertise in the voluntary and community sector is the Leicester Counselling Centre (TLCC). Given that there is a high demand for psychological therapies TLCC is a VCS organisation which is in a position to provide more counselling. In a study of voluntary sector counselling¹⁴⁴ it was found that those people with mental health problems presenting at TLCC are almost identical to those in NHS primary care therapy services. The most common conditions were depression, anxiety and interpersonal problems. Proportionally more clients at TLCC had experienced trauma or abuse

and problems which were related to addiction or eating disorders than those which were treated in statutory sector primary mental health services. Therapy at TLCC is delivered by appropriately qualified and experienced practitioners. When completed pre and post-therapy scores were compared, clients at TLCC were shown to have a higher than average improvement in their condition.

Counselling gives people the opportunity to talk in confidence and reflect on the causes of their problems, helping them to achieve a better understanding of their situation and feelings and to find ways of dealing with them. Current TLCC data suggests that 67% are clients from Leicester, 31% are County clients and 2% from Rutland. 69% are female clients and 31% male. Most of the clients are from a White/White British ethnic background (69%), with 16% from and Asian/Asian British ethnic background. 57% of the client group are under 40 years. 56% of the clients are in either full time or part time employment.¹⁴⁵

In terms of the impact of TLCC in individuals, families and communities, service feedback suggests that there is a positive impact on individuals' sense of self-esteem, the potential for self-harm and suicide ideation. Other feedback suggests that families have been supported and that a non-stigmatising service has a beneficial impact on communities.

Some voluntary sector organisations have a wider remit, such as focusing on supporting people with long-term conditions. This is another important source of non-stigmatising support for people with mental health problems, which would not be provided by the statutory sector.

For instance, LASS works with people who are living with or affected by HIV and hepatitis. It works in collaboration with organisations, communities and agencies to raise awareness about HIV, Hepatitis and sexual health. As part of this LASS supports individuals and communities who experience mental illness, through peer mentoring, partnership work with Department of Medical Psychology at University of Leicester, counselling, therapy and the Wellness Recovery Action Plan (WRAP). WRAP is a self-management and recovery system developed by people with a lived experience of mental health difficulties. It is used to sustain wellbeing by focusing on five key recovery concepts: hope, personal responsibility, education, self-advocacy and support. WRAP aims to prevent isolation and develop support.

LASS work with many other communities and groups of people who are marginalised and struggling with stigma and prejudice as a result of ethnicity, homelessness or problems of addiction. An HIV diagnosis can often be a catalyst to mental ill health and depression for people who are already stigmatised or suffering discrimination. In cases where people are on medication, for HIV or to treat Hepatitis, the medication itself can be a cause of poor mental health, such as insomnia or depression and anxiety.

Primary Care (Steps 1-3)

More than 90% of people with mental health problems are managed entirely in primary care, including approximately one in four people receiving treatment for psychosis. Primary care also manages many people with medically unexplained symptoms which may have a mental health origin. From the perspective of the health care system, effective primary care is cost-effective in that it allows specialist resources can to care for those most in need. Analysis of the latest Adult Psychiatry Morbidity Survey shows:

- 38% of those with common mental disorders accessed GP services and 18% made use of community or day care services.
- GPs used are good at recognising moderate to severe depression

General Practice (Step 1)

A GP with a list of 2,000 patients would expect to treat 50 people with depression, 10 people with a serious mental illness such as schizophrenia or bipolar disorder, about 180 people with anxiety disorders and a further 180 or so with milder degrees of depression and anxiety.

General Practice is the main point of access to Step 1 mental health care services, and for referral to other parts of the pathway. GPs who are interested in community support for people with mental illness have knowledge of the VCS infrastructure; however this is by no means the case for all GPs. NICE recommends that GPs should be alert to their patients' mental health and wellbeing, conducting assessments in primary care, enabling people with mental health problems to access the services where they will achieve most health gain.

GPs investigate whether a person is presenting with a possible mental disorder, if they have a past history of mental illness, possible physical symptoms related to a mental disorder or experienced of a recent traumatic event. With conditions such as anxiety and depression GPs should ask the patient about their feelings of anxiety and depression using the Generalized Anxiety Disorder scale (GAD 7) and the PHQ-9 questionnaires.

Under the Health and Social Care Act 2012, and the formation of the Clinical Commissioning Group and the Health and Wellbeing Board, GPs have a role in commissioning services, fostering collaboration between practices, linking with the local community and social services, considering problems which arise from uneven quality of care, promoting good practice and encouraging public participation in decisions.

Thus General Practice is a crucial in sustaining the confidence and competence of local mental health services. In August Leicester City CCG conducted a short survey on GP attitudes to local mental health services; 29 practices responded. GPs rated most mental health services rated as either average or poor according to GPs.

The survey showed that GPs experienced poor communication with the mental health crisis team, the community mental health team and Open Mind. They described mental health services as lacking in continuity of care, having long waiting lists, and lack of expertise in undertaking some physical health checks such as blood pressure, electro-cardio gram, phlebotomy and letter writing. They felt that medication changes are delayed when they are sent to GPs and that the Crisis team does not update GPs after assessment.

CCG commissioners concluded from the GP Mental Health Survey that whilst there is evidence of good mental health care and service delivery to patients across the city, there are concerns about operational deficiencies of the Crisis Resolution Home Treatment Team, waiting times and response times for patients requiring mental health care.

Anti-depressant medication

GPs have a role in treating and referring for treatment those people with mental health problems who have sought medical advice. One such treatment is the prescription of anti-depressant medication. The Leicester City Improving Access to Psychological Therapy Steering Group compared local anti-depressant prescribing with national trends.

When the total number of anti-depressant items prescribed in 2009 was compared to those prescribed it is clear that the total items and total costs both had increased. The cost of these medications totalled £1,214,779 in 2010 compared with £1,190,708 in 2009 a 2% rise. The total number of prescribed items under consideration increased by a much larger proportion of 10.2%, from 250,501 in 2009 to 275,948 in 2010.

Table 8: Table: Anti-depressant prescribing trend in Leicester 2009 compared with 2010

BNF Name	January 2009 to December 2009			January 2010 to December 2010		
	Items	Actual Cost	Cost per item	Items	Actual Cost	Cost per item
Anxiolytics	41,715	£147,306	£3.53	44,334	£150,541	£3.40
Tricyclic & Related Antidepressant Drugs	64,196	£203,908	£3.18	69,449	£211,445	£3.04
Selective Serotonin Re-Uptake Inhibitors	11,4032	£349,352	£3.06	125,777	£400,845	£3.19
Other Antidepressant Drugs	29,940	£482,109	£16.10	35,823	£445,645	£12.44
Monoamine-Oxidase Inhibitors	618	£8,033	£13.00	565	£6,303	£11.16

The Guardian reviewed raw prescription numbers with ONS population estimates. The findings indicated that there are higher rates in parts of Lancashire and the north-east, although deprived areas in the south and south-east had lower prescribing rates. Rates of depression are generally higher in deprived areas, where there is more poverty and unemployment. There are also higher rates of depression in areas where there is chronic ill health, such as diabetes and heart disease.

The data showed a rise in the number of prescriptions for antidepressants in every PCT area when the patterns for 2008-09 and 2009-10 were compared. Those with the fewest numbers of prescriptions per 100,000 people were all from London PCT areas. Table 9 shows the rate from Brent PCT was 35,914 prescriptions for antidepressants per 100,000 in comparison with 69,088 for Leicester City PCT. The rate for Leicester was also higher than Nottingham and Derby but lower than Leicestershire and Rutland.

The rate rise in Leicester between the years 2008-09 and 2009-10 was higher than average 12.7%. Nationally there were some with similar rate rises, especially in London PCT areas (for instance Kensington and Chelsea 12.2% rise; Newham 12.5%) and higher in other south eastern PCT areas (Barking 14.3% and Medway 14.1%). However, there were lower rate rises locally; Nottingham 9.1%, Derby 9.4% and Leicestershire and Rutland 10.9%).

Table 9: Comparisons in prescriptions per 100,000 and % increase

PCT Area	Prescriptions per 100,000 2009-10	% increase in prescriptions
Brent	35,914	8.5
Derby City	62,667	9.4
Hackney	43,613	5.8
Leicester City	69,088	12.7
Leicestershire County and Rutland	71,983	10.9
Lincolnshire	98,720	10.1
Nottingham City	66,835	9.1
Tower Hamlets	56,276	10.9

CCG commissioned services

Open Mind IAPT (Steps 2-3)

Improving Access to Psychological Therapies (IAPT) is a national programme of commissioning and service redesign which aims to deliver psychological treatments (“Talking Therapies”) which are compliant with National Institute for Clinical Excellence (NICE) guidelines within Primary Care. IAPT provides treatments for people with mild to moderate mental health problems at Steps 2 and 3 of the Stepped Care model.

Since 2012 LPT, operating as Open Mind, has been the main IAPT provider for Leicester. LPT currently runs this service in collaboration with 2 other organisations, the VCS organisation Savera and the Fit for Work service. In addition Open Mind focuses on:

- Developing and implementing the role of *Mental Health Facilitators*
- Moving from a GP referral only service to one which would expand to develop self-referral pathways
- Investigating ways of expanding the service further to include *Vulnerable Groups*, including Asylum Seekers, Homeless People, Older People and those with Long Term (physical) Conditions
- Expanding from 15% to 20% coverage of depression and anxiety by 2015 to meet the expected rise in demand for treatment.

The City IAPT service was independently audited in September 2011 by the University of Central Lancashire. The scope of the evaluation included service design, commissioning processes, equitable access, experience of service users, especially those from ethnic minority backgrounds, and partnership working with voluntary and community partners. The report found that, in contrast to other IAPT services, Open Mind had secured largely fair and equitable access and progress through treatment for black and minority ethnic groups. It suggested that

“This is a major achievement, especially at this stage of the service’s development, and puts Open Mind at the forefront of national work in the area. No other service was found that could show such equity for different ethnic groups.”

The evaluation also highlighted a number of key areas for consideration, which have been tackled during the intervening period. These included a need for improved commissioner support and for

improved communication among key stakeholders. There were other recommendations concerning improved patient access the service, including self-referral.

IAPT aims to reach as wide a population as possible who meet the clinical criteria for treatment. It is estimated that approximately 17.7% of adults aged 18 years and over will meet the diagnostic criteria for at least one common mental health disorder in England. At present the commissioned target is to meet at least 15% of the total need. Based on an estimated figure for adult anxiety and depression in Leicester of 36,000 cases, the annual target of 15% for Open Mind IAPT, is 5,400 cases.

Evidence from the Open Mind IAPT service suggests that in 2012-13 the service reached 12% of the 36,000 cases. Although the annual rate of people entering treatment for depression and anxiety was below that of national KPI, it was higher than populations accessing similar services in peer areas, such as Tower Hamlets, Newham, Derby and Nottingham. However, the rate of recovery of people accessing IAPT in Leicester was the lowest of the peer group (40.5%). This indicates that people are entering treatment, but that the need of the patient is not at the appropriate threshold for IAPT.

Evidence gathered for this needs assessment suggests a complex picture of depression and anxiety in Leicester, with lower than expected rates of diagnosed depression, especially given the high rates of risk factors for poor mental health, such as high levels of deprivation, unemployment and low levels of educational attainment. The factors which may explain this low recovery rate may be sub-optimal patient assessment prior to referral to Open Mind, and lack of knowledge of the range of mental health services across the statutory and voluntary sectors.

Data from Open Mind for July 2013 showed that from 152 consecutive referrals 104 had no PHQ-9 or GAD 7 assessment scores, 35 had PHQ alone, 1 had GAD alone, and 12 had both PHQ and GAD. In some cases, without proper assessment, people have been inappropriately referred to IAPT for treatment at Steps 2 or 3 in the Stepped Care model.

These cases include individuals who are experiencing acute distress, who may not attend their first appointment, not engage with the service or may attend a small number of sessions before disengaging. They also include cases where the mental health problem may be linked to issues like marital problems, domestic violence, changes in benefits and debt. For such cases Open Mind is incorrectly seen not as a care provider for people with mild to moderate depression or anxiety, but as a portal to other services.

For such cases it is unlikely that, without the wider support of social care and VCS organisations to advise people with debt management or domestic problems, a programme of talking therapy will lead to recovery. Furthermore, recovery is unlikely for those people with acute illness who have been inappropriately referred to Open Mind unless IAPT has the explicit right to identify and facilitate referral into a range of secondary care services with the capacity to receive those patients.

Of those who are accessing Open Mind at the moment, when compared with the population of Leicester (2011 UK Census):

- Those in the 18 to 29 and 30 to 49 years age groups were overrepresented amongst both those who entered treatment and amongst all referrals.
- Whilst those in the 14 to 17, 65 to 84, and 85 years and over age groups were underrepresented amongst both those who entered treatment and amongst all referrals, and those in the 50 to 64 years age group were underrepresented only amongst all referrals (please refer to Table 10 below).

- Women were overrepresented and men were underrepresented amongst both those who entered treatment and amongst all referrals.

Mental Health Facilitators (Step 3)

Mental Health Facilitators are managed as part of the Open Mind IAPT service procured in 2012. The Facilitators offer a primary care based service to patients with more severe and enduring mental illness, such as schizophrenia or bi-polar disorder. Before 2012 these patients were assessed through secondary care out-patients. Facilitators are establishing clear links between mental health and primary health care teams.

Currently there are 5 whole-time equivalent Community Psychiatric Nurses who are Mental Health Facilitators in Leicester. They deliver a range of care interventions, such as managing psycho-tropic medication, monitoring practice Serious Mental Illness (SMI) Registers and cross-referencing registered cases with patients registered with a long term condition. They manage cases of unexplained physical health symptoms and provide psycho-social interventions where appropriate.

The current potential caseload for Mental Health Facilitators, based on the SMI registers and information about the prevalence of SMIs is estimated to be 3,400 people. However, the majority of these patients will be cared for by secondary care community based mental health services, either as out-patients or in their own homes. Only a proportion of them are expected to be cared for by the Mental Health Facilitators; in the period April – August 2013 there were 1,800 contacts made by this service.

Mental Health Specialist Nurse (Step 1)

The North East Leicester (NEL) Extended Integrated Team pilot is based on collaboration between 6 general practices with social and community health services. The registered population is about 60,000 people with an older average age than the city generally. Since June 2011 Mental Health Specialist Nurses have been providing access to mental health assessments for patients with mental health problems. The service is also available to adults with long term physical conditions and suspected cognitive impairment. Referrals to the specialist nurse are accepted from Primary Care teams, including GPs and Community Matrons.

Since June 2011 a total of approximately 332 patients have been referred and assessed by the service and the demand for the service is now exceeding capacity. 93% of referrals are requests for assessments of patients who are considered to be frail elderly people; that is, they are aged over 65 years and they have suspected mental health (cognitive) symptoms/deficits. The service is also open to referrals for assessment for those over 18 years who have Long Term Conditions and suspected cognitive impairment. Anecdotal evidence suggests that the service is highly valued both by GPs and by Consultant Psychiatrists locally, although it has not yet been independently audited

An interim report covering 224 cases in the first 18 months of the mental health nurse specialist suggested that:

- ❖ 25 additional referrals had been received during that period, but have fallen outside the referral criteria
- ❖ Of the total number of cases accepted and assessed 63.4% ($n=142$ patients) were treated in the community before being discharged back to the care of the GP

- ❖ 36.6% ($n = 82$ patients) were assessed, sometimes treated and referred on to Secondary Mental Health Services because there were concerns regarding cognitive impairment beyond the scope of the pilot project.

Continuing Health Care

Leicester City CCG Commissions 3 separate continuing care services:

- Nursing Care (packages) at Home,
- Non-Specialised Nursing Home placements
- Specialist Nursing Home placements

People who are eligible for continuing health care can receive NHS funded continuing healthcare in one of the 3 settings following an assessment of eligibility and need. These services may include community nursing or specialist therapy, and personal care, such as help with bathing, dressing and laundry. When the person is looked after in a care home it is possible for the NHS to pay for care home fees, including board and accommodation. To be eligible for NHS continuing healthcare a person must be over 18 and have a complex medical condition and substantial and ongoing care needs. They must have a 'primary health need', which means that a person's main or primary need for care must relate to their health.

According to Leicester City CCG there are currently a total of 177 patients being funded within City local care provision through the Continuing Health Care service. In addition there are a total of 17 patients being funded in "Out of Area" care placements. These do not include patients who meet the criteria for the Section 117 Aftercare arrangements.

Section 117 Aftercare: Statutory Obligations for City CCG and Leicester City Council:

Under the NHS and Community Care Act 1990, Section 117 refers to community care services. Both CCG's and local authorities are responsible for providing such services to patients who meet the criteria for Aftercare arrangements as described below.

Section 117 Aftercare arrangements refer specifically to patients meeting these criteria:

- Any patient detained for treatment under Section 3 of the Mental Health Act (MHA)
- Any Patient detained under a Hospital Order pursuant to Section 37 of the MHA (with or without Restriction Order) or Following Transfer from prison under Section 47 or 48 of the MHA (Hospital assessment Order)
- Patients who are now living in the community subject to a Community Treatment Order and patients who have been "Conditionally Discharged" (that is patients previously subject to Ministry of Justice Restriction)

Section 117 Aftercare arrangements do NOT apply to the following patients:

- Patients detained in hospital for assessment under Section 2 of the MHA
- Patients Detained Under Emergency Section 4 of the MHA
- Patients detained whilst already in hospital under Section 5(2) of the MHA
- Patients who have not been detained under any section (i.e. informal patients)

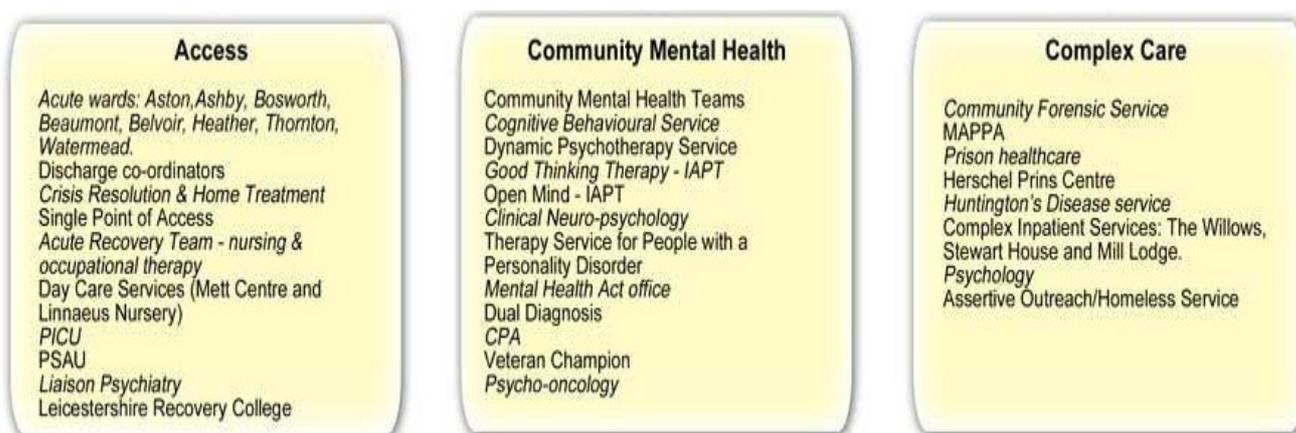
These services usually include support from a Community Psychiatric Nurse, Counselling or talking therapy, social work services as well as financial, employment and accommodation support. The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care 2012 guidance states that the Continuing Health Care framework should not be used for patients subject to Section 117 Aftercare arrangements.

Acute Services (Step 3+)

Acute Inpatient and Specialist Secondary and community care mental health services are provided across LLR by Leicester Partnership NHS Trust (LPT). There are 3 distinct services within Secondary Care Adult Mental Health; these are Community Services, Complex Care Services and Access Services: Crisis and inpatients. The role of these specialist services begins at Step 3 in the stepped care model; they are expected to provide services for people with needs for high intensity psychological therapy or complex medication regimes cannot be met in primary care.

The different Adult Mental Health services provided by LPT under each of these broad headings are listed in Figure 8. These services are important because they provide key support across the spectrum of mental health.

Figure 8: Current Adult Mental Health service provision at LPT (Source: Leicester City CCG)



Acute Services: Crisis and Inpatient care

Services to meet acute mental health need include crisis resolution and home treatment, in-patient services and a range of community based support which may be commissioned to complement treatment at home or in hospital, such as a crisis house. People with poor mental health can be cared for at home if the environment is suitable, if there is capacity in the home treatment team to keep them safe and if they agree to be cared for at home. The aim of acute care is to support patients and carers, assessing and implementing care and identifying goals for recovery. Some people in acute care services will be detained in hospital under the Mental Health Act 1983. Others will be informal or voluntary patients.

The services which could be offered in a model of acute care are:

- Crisis Resolution and Home Treatment team (CRHT) for treatment of acutely unwell people at home who would otherwise require hospital admission. The CRHT assesses the appropriateness of inpatient admissions and can facilitate supported discharge from secondary care.
- Crisis House and recovery house provision for support in a residential setting for people in crisis who do not need to be admitted to hospital, but cannot be treated at home. Crisis house provision is often organised in partnership with local voluntary or social care organisations. CRHTs provide a gate-keeping function to some Crisis House facilities. In some areas this provision may also be used to support people making the transition from hospital to home. A Crisis House event, scoping out the possibility of a Crisis House in Leicester, Leicestershire and Rutland was held in June 2013.

- In-patient services provide care in a safe setting for patients in the most acute stage of illness when admission will help in a person's progress to recovery. There are at least four types of in-patient service, acute in-patient wards, psychiatric intensive care units (PICUs), rehabilitation units and specialist beds.
- Acute day services provide an alternative to admission for people who are acutely unwell and are a means of facilitating early discharge and preventing readmission.
- Place of safety provision often comprises a suite of rooms for the emergency psychiatric assessment of those detained by the police under S136 of the Mental Health Act. Police custody is sometimes used as a place of safety but guidance makes it clear that this should be on an exceptional basis only and that it is preferable for the person to be detained in a healthcare setting.

In Leicester commissioning acute services is an important function of Leicester City CCG, which focuses on,

- The most urgent mental health care or crisis care needs, where there is a risk to oneself or others
- Individuals at high risk of self-harm or suicide requiring intensive support and a safe environment
- Inpatient care in the most urgent, high risk circumstances of mental health care need.
- Upholding legal rights of patients who are detained under the Mental Health Act 1983 or who lack capacity to make informed decisions on treatment (Mental Capacity Act 2005)
- Delivering care to patients in the least restrictive way and environment- ideally within the patient's own home (CRHT)

Crisis Resolution Home Treatment Team

When issues of risk, or intensity of care, move beyond the resources of the Community Mental Health Teams, patients can be referred to the Crisis Resolution Home Treatment (CRHT). CRHT teams act as gatekeepers to care in either the hospital or at home. The CRHT forms part of Access Services which should provide a rapid response to people deemed to be in mental health crisis in the community, who are typically referred by local GP's and other community based mental health services. In the past effective CRHT teams have allowed the reduction of in-patient care. The service aims to work closely with in-patient clinicians and bed managers to support the timely, appropriate, discharge of patients back in to the community and organise consequent packages of care.

LPT Adult Mental Health Division has reviewed the overall planning and management of patients moving through the Acute Care Pathway, from admission, in-patient treatment and post discharge return to community based mental health services. These services have recently faced challenges including high bed occupancy rates, lack of bed capacity, the use of out of area beds, high lengths of stay and delayed discharge. The Adult Mental Health Division has implemented redesign of the CRHT single point of access service to ensure that a systematic response is in place to address such pressures.

LPT data shows that CRHT have to a limited degree been able to impact positively on admissions in to acute care. However, the flexibility of CRHT teams in improving care is stymied by the paucity of alternatives in the community to acute admission, such as a crisis house, the METT Centre, Day Care and step-down residential and nursing rehabilitation placements. Leicester City has a higher rate of access to the CRHT than the national average.

Acute Admissions

In-patient services provide care in a safe setting for patients in the most acute stage of illness, when admission will help a person's recovery. There are at least four types of in-patient service, acute inpatient wards, psychiatric intensive care units (PICUs), rehabilitation units and specialist beds. The current provision of beds at LPT is as follows:

- Brandon Mental Health Unit (Leicester General Hospital) 3 Wards of 24 beds (mixed sex)
- Bradgate Mental Health Unit (Glenfield General Hospital) 4 Wards ranging from 18 to 21 beds (1 ward single sex – female)¹⁴⁶

LPT has higher rates of hospital admissions for acute mental illness than both the national average and peer populations. However, there are different rates of admission for different conditions. Leicester shows a lower rate for unipolar depressive disorders, but a higher rate for schizophrenia, schizotypal and delusional disorders. In addition, Leicester has a higher than average proportion of people detained under the mental capacity act.

Leicester City CCG commissions in-patient bed provision to meet local needs. In 2012 43 NHS Trusts contributed to an NHS benchmarking exercise concerning inpatient care and bed occupancy. This showed that there were 148 adult acute beds provided by LPT, which was higher than the national average (n=139). The range of adult acute beds per 100,000 people varied across the 43 trusts, from 15 beds per 100,000 to 53 beds per 100,000 with a mean of 23 beds per 100,000. The rate for LPT was found to be the same as the mean national rate. There are fewer Psychiatric Intensive Care Unit beds in Leicester (10) compared to the national average (15). Analysis of the bed occupancy data for adult acute beds showed a mean occupancy rate of 91% across the 43 providers. LPT's occupancy rate was reported as 96%.

The number of adult acute admissions showed a range of 150 to 550 per 100,000, with a mean of 234 admissions per 100,000. LPT was above the national average with 260 per 100,000. The number of occupied bed days also showed a wide range, from 5,000 to 16,000 per 100,000. This is affected by the number of beds provided and the average length of stay of patients and is related to provision of community services. LPT was on the mean position of 8,125 occupied bed days per 100,000.

Length of stay and delayed transfers, are key performance measures for mental health providers. Length of stay is influenced by a number of variables including the acuity of the caseload, extent of delayed transfers of care and ability to hand patients over to community based services. The mean length of stay was 32 days for the 43 providers, lower than the mean length of stay for LPT, which was 38 days. Delayed transfers these are presented as a proportion of the total bed days lost due to delays. The causes of delayed discharge include waiting for an alternative placement or the implementation of packages of care. The rate for LPT was the same as the national average, 3.5%.

The pressure on acute services is great. This can be seen, for instance in 2013-14 20 patients, at a cost of £4 million, required out of area in-patient treatment because of a lack of bed capacity at LPT. The Care Quality Commission inspection of the Bradgate Mental Health Unit in September 2013 found that improvements were required in providing care treatment and support to meet people's needs, caring for people safely, staffing and quality and suitability of management¹⁴⁷.

Place of Safety and Triage Car

The place of safety is the Section 136 (S136) suite at the Bradgate Mental Health Unit. This suite of rooms is for emergency psychiatric assessment, by an Approved Mental Health Practitioner, of

people detained by police under S136 of the Mental Health Act. This applies when the police believe that someone is suffering from a mental illness requiring immediate care. The individual should be medically fit on examination, and not physically unwell, injured or intoxicated. S136 is utilised on an exceptional basis, although when appropriate it is preferable for the person to be detained in a hospital or other healthcare setting than in the criminal justice system.

Since January 2013 LPT, in partnership with Leicestershire Police, has been running a Nurse Triage Car pilot service, as 1 of 10 national pilot sites. This allows police officers and mental health nurses to travel together in response to incidents in the community in which someone may require immediate mental health support. Leicester, Leicestershire and Rutland part of 10 national pilot sites.

The aim of the Triage Car service is to identify and provide care and support which may reduce self-harm, harm to others and offending behaviour. Where appropriate, it may reduce the cases of individuals presenting in mental health crisis at the UHL emergency department, admissions to LPT and detentions under the Mental Health Act.

The advantage of this partnership seems to be effective assessment of situations in the community and reduction of the stress experienced by a person at a time of crisis¹⁴⁸. The police officer gives advice on policing solutions, and the mental health nurse gives advice on mental health care. Since the pilot started the Triage Car has seen a reduction of approximately 40% in the number of people detained under S136, and a saving to the partner organisations of £9,700 per month. Although there have been improvements to this part of the mental health pathway, more partnership work is required to ensure better integration and use of resources by key stakeholders, such as the police, the Police and Crime Commissioner and mental health and social care providers and commissioners.

Liaison psychiatry: Mental Health admissions at UHL Emergency Department

This needs assessment has shown the links between physical and mental health. There are high rates of poor mental health among people with long-term conditions, and psychological stress may manifest as physical, medically unexplained, symptoms (MUS). Often the mental health need of a patient in physical health care settings is undiagnosed and therefore untreated.

To optimise the physical health care of patients, it is essential that their mental health and wellbeing is addressed. To facilitate this it is important that liaison psychiatry services should be provided throughout the acute hospital, including in emergency departments. These services should be provided to meet the needs of patients with a mental disorder secondary to their physical disorder, a physical disorder alongside a mental disorder, and for patients where it is not possible to distinguish between conditions.

In Leicester acute liaison services operate within UHL. They support all age groups to increase the detection, recognition and early treatment of impaired mental wellbeing. In doing so it:

- Reduces excess morbidity and mortality associated with co-morbid mental and physical disorder
- Reduces excess lengths of stay in acute settings associated with co-morbid mental and physical disorder
- Reduces risk of harm to the individual and others in the acute hospital by adequate risk assessment and management
- Reduces time spent in the emergency department and general hospital beds, and minimises medical investigations and use of medical and surgical outpatient facilities
- Ensures that care is delivered in the least restrictive and disruptive manner possible.

Community Mental Health Teams

Community Mental Health Teams (CMHTs) are multi-disciplinary, health and social care, teams supporting people with mental health problems, their carers and primary care services. Team members design, implement and evaluate packages of care to enable people to remain at home in the community. CMHTs have statutory and mandatory duties to deliver care under the Mental Health Act and the NHS and Community Care Act.

There are 3 CMHTs providing care in Leicester from St Peters Health Centre (City Central), Merlyn Vaz Centre (City East), and Braunstone Health & Social Care Centre (City West). These teams are the main point of access to non-acute secondary care via referrals from GP's and Social Service Access teams. City CMHT's will also take referrals from other services within LPT.

Across LLR the potential population served by a CMHT ranges from 10,000 to 60,000 people, depending on levels of local morbidity and the distance travelled to access a service. City CMHTs often work across the county border to care for patients registered with Leicester GPs.

Tables 10 and 11 below show the referrals and contacts of CMHTs in Leicester in 2012/13. Table 10 shows that there were 29,996 patient contacts by CMHTs with Leicester City CCG patients. Table 11 indicates that CMHTs have had 2,675 total service user contacts for patients registered with Leicester GPs.

Table 10: Number of contacts made by different CMHT teams in 2012/13 to see Leicester City CCG patients

Team Name	Community	Outpatient	Telephone	Total
City East Adult Team	7,023	2,212	751	9,986
City West Adult Team	6,302	2,433	894	9,629
City Central Adult Team	6,094	2,304	826	9,224
South Leicestershire Adult Team	413	201	14	628
West Leicestershire Adult Team	113	57	15	185
East Leicestershire Adult Team	62	60	35	157
Charnwood Adult Team	88	45	15	148
North West Leicestershire Adult Team	26	10	3	39
Total	20,121	7,322	2,553	29,996

Assuming that these are individual contacts this means that, of the estimated prevalence of 3,400 people with a severe mental illness in Leicester, roughly 78% were seen in 2012/13. The remainder of patients with SMIs will have been cared for in acute in-patient services or supported within primary care. There is likely to be an unknown, very small number of such patients who are currently not in contact with any service. This is likely to include those who have not been diagnosed or others who may have disengaged from all mental health service provision.

Table 11: Number of referrals made to CMHT teams in 2012/13 to see Leicester City CCG patients

Team Name	Community	Outpatients	Total
City West Adult Team	355	842	1,197
City Central Adult Team	242	431	673
City East Adult Team	177	466	643
South Leicestershire Adult Team	18	26	44
West Leicestershire Adult Team	11	28	39
Charnwood Adult Team	15	13	28
East Leicestershire Adult Team	10	14	24
General Psychiatry	18		18
North West Leicestershire Adult Team	2	7	9
Total	848	1,827	2,675

Complex care services

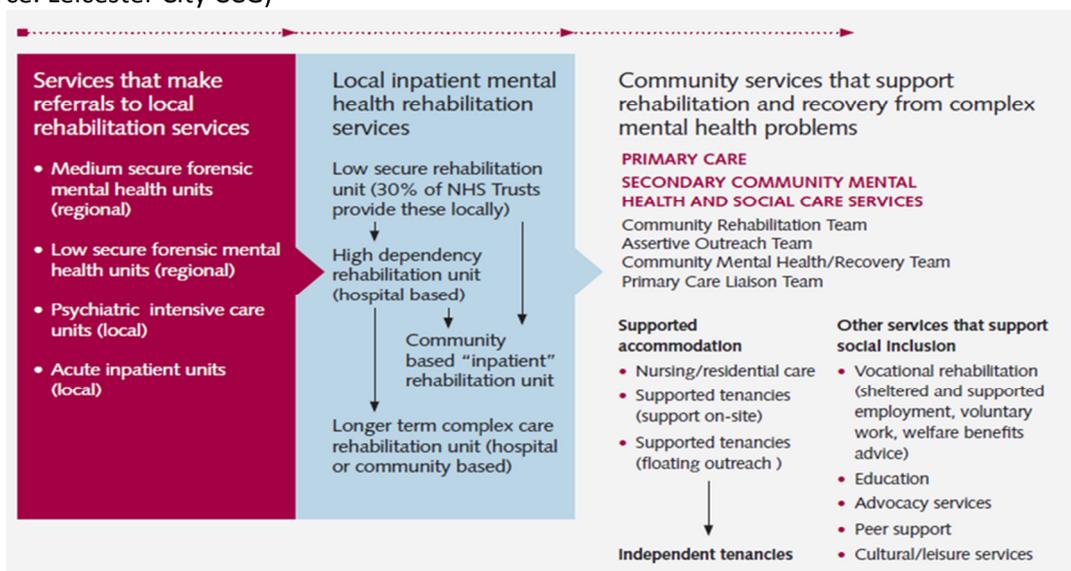
Figure 9, below, shows the range of services which are required to develop a Complex Care Pathway. Patients receiving complex care are among some of the most vulnerable and dependant of all patients in contact with mental health care services. Complex care is an important part of the NHS and local authority Joint Commissioning Strategy. An example of complex care is the appropriate development of a guided care pathway when a person moves from hospital or residential care to specialist supported housing or intensive supported living.

Although the total number of people in receipt of complex care is relatively small, the cost of care and treatment places a considerable demand on the commissioning budget. Nationally, complex care accounts for about 25% of total mental health expenditure. The commissioning imperative is to reduce number of Out of Area placements and to promote local care pathways in order to ensure patients are not displaced from their families or local services and to reduce high costs of such placements.

Local commissioning includes hospital based rehabilitation at:

- Mill Lodge (Unlocked) -18 patients with Diagnosis of Huntington’s disease, (physical and psychiatric care/challenging behaviour).
- Willows Unit (Unlocked) 30 bed unit for patients with severe and enduring mental illness with challenging behaviours
- Stewart House (Unlocked) 26 inpatient beds for patients with severe and enduring mental illness, all detained under the Mental Health Act, some under Ministry of Justice Restriction Orders, and some patients with long term care and risk management needs who are deemed very “slow stream” rehabilitation potential.

Figure 9: Commissioning a “Whole System” Rehabilitation Care Pathway- In Complex Care:
(Source: Leicester City CCG)



CCGs in LLR have about 70 rehabilitation beds provided by LPT. In practice the use of these beds is usually about 30 for those undergoing active rehabilitation, 30 for people in long term care and 10 for people with Huntington’s disease. LLR is relatively unusual in retaining this traditional profile of service, in contrast other health economies have a wider range of provision and rely less on traditional hospital care. Across LLR the pattern of use is gradually changing, with a focus on finding appropriate care and rehabilitation. Table 12 shows that in the year April 2012 to March 2013 there were on average 66 patients per month receiving complex care, a total of 795 cases. The average cost of these cases was £594,000 per month, a total cost of £7.1 million for the financial year.

Table 12: Number of and costs of LLR cases being treated in Complex Care 2012-13 (Source Leicester City CCG)

Number of Patients 2012/13																
Month	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	
Rehabilitation	34	33	33	32	30	28	27	27	30	27	30	28	28	27	26	
Long Term Care	26	26	27	26	24	28	29	30	29	27	22	27	27	27	28	
Huntingdon's Disease	11	11	11	10	9	8	9	9	10	9	9	10	11	10	10	
Total	70	71	70	67	63	64	65	66	69	64	61	65	66	65	64	
Cost £000's 2012/13																
Month	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	
Rehabilitation	228	231	221	224	213	188	189	185	210	191	187	196	187	190	177	
Long Term Care	289	301	299	298	277	309	334	332	340	315	231	309	301	312	309	
Huntingdon's Disease	96	106	94	87	79	70	83	80	89	84	75	96	97	92	90	
Total	613	638	614	609	568	567	606	596	638	590	493	600	586	594	575	

Huntington’s disease

Huntington's disease is an inherited deteriorating neurological condition. It can affect movement, cognition (perception, awareness, thinking, judgment) and behaviour. Early symptoms may include personality changes, mood swings and unusual behaviour. The symptoms of Huntington's disease

can include psychiatric problems and difficulties with behaviour, feeding, communication and movement. These are often overlooked and attributed to something else. People with a family history of Huntington's can inherit the disease. Symptoms usually appear between 35 and 55 years, although between 5% and 10% of all cases are developed before a person reaches 20 years.

It was previously thought that 4-6 people in a population of 100,000 were affected by Huntington's disease. However, UK research carried out in 2012 has found the actual figure for those affected by the condition to be about 12 people per 100,000.¹⁴⁹ This means that it could affect about 40 people in Leicester. It is thought the number of people who have the Huntington's gene and are not yet affected is twice that of those who have symptoms.

Symptoms vary between people and there is no typical pattern. Some people with Huntington's disease may refuse to accept the seriousness of their illness; others may have depression as part of the disease, not just as a response to the diagnosis. The symptoms can include low mood, tearfulness and feelings of hopelessness. Some people may also develop problems such as obsessive behaviours and sometimes schizophrenia. Studies have shown that people with Huntington's disease are more likely to consider taking their own lives than the population generally. A time of particular risk is the period of diagnosis when symptoms are already apparent, and when the person starts to lose their independence.

Behavioural changes are often the first symptoms to appear in Huntington's disease and can be the most distressing. These symptoms often include a lack of emotions and not recognising the needs of others in the family, alternating periods of aggression, excitement, depression, apathy, antisocial behaviour and anger and short term memory lapses. A person with Huntington's may display a lack of drive, initiative and concentration; they may also develop a lack of interest in hygiene and self-care¹⁵⁰.

Huntington's disease affects movement. Early symptoms include slight, uncontrollable movements of the face, and jerking, flicking or fidgety movements of the limbs and body. These move from one area of the body to another and can cause the person to lurch and stumble. As the disease progresses, the uncontrollable movements are more frequent and extreme. This may change over time so that movements become slow and muscles more rigid.

People with Huntington's disease tend to lose weight despite having a good appetite. They can find eating tiring, frustrating and messy because the mouth and diaphragm muscles do not work properly, due to the loss of control; for instance, loss of co-ordination can lead to spilling or dropping food. Swallowing can also be difficult for people with Huntington's disease, so choking on food and drink, particularly thin drinks such as water, can be a common problem.^{151 152}

In the later stages of Huntington's disease, the person will be totally dependent and need full nursing care. Death is usually from a secondary cause, such as heart failure, pneumonia, or other types of infection.

With regard to the complex care service linked to Huntington's disease, LPT has given notice on the 4 nursing care beds on the basis of clinical and financial viability. Commissioners are working with the service users, carers and LPT to find alternative placements for these patients in care homes. Additional patients requiring care will emerge periodically; where there are continuing care needs these will be addressed by GEM CHC service.

A revised specification has been agreed as part of the regional procurement, this will ensure appropriate treatment is available at a cost subjected to market testing. Essentially the model is

that length of stay will be a maximum of 2 years, followed by a move to greater independence in either a residential care setting or more independence with domiciliary and out- reach support. Through examination of local need, the national evidence and benchmarking it is assumed LLR needs approximately 25 to 30 beds for the foreseeable future.

There are about 26 people in the current service who do not need and are unlikely to benefit from further rehabilitation, but retain significant dependencies. This group is likely to increase by an additional 2 to 3 people a year. There are currently 8 people waiting for agreement between CCGs and LAs on the funding of care packages. On an individual basis more appropriate accommodation and care packages are gradually being found for this group of people. As individual needs are better understood it is apparent significant needs are a social care responsibility, representing significant pressure on LA budgets and potential saving to CCGs.

Domiciliary and day care services in the community

In addition to the Community Mental Health Teams (CMHT) other specialist community services are commissioned to support people with complex mental health needs beyond the scope of primary care. These include Assertive outreach teams (AOT), Crisis response and home treatment teams (CRHT) and Rehabilitation services, the Recovery College and METT Centre day service.

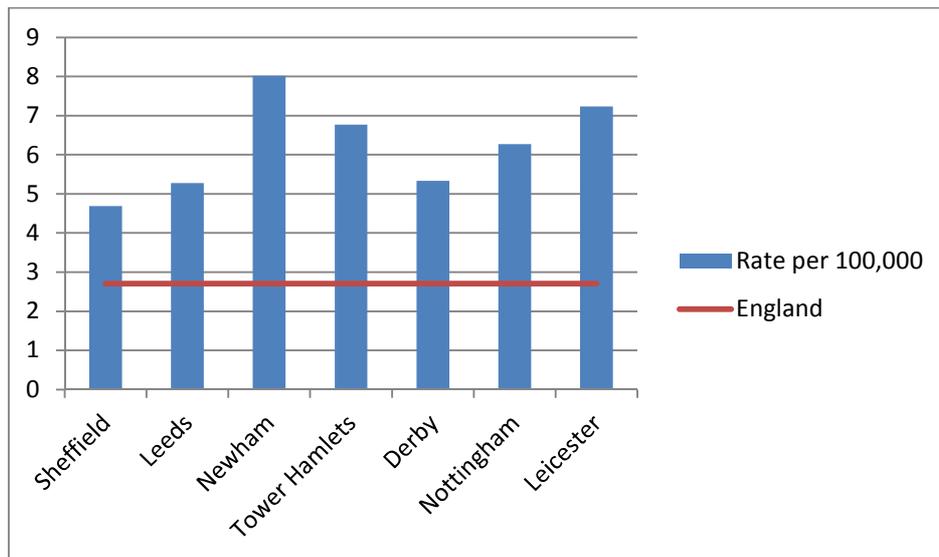
The METT Centre is a day service within LPT for adults with severe and enduring mental health problems, who would find it difficult to access mainstream groups or resources. It offers a wide range of groups, including: art, cooking, photography, IT, relaxation, cinema, beauty and an open social group daily. These services are provided in an environment which is safe for socialising and can also offer 1:1 work with clients if required. A review of the METT Centre day service is being undertaken to ensure there are appropriate alternatives to acute admission and the ability to support recovery of people with longer term needs.

Assertive outreach teams were established under the National Service Framework for Mental health to provide mental health and social care to patients with challenging, complex mental health problems who do not engage with CMHTs. Generally they have high rates of service user satisfaction and evidence suggests that they are effective in reducing hospital admissions, clinical and social outcomes¹⁵³. According to data from Leicester City CCG, the Assertive Outreach team for Leicester has consistently treated more cases a month than the target number of cases. Figure 20 shows that Leicester (7.23 per 100,000) the use of Assertive Outreach is above the England average (2.71 per 100,000), and is the second highest of the peer populations.

Table 13: Number of cases being treated by Assertive Outreach Team in Leicester 2012-13 (Source Leicester City CCG)

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Actual	176	179	176	181	180	181	179	182	183	181	182	183
Target	163	163	163	163	163	163	163	163	163	163	163	163

Figure 10: Rate of activity of Leicester Assertive Outreach Team benchmarked against national and peer population activity per 100,000 (Source: Leicester City CCG)



LPT has initiated a recovery college programme, funded mainly from within the Trust. Recovery Colleges aim to empower people with mental health problems to be experts in their own recovery, to live well and make the most of their skills. Anthony¹⁵⁴ identifies recovery as a “unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness.” Although recovery is different for each individual, it entails core concepts, such as self-direction, empowerment, peer support, education and hope.¹⁵⁵

The ethos of a Recovery College model lends itself to the self-care, expert patient and peer educator approach adopted in the management of long term conditions. Supporting self-management is a NICE quality standard for adult mental health services. Furthermore, self-management and independence are consistent with mental health promotion, improved self-esteem, social inclusion and access to education.

A search on Google suggests that there are 3 Recovery Colleges in the UK; South West London,¹⁵⁶ Nottingham,¹⁵⁷ and Central and North West London.¹⁵⁸ The first 2 colleges appear to have generated some evidence of the effectiveness of their treatments.

A pilot study prior to the development of the South West London Recovery College showed that:

- 68% of students felt more hopeful for the future than they had at the start of their course
- 81% of students had developed their own plan for managing their problems and staying well
- 70% had become mainstream students, gained employment or become a volunteer
- Students who attended more than 70% of their scheduled sessions (67% of those who started) showed a significant reduction in use of community mental health services

Qualitative data suggests that Recovery Colleges are popular among the people who use them:

- “I wouldn’t be here if it wasn’t for the College.”
- “What a positive and helpful approach. This type of course should have started years ago.”
- “Extremely informative... it has given me further insight into myself and my thinking.”
- “I can study in a safe place so I don’t have to worry if it goes pear-shaped if I get unwell.”¹⁵⁹

The recovery model of care is congruent with the current direction of national health and social care policy. It is one of the 6 key areas in the cross government mental health strategy *No Health without Mental Health*, and in February 2013¹⁶⁰ the Care Services Minister, Norman Lamb, launched the next phase of the Implementing Recovery through Organisation Change (IMROC) project, designed to help local services focus more on recovery.

However, there are ongoing debates about the recovery approach, with some clinicians suggesting that it is unrealistic to promote the hope of recovery for everyone, especially for those with serious mental illness¹⁶¹.

The NHS Confederation Mental Health Network suggests that there are 8 features of a Recovery College¹⁶², which are consistent with the quality framework for mental health promotion¹⁶³, including promoting access to education, promoting self-esteem and life and coping skills.

- Co-production between people with personal and professional experience of mental health problems
- A physical base with classrooms and a library where people can do their own research; this includes 'hub and spoke models'
- Operation on college principles, rather than a day centre model; students select courses from a prospectus
- For everyone, from people with mental health problems, their families, carers, staff from mental health service providers and people from partner agencies.
- A Personal Tutor (or equivalent) offers information, advice and guidance, to help students select suitable courses and develop individual learning plans based on their hopes and aspirations
- It complements rather than substitutes traditional assessment and treatment
- It can offer a route to mainstream education
- All aspects of the college reflect recovery principles; including the physical environment, culture and the language used.

The Leicestershire Recovery College, led by LPT in partnership with several other local organisations, is currently piloting 27 courses.¹⁶⁴ It is based at the Glenfield Hospital site in Leicester. The philosophy and culture of the Leicestershire Recovery College is based on recovery principles of hope, control and opportunity. There is no cost involved in enrolling on the courses. Achievements and success will be regularly celebrated.

The courses cover a range of recovery focused topics for people with lived mental health experience, their friends, families and Leicestershire Partnership NHS Trust staff. These courses are co-produced and co-delivered in partnership with LPT staff, local groups, organisations and people with lived experience of mental illness. The courses are designed to contribute to wellbeing and recovery, supporting adults to recognise their own resourcefulness and talents in order to become experts in their own self-care and make informed choices and achieve the things they want to in life.

Courses are available on a range of topics in areas such as:

- Understanding/Experience of Mental Health Conditions
- Building your Life
- Developing Skills and Knowledge
- Physical Health and Wellbeing
- Getting Involved

LPT provide a link to the current Prospectus:

<http://www.leicspart.nhs.uk/Library/ProspectusJune2013Final.pdf>

Service user feedback

SUCRAN¹⁶⁵ conducted a qualitative study of mental health service users and their carers in Leicester. The views of **60** people were obtained to ascertain the features of services which protect their mental health, prevent admission to hospital and ensure positive health outcomes when secondary care is needed. In addition, the views of **407** mental health service users, across Leicester, Leicestershire and Rutland were captured through one to one interviews¹⁶⁶. The findings covered a range of issues, as follows:

Housing: The importance of a stable home environment with a mix of personal and shared space was said to be a cornerstone of recovery and good mental health. Supported housing is seen as a positive long term solution for both service users and the people who care for them, providing a safe place to nurture the survival skills necessary to become a more independent and productive member of the community and thus reducing the likely-hood of intervention by statutory services. When service reconfigurations threaten the possibility of someone’s “home” ceasing to exist, this creates anxiety, insecurity and undermines good mental health

<p>“Living in shared housing benefits us, and there are less admissions to hospitals. Living in a smaller shared house gives support workers time to see each one of us.”</p>	<p>Service user</p>
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Referral and Information: Help to find out about services appears inconsistent and over half of participants¹⁶⁷, felt they should have been referred to services earlier. Service user experience suggests that information about services is not easily available to those who initiate referrals into secondary mental health care. It is of particular concern that both the GP and the service users’ families may not be in a position to assist an informed understanding because of a paucity of available and appropriate documentation.

Medication: Whilst most participants were taking prescribed medication their knowledge and understanding of what they are taking was reported to be inconsistent as only 33% of respondents, feel they have a “good understanding” with over 50% stating they had not been told about side effects.

Communication: Miscommunication and rivalry between competing voluntary sector groups has resulted in confusion brought about by service tendering, and the view that when voluntary sector providers are actively competing for resources, then opportunities to share good practice will be usurped by commercial interests. Respondents gave some very negative perceptions about how they feel they were treated by staff and despite some improvements from the study these are of particular concern. However not all participants were negative and some disciplines and services were applauded for the quality of their efforts¹⁶⁸.

Ethnicity: The uptake of services and consequently respondents from a Black and Minority Ethnic background is concerning in that, the profile of respondents does not reflect the demography of the City population, although it does reflect the adult mental health population.

Employment: This on-going theme identifies that only 6% of participants were in full time paid employment and over half of participants perceived that they had lost their job as a direct result of their mental health condition.

Services: In this changing environment the emergence and growth of self-help is increasingly replacing provided services and considered to be both economically sound and empowering.

The work of the PIER Team (Psychosis Intervention and Early Recovery) was endorsed. Continuity and communication between services and agencies is very important. IAPT services are perceived as valuable¹⁶⁹.

“I wouldn’t be here without it. Everything was on top of me and I felt panicky, but therapy changed everything. Medication was an instant relief, but the therapy gave me the building blocks to help myself.” Service user

Activities: The notion that meaningful and worthwhile activity is a costly and complex process was challenged by participant views. Service users enjoyed apparently simple activities, such as talking, playing cards, bingo and games, music and poetry, art, yoga, concentration games, trips out, leisure cards, newspapers and using computers and walking groups.

A range of drop in facilities was promoted as not only working well, but providing the basis for social interaction, and for some, the only opportunity to meet with other people.

The isolation of living alone was highlighted by a number of participants and the benefits of just getting out of the house, meeting and mixing other people was highlighted consistently. Participants seek peer support and someone to talk in the absence of formal help. Implicit in these comments is a theme of loneliness and the importance of being able to socialise in an environment that is safe and comfortable

The importance of social contact facilitated by the voluntary sector in Leicester cannot be underestimated.

Human contact was valued and appears to have value in averting intervention from statutory services including hospital admissions, preventing isolation and promoting friendships that form the glue of a cohesive community.

Key issues, concerns and gaps in the current service provision

Loss of services: The impact of service redesign has not only resulted in the voluntary sectors inability to plan strategically for the medium term, but in anxiety and anger for the people who wish to use those services.

Participants identified their perception that Leicestershire Partnership Trust (LPT) seem to have had difficulties with implementing change, financial problems, shortages of nursing staff and an over reliance on agency staff who may not know service users.

There is a real concern about the premature discharge of individuals from hospital too quickly.

Participants suggested that there is not enough provision for advice on welfare benefits and housing related support

A largely unseen effect of service provision is the effect upon the role and responsibility of the carer. In the absence of a consistent statutory safety net, informal carers become the primary backstop when things go wrong.

Carers often have no choice, and often provide both emergency, out of hours assistance, and day to day support, which invariably impacts upon their own economic productivity, and potential stress.

In primary care there is concern with General Practitioners who are said to be difficult to access and sometimes unhelpful. It appears that it is family, the voluntary sector or non-mental health services that people turn to in these situations.

Primary and Secondary Care: A lack of consistency and understanding of mental health conditions in acute secondary care (University Hospitals of Leicester)

Access to GPs and the communication between GPs and psychiatrists were highlighted poor in some cases. Difficulty in obtaining a GP appointment was seen as “rationing by delay”,

Communication between services could be better to improve continuity e.g. between GPs and Psychiatrists, between inpatient wards and homeless services and between early intervention services and continuing care services.

Finance and benefits: The roll out towards personalisation and testing of ability to work often ignores mental health issues. People who may be entitled to a personal budget have not had the process or the safety measures and alternatives explained sufficiently which appears to be causing anxiety.

Service users and carers were consistently worried about Disability Living Allowance interviews, transport being reduced, funding cuts, reduction of services and general benefit change. It appears that this anxiety has been produced by a lack of accessible information and the attitudes of some people who work for the Department of Work and Pensions.

Gaps, Findings and Recommendations

Prevalence rates from national surveys show 16-18% of working age adults may experience a common mental health problem at any time. Applied to the 2011 Census population of Leicester aged 18-64 years, this equates to somewhere between 34,000 and 38,000 people. Half of adults with mental health problems have symptoms severe enough to require treatment. Common mental health problems are more frequent among females than males (19.7% and 12.5%). The estimated number of people in Leicester with serious and enduring mental illnesses, such as schizophrenia, bipolar affective disorder and other psychosis, is about 3,400 people.

In Leicester there are fewer cases of diagnosed depression than expected, higher rates of hospital admission for mental illness and worse than average outcomes. Commissioners should work to improve diagnosis of mental health problems, tackling issues such as stigma and according parity of esteem between mental and physical health.

Adult mental health services are organised according to a stepped care model. More than 90% of people with mental health problems are managed entirely in primary care. General Practice is also the main point of referral to other parts of the pathway, which includes the Improving Access to Psychological Therapies Service (IAPT), Mental Health Facilitators, and Community Mental Health Teams, Liaison Psychiatry and Access and Complex Care services.

Commissioners should focus on preventing mental illness from worsening and enabling earlier access to appropriate care. This means improving the capacity and capability of resources in primary care. There is an opportunity to do this using the proximity of Clinical Commissioning Groups to local problems to develop an integrated approach to mental illness, which includes statutory and voluntary sector organisations (Recommendation 5.4). They should work with service providers,

users and carers to develop the recovery model of care, for instance through the Recovery College (recommendation 5.3).

Some people with a mental health crisis are treated out of area. Commissioners should work with service users (Recommendation 5.1) providers from all sectors to improve crisis response to mental illness. This should include models of care such as the crisis house (Recommendation 5.2).

Commissioners are recommended to

- Facilitate increased support for the involvement of service users and carers in the planning, development and delivery of mental health services.
- Develop the crisis response, including a crisis house, to reduce the number of people with acute mental illness who are treated out of area.
- Improve commitment to the recovery model; for instance by better support of the Recovery College
- Improve the capacity and capability of primary care teams to manage mental health problems as early as possible
- Improve timely diagnosis of mental illness
- Ensure that services offer non-stigmatising support for people with mental illness
- Work towards delivering parity of esteem between mental and physical health.

Mental health of older people

Ageing and retirement both involve a change in lifestyle which can have an impact on mental health and wellbeing. For instance, retirement can affect wider determinants of well-being, such as social isolation, self-esteem and financial security. Older people are more affected by depression than any other age group. This is because older people are much more vulnerable to factors that lead to depression, such as living alone and having physical disability or illness. There are a number of rarer mental health problems that affect older people too, including delirium, anxiety and late-onset schizophrenia.

Although alcohol abuse is a problem for people of all ages, it is more likely to go unrecognised among older people. Reasons for alcohol abuse in older age include bereavement and other losses, loneliness, physical ill health, disability and pain, loss of independence, boredom and depression. Retirement may also provide more opportunities for drinking too much.

Prescribed medications often cause symptoms associated with mental illness in older people. Many older people take medication, and many are taking several at the same time. There are risks associated with taking multiple medications, including confusion.

People with dementia or severe mental illness may be unable to make and communicate decisions. Very few people are completely incapable of making any choices or decisions, but some older people may have partial or fluctuating mental capacity and may need help. People with dementia often need special support, they may take longer to make decisions, may need an advocate to speak on their behalf and their mental functioning may also vary by day, and time of day. Family members or carers are often useful sources of information but it is important to take account of the views of the person with dementia alongside those of their carer. Being a carer isn't always easy. Many find it demanding both physically and emotionally.

This chapter shows that older people suffer with a range of mental health problems. Poor mental health in the elderly is associated with increased mortality at age 65. A meta-analysis of 15 population based studies found that a diagnosis of depression in those over 65 was increased subsequent mortality by 70%.¹⁷⁰

Older People's mental health	<ul style="list-style-type: none"> • Depression is the most common mental disorder in later life, affecting around 15% of older people • Schizophrenia affects about 1% of the older population • Substance misuse is a problem for older people
Mental Health Profile of older people in Leicester	<ul style="list-style-type: none"> • More than 3,000 people aged over 65 years in Leicester will have depression • A further 1,500 will have severe depression
Service Provision for Leicester	<p>Social Services Care Primary Care Continuing Care Specialist old age psychiatry services</p>

Evidence from the literature

Older people suffer from the full range of mental health problems. Depression is the most common mental disorder in later life, affecting around 15% of older people.¹⁷¹ It is marked by a wide range of severity, with a major depressive episode characterised by low mood and diminished pleasure in most activities. It can be accompanied by, for example, poor appetite, insomnia, and withdrawal, feelings of worthlessness and loss of energy.¹⁷² Depression impairs an older person's social function more than a range of chronic physical conditions, such as heart and lung disease, arthritis, hypertension and diabetes.

Anxiety disorders are characterised by nervous anticipation, and may result in symptoms such as palpitations, tremor and chest tightness. Whilst the symptoms may result from wide open spaces, crowds and being away from home, the risk of anxiety also increases with social isolation and loneliness. As with depression, anxiety can be related to acute illness, it could also occur as the older person comes to terms with a fall, and the inability to undertake activities of daily living. Epidemiological studies suggest that there is a link between neuroses and depression.¹⁷³ Lindsey suggests also that there are psychosocial factors associated with neurotic disorders in the elderly, and indicates that generalised anxiety is associated with low household income. In the community the prevalence of anxiety disorders is linked to increased mortality and morbidity, such as cardiovascular, respiratory and gastro-intestinal illnesses.^{174 175}

Schizophrenia is a condition which results in delusions and hallucinations as well as apathy and a reduced level of social functioning. Most elderly people with schizophrenia will have developed the illness before the age of 45. It affects about 1% of the elderly population¹⁷⁶, which would equate to about 400 people over the age of 65 in Leicester.

Bipolar disorder is characterised by mood swings that are far beyond what most people experience in their lives. These include episodes of intense depression and despair, feelings of elation, the over activity of a manic episode, and the mix of a depressed mood with restlessness. Those who suffer with bipolar disorder usually experience both depressive and manic episodes, but some will have only manic episodes. According to Yassa et al,¹⁷⁷ bipolar disorder accounts for perhaps 5% of all psychiatric admissions of the elderly.

A JSpNA on Dementia is available on the JSNA website; however, dementia is clearly an issue which merits mention in a mental health needs assessment. Dementia can be sub-divided into specific diagnostic categories. It can be defined as a syndrome due to the disease of the brain, usually of a progressive and chronic nature, in which there is impairment of multiple higher cortical functions.

The sub-groups include diseases which can occur separately or together, such as Alzheimer's disease and Vascular Dementia. Dementia with Lewy bodies has also gathered recognition as a form of dementia which shares characteristics with both Alzheimer's and Parkinson's diseases. It may account for 10 to 15 per cent of all cases of dementia in older people. The most common causes are Alzheimer's disease and vascular dementia.

Alzheimer's disease is characterised by an insidious onset, an increasingly impaired memory which eventually results in a global disorder of cognition, orientation, linguistic ability and judgement. These factors cause behavioural disturbance, a reduced ability to undertake activities of daily living, and an increased risk to self and others. The clinical course of Alzheimer's is associated with growing disability and dependency on care.

Vascular Dementia is distinguished from Alzheimer's disease by its clinical characteristics and course. People who suffer with Vascular Dementia will have a history of transient ischaemic attacks, with brief impairment of consciousness; this is a dementia which follows a series of cerebrovascular attacks or a major stroke.

Delirium is often associated with dementia, although it is a distinct condition, commonly defined as a transient organic disorder. It is characterised by a global disorder of attention and cognition, and is a predictor of long term decline of a person's function and independence.^{178 179} Delirium can be caused by a range of physical problems, such as infections, cardiac failure and the rapid withdrawal of drugs or alcohol. Moreover a predisposition to delirium caused by old age is common, with factors such as physical frailty, constipation, visual impairment, deafness and malnutrition being important characteristics. Even environmental factors, for instance frequent moves within a strange environment, such as a hospital; the absence of a person's pair of glasses and the use of physical restraints, can trigger a reaction in an older person that may lead to delirium. The prevalence of delirium increases rapidly with age. In one community study 14% of those aged 85 and older were found to be suffering¹⁸⁰ with delirium.

Older people and substance misuse

Problems with alcohol have a high co-morbidity with mental illness. In a study of older people being discharged from psychiatric hospital, Blixen et al found that among those diagnosed with alcohol or drug abuse problems, 71% were depressed and 11% had dementia; 37% of those with major depression had a diagnosis of alcoholism. Similarly, those with both depression and alcohol dependence were more impaired than those with one or other problem. Waern found that alcoholism is associated with suicide.

As a problem for older people, alcoholism can be divided into early and late onset. Those who have been heavy drinkers for most of their lives account for approximately 70% of older alcoholics. A family history of alcoholism is more common in this group. For late onset older alcoholics, there are two distinct patterns. First, social drinkers may become increasingly vulnerable to alcohol even if their consumption does not change. Second, there is an increase in drinking which is associated with particular precipitants such as bereavement, social isolation, retirement and medical and psychiatric morbidity. In the elderly the ageing process itself can be a cause of alcoholism and the relationship between substance abuse and the stressful precipitating factors may be a reciprocal one.

Whilst alcohol use and abuse is often precipitated by ill health, it also results in morbidity. Studies show that individuals with a current or past alcohol disorder have higher mortality rates than those without. As a result of alcoholism, illnesses such as cirrhosis and other liver diseases, falls and fractures, malnutrition, anaemia and cardiac myopathy are common. However, it is a contentious issue as to whether alcohol misuse is a causal factor of dementia since specific post-mortem findings have not yet been identified.¹⁸¹ There is some evidence to show that alcohol does have a toxic effect on the brain, but according to Godfrey *et al*¹⁸² there is evidence also that alcohol induced damage may be reversed with abstinence.

There are also studies which point to a higher risk of disease such as cancers of the mouth, oesophagus, pharynx, lung and liver, breast cancer in women. Among older people, heavy alcohol use may increase risks of trauma, through falls because of adverse effects on gait and balance.¹⁸³¹⁸⁴¹⁸⁵ Moreover, withdrawal from intoxication may result in symptoms such as hand tremors, insomnia in sleeping, nausea or vomiting, irritability, anxiety, transient hallucinations, confusion and seizures.

Misuse of other substances among older people is uncommon, though the numbers may be underestimated.¹⁸⁶ The commonest group of drugs misused by the elderly, and associated with mental health issues, is the benzodiazepines, which are mainly prescribed for anxiety or insomnia. According to Vinkers *et al*¹⁸⁷ the use of benzodiazepines is common in individuals aged 85 years or older, despite the fact that they are indicated for a limited number of psychiatric disorders. Furthermore, the use of these drugs by the elderly has been related to poor outcomes such as hip fractures, motor vehicle crashes, and suicide.^{188 189 190}

Older People’s mental health in Leicester

The population aged 65 years and over is projected by POPPI (Projecting Older People Population Information System), to increase from 38,000 in 2012 to 43,400 by 2020. Rates for the prevalence¹⁹¹ of depression and severe depression are applied to these population figures in Tables 7 and 8. These show that there are currently an estimated 3,295 people aged 65 and over with depression in Leicester and that this is projected to increase to 3,715 by 2020.

Table 14: Estimated prevalence of depression in people aged 65 and over, in Leicester. Source: POPPI

	2012	2014	2016	2018	2020
People aged 65-69 predicted to have depression	913	980	1,052	1,075	1,097
People aged 70-74 predicted to have depression	706	720	734	832	888
People aged 75-79 predicted to have depression	644	644	628	617	629
People aged 80-84 predicted to have depression	536	527	527	546	546
People aged 85 and over predicted to have depression	497	502	518	534	555
Total population aged 65 and over predicted to have depression	3,295	3,372	3,458	3,604	3,715

Severe depression is somewhat less common, perhaps affecting 3% of older people, or about 1,050 people in Leicester. This is projected to rise to 1,177 people by 2020.

Table 15: Estimated prevalence of severe depression in people aged 65 and over, in Leicester. Source POPPI

	2012	2014	2016	2018	2020
People aged 65-69 predicted to have severe depression	273	293	315	320	328
People aged 70-74 predicted to have severe depression	136	139	142	160	174
People aged 75-79 predicted to have severe depression	263	263	259	252	256
People aged 80-84 predicted to have severe depression	168	168	168	171	174
People aged 85 and over predicted to have severe depression	215	222	226	238	246
Total population aged 65 and over predicted to have severe depression	1,054	1,085	1,111	1,141	1,177

NICE Guidance: Mental Wellbeing and older people

Mental wellbeing and older people (PH16) (2008) focuses on the role of occupational therapy and physical activity interventions in the promotion of mental wellbeing for older people.

This guidance is for all those involved in promoting older people's mental wellbeing. It focuses on practical support for everyday activities, based on occupational therapy principles and methods. This includes working with older people and their carers to agree what kind of support they need.

NICE recommendations for those involved in the care of older people include:

- Offering regular sessions that encourage older people to construct daily routines to help maintain or improve their mental wellbeing. These sessions should also increase their knowledge of a range of issues, from nutrition, how to stay active and personal care.
- Offering tailored, community-based physical activity programmes. These should include moderate-intensity activities (such as swimming, walking, dancing), strength and resistance training, and toning and stretching exercises.
- Advising older people and their carers how to exercise safely for 30 minutes a day on 5 or more days a week, using examples of everyday activities such as shopping, housework and gardening
- Promoting regular participation in local walking schemes as a way of improving mental wellbeing. Help and support older people to participate fully in these schemes, taking into account their health, mobility and personal preferences.
- Involving occupational therapists in the design of training offered to practitioners.

According to Living well in later life the care of people over the age of 65 in 2003/2004 accounted for more than 40% of the NHS and social services budgets, or £16 billion and £7 billion respectively. The management of the needs of older people with mental health problems depends upon the complex partnership of conventional health and social care services and the voluntary sector. In addition, it has depends upon a host of informal care networks which help to support older people in meeting their activities of daily living.

Overview of health and social care services available

Self-care, informal and semi-formal care: Informal caring is an important element of the care of older people, for evidence suggests that most of the elderly wish to remain in their own homes, and would rather have their homes adapted than move out. In April 2001 there were 5.2 million people providing unpaid care in England and Wales. Of the carers who were younger than 65, the majority were female; however those carers aged 65 and above were more likely to be men. In Leicester there are 5,800 people over the age of 60 who are carers, 3,000 of whom are women.

A JSNA on Carers in Leicester is on the Leicester City Council JSNA website. This shows that carers have worse mental health than the population generally. Carers' consultations show that the carers want to be better recognised for their role, receive better information and flexible support, including breaks from caring. Health promotion, accommodation needs and transport also feature in their needs.

Local Authority Social Services Care: The function of the local authority with respect to the care of the elderly with mental ill health needs is to carry out an initial social care assessment. This will include an assessment of the care giver's needs, a social care plan, and the appointment of a care manager. Care offered may involve carer support and practical assistance with caring tasks, including home help, meals on wheels, day and respite care, funding for residential or nursing home care depending on needs and financial entitlement.

Primary Care: Early recognition, assessment and treatment of coexisting illness, rationalising prescribed medication, specialist referral, monitoring, arranging support services, medical supervision in long stay institutional settings, terminal care and bereavement counselling.

A typical general practice of list size 10,000 will include approximately 1,500 people aged 65 and over. These are likely to include around 75 with dementia, 225 with depression (including 30 with severe depression), 30 with psychoses and 30 others with various less common though significant conditions.

Continuing Care: Continuing Care packages are arranged and funded by the NHS. The criteria for eligibility for a Continuing Care are set locally, in the context of national guidance. Such packages are usually for people with long-term complex health needs, often towards the end of their lives. Within an old age psychiatric service those needing this care are likely to have a diagnosis of dementia, behavioural difficulties or to have a long-term functional illness. To qualify for Continuing Care the nature, complexity, intensity, unpredictability or deterioration of the condition is assessed as requiring constant or regular attention and supervision by multidisciplinary team members, often based on the requirement for specialised nursing support.

Intermediate Care: Intermediate care offers an alternative to inpatient hospitalisation, for patients whose care lies beyond the scope of the traditional primary care team. The development of intermediate care offers the opportunity to explore a range of options for flexible community assessment, treatment and support of older people with mental ill health.

Old age psychiatry services: There is a specialist psychiatric service offering investigation and diagnosis, symptomatic treatment including management of behaviour problems, treatment of coexisting psychiatric illness, specialist day care and carer support/education.

Gaps, Findings and Recommendations

As people live longer so protecting the mental health and wellbeing of older people will become more of a problem. Depression is the most common mental disorder in later life, affecting 3,000-4,500 older people on Leicester. Schizophrenia affects about 1% of the older population, about 400 people aged over 65 years in Leicester. Dementia, delirium and substance misuse are also linked with poor mental health in older people. Mental illness in old age is affected by deprivation, bereavement, isolation and physical illness. There is a need to meet the combination of mental and physical health problems where they co-exist in older people.

In Leicester there is a need to ensure that mental health services for older people are commissioned on the basis of need (Recommendation 6.1) rather than focusing specifically on age or disease. Although there is an integrated approach between health, social care and voluntary and community sector services to ensure co-ordination between secondary and primary care and community services, this needs to be improved to ensure that the mental health needs of older people are addressed as early and effectively as possible, including access to crisis services, psychiatric liaison in the Emergency Department and routes for safe discharge into the community.

Commissioners should consider the following with regard to improving mental health services for older people

- Mental health services are commissioned on the basis of need; the needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people.
- There is an integrated approach between health, social care and voluntary and community sector services to ensure co-ordination between secondary and primary care and community services
- Meet the combination of mental and physical health problems which often co-exist in older people
- There is a multi-disciplinary approach to older people's mental health, including integrated

input from nurses, psychologists, physiotherapists, occupational therapists and speech and language therapists is necessary.

- Older people have access to crisis services. With extended hours of working and intensive crisis management, home treatment workers help to reduce the need for admission, facilitate early discharge and reduce transfer to residential care

Equalities and mental health

Commissioners should tackle inequality by ensuring that people from disadvantaged and minority communities receive the levels of service provision to maintain and improve their mental health and wellbeing. The Equality Act 2010 pulled together existing equalities legislation covering disability, gender, race, religion/belief and sexual orientation. It introduced an age equality duty on the public sector and a duty to consider reducing socio-economic inequalities. This chapter is an initial attempt to cover some of the key areas of equalities and mental health in Leicester.

A core requirement of the equalities agenda is to give due regard to eliminate discrimination and promote equality. Commissioners have to consider the likely impact of proposed policies and service developments on people with protected characteristics. To avoid perpetuating inequality it is important for mental health and social care commissioners to ensure their decisions do not impact disproportionately on any one group, and that they protect the interests of minority and social excluded groups and individuals.

Black and Minority Ethnic (BME) Groups

Leicester has a diverse population compared with England as a whole; 50% of Leicester's residents are from BME backgrounds compared with only 13% in England overall. Around a quarter of Leicester's population are of South Asian origin, (mostly Indian), 4% are Black/British, 3% mixed and 3% from other ethnic origins (see below, table 16) The age profile of Leicester's BME population is relatively younger than the White population.

Table 16: Population estimates by ethnic group 2009

Ethnic Group	Leicester		England
	Number	%	%
White: British	183,000	60.1	82.8
White: Irish	3,200	1.1	1.1
White: Other White	9,100	3.0	3.6
Mixed: White and Black Caribbean	3,100	1.0	0.6
Mixed: White and Black African	900	0.3	0.2
Mixed: White and Asian	2,900	1.0	0.6
Mixed: Other Mixed	1,900	0.6	0.5
Asian or Asian British: Indian	56,900	18.7	2.7
Asian or Asian British: Pakistani	14,000	4.6	1.9
Asian or Asian British: Bangladeshi	2,800	0.9	0.7
Asian or Asian British: Other Asian	5,800	1.9	0.7
Black or Black British: Black Caribbean	4,800	1.6	1.2
Black or Black British: Black African	5,800	1.9	1.5
Black or Black British: Other Black	1,000	0.3	0.2
Chinese or Other Ethnic Group: Chinese	6,500	2.1	0.8
Chinese or Other Ethnic Group: Other	3,000	1.0	0.8
All Groups	304,700	100.0	100.0

Compared to the general population some BME groups carry a higher burden of poor health, premature death and reduced access to services. There are variations in the underlying morbidity, diagnosis, and management in mental health of people from BME communities. Specifically, people

from BME backgrounds are dissatisfied with the mental health services they receive, they are over-represented in compulsory detention under the 1983 Mental Health Act, are overrepresented in incidents of violence, restraint and seclusion in psychiatric inpatient settings, and are under-represented in counselling and psychotherapy, and in involvement in planning and delivering mental health services. So, appropriate provision of mental health services is vital requirement for commissioners.

There is evidence of inequality in the mental health of BME communities, especially in the incidence of severe mental illness. The Aetiology and Ethnicity in Schizophrenia and Other Psychoses¹⁹² (AESOP) study showed that compared with the White British population people from African-Caribbean communities are 9 times more likely to experience schizophrenia and 8 times more likely to experience manic psychosis; people from Black African communities are 6 times more likely to experience either condition. Other BME groups have more modestly increased rates.

The AESOP findings apply across the adult age range and for both women and men. The rates of psychosis in Africa and the Caribbean are comparable to those in the UK overall. This suggests recognised risk factors for mental illness, including poor housing, unemployment, social exclusion and the experience of racism itself, are burdens borne disproportionately in the UK by BME populations and are significantly increasing the incidence of mental ill health.

The Sainsbury Centre Breaking the Circles of Fear¹⁹³ report suggested that early intervention services can find it difficult to reach young African-Caribbean men. When the Mental Health Act Commission interviewed inpatients in 2006, people from BME groups reported discrepancies in their experience. For example, more Black patients said they did not regularly see the same psychiatrist, and that they felt that staff members were not always open and honest with them.

Distinct cultural differences in how mental health and well-being are thought about affect access to, and experience of, statutory services. The issues vary widely, both between and within BME groups by factors like age and gender. This means that there is no single 'BME mental health problem'. They may range from a person whose first language has no word to describe depression through to a person who has no trust of statutory services.

A summary of the ENRICH study suggests that:

- There were no differences in how long it took for people of different ethnicities to receive treatment after their first symptoms of psychosis started
- What people thought caused their illness did not affect how long it took for them to receive treatment
- Young people and those who lived alone were more likely to take longer to receive treatment
- Health care organisations need to work with community groups to improve the way in which black and minority ethnic groups first access mental healthcare when they experience psychosis
- Black patients were more likely to have first contact with mental health services in a crisis situation than white or Asian patients
- Asian patients and carers were the most likely to think that there were faith-based or supernatural explanations for their symptoms, and to first seek help from faith organisations
- Faith-based help-seeking, although offering comfort and meaning, risked delaying access to mental healthcare
- The greater risk of BME groups being detained under the Mental Health Act was not because of their ethnicity itself. People were more likely to be detained if they: had been diagnosed

with a mental illness, were judged to be a risk to themselves or others, or had little social support

- The focus groups felt that the existing early intervention services for people experiencing their first episode of psychosis were accessible, supportive, acceptable and culturally appropriate for BME groups
- The focus groups did not report a strong demand or perceived need for separate early intervention services for BME groups or for a person's doctors to be from the same ethnic group as them.

With regard to schizophrenia and psychoses, the AESOP study indicated that, compared with the White British population:

- People from African-Caribbean communities are 9 times more likely to experience schizophrenia and eight times more likely to experience manic psychosis
- People from Black African communities are 6 times more likely to experience either condition
- Other BME groups have more modestly increased rates¹⁹⁴

The AESOP findings apply across the adult age range and for both women and men. However, the rates of psychosis in Africa and the Caribbean are comparable to those in the UK overall. This suggests recognised risk factors for mental illness – including poor housing, unemployment, social exclusion and the experience of racism itself – are still burdens borne disproportionately in the UK by BME populations and are significantly increasing the incidence of mental ill health.

Distinct cultural differences in how mental health and well-being are thought about affect access to, and experience of, statutory services. The issues vary widely, both between and within BME groups by factors like age and gender. This means that there is no single 'BME problem'. They may range from a person whose first language has no word to describe depression through to a person who has no trust of statutory services.

Evidence from a literature search on schizophrenia in minority ethnic communities showed factors which may be summarised under a number of headings:

Genetic relatedness

The greatest risk factor for schizophrenia is genetic relatedness. Lifetime risk increases by 2% in third-degree relatives (first cousins); 2% (uncle/aunt) to 6% (half-siblings) in second-degree relatives; and 6% (parents) to 9% (siblings) to 13% (children) in first-degree relatives of affected individuals; there are higher risks among twins. Parents of people with schizophrenia and psychosis have similar levels of risk of developing schizophrenia, regardless of ethnicity.¹⁹⁵

The lifetime risk of developing schizophrenia in siblings of second generation (UK-born) African-Caribbeans is 17%, in first-generation African-Caribbeans it is 9%, and in white British patients it is just 2%.¹⁹⁶ If genetic predisposition is a substantial factor contributing to high incidence rates of schizophrenia in UK black Caribbeans, then high rates in their country of origin would also be expected. Studies conducted in the 1990s suggest similar schizophrenia incidence rates to those found in the native UK population.^{197 198 199} These studies would suggest that high rates of schizophrenia among black Caribbeans are a feature of the emigrated rather than the native community.

Selective migration

Ødegård found that Norwegians migrating to the US were twice as likely to be admitted to hospital with first-onset schizophrenia as native-born Americans or Norwegians residing in Norway.²⁰⁰ Other studies have also showed high incidence of schizophrenia in migrants. A meta-analysis suggests a higher relative risk of 2.7 in first-generation migrants and 4.5 in second generation migrants.²⁰¹

Ødegård suggested that the raised schizophrenia rates in migrants occurred because those vulnerable to schizophrenia were predisposed to migrate. If this were the case, there would be diminishing rates of schizophrenia rates in post-migration generations, whereas the opposite appears to apply to UK black Caribbeans: studies report higher rates in second generation African-Caribbeans and other migrant groups.²⁰² This hypothesis fails to explain why groups such as Asian/Asian British population.

Misdiagnosis

At least 2 explanations may account for misdiagnosis of schizophrenia.

- Clinician bias, where a psychiatrist may misinterpret symptoms and thereby over diagnose schizophrenia in some ethnic groups
- Cultural relativity describes different ways that schizophrenia is exhibited in different ethnic and cultural groups.²⁰³

The diagnosis of schizophrenia has a subjective element. To quantify the possibility of clinician bias, a study compared the diagnostic patterns of British and Jamaican psychiatrists.²⁰⁴ The British psychiatrists classified 62% of black Caribbean patients as having schizophrenia, and the Jamaican psychiatrist recorded this diagnosis in 55% of these patients.

Cultural differences may also contribute to diagnostic error. Fernando argues that existing cross-cultural incidence studies are flawed by the category fallacy, in which western definitions of mental illness are applied to non-western cultures.²⁰⁵ Differences between cultures in the way hallucinations and religious experiences are regarded may contribute to excess diagnoses in ethnic minority groups,²⁰⁶ as many non-western cultural beliefs could be considered to overlap with features of schizophrenia.

Although contributions of clinician bias and cultural relativity to higher rates of schizophrenia in UK black Caribbeans in a routine service setting cannot be excluded, they cannot account for research findings based on standardised diagnostic criteria and diagnostic assessments carried out by ethnically matched or blinded interviewers.²⁰⁷

Health service factors

There are differences between the ways in which people from Black/Black British and White/White British ethnic backgrounds access mental health services. The former are 2.3 times more likely to experience compulsory admission,²⁰⁸ almost twice as likely to be referred through the criminal justice system and less likely to be referred by their GP.²⁰⁹ People from Black/Black British ethnic backgrounds also have more delayed untreated symptoms.²¹⁰

Cannabis use

Some evidence points to cannabis use as a possible factor in the development of schizophrenia, with a meta-analysis showing a twice the risk for the development of schizophrenia among cannabis users.²¹¹ The risk may be dose related.²¹² Pinto et al suggest that the link is controversial and that there is no clear evidence that cannabis is a factor in the high incidence of schizophrenia in people from Black/Black British ethnic backgrounds.

Psychosis among cannabis users did not appear to be more common in Black British patients compared to white British patients,²¹³ although a study of patients in London suggests that cannabis may play a role in high incidence rates of schizophrenia among second and subsequent generations of people from African-Caribbean backgrounds.²¹⁴

Social factors

There is an association between schizophrenia and unemployment, poverty and lower social class. This association appears to be more related to the social chances of people with schizophrenia rather than schizophrenia being caused by socioeconomic adversity.²¹⁵ Living in an urban area is linked to an increased risk of schizophrenia.²¹⁶ As most people from Black/Black British ethnic backgrounds are resident in urban areas, Pinto et al argue, this may account for some ethnic variation in the incidence of schizophrenia.²¹⁷

Measures of social capital (voter turnout) and social cohesion (ethnic fragmentation) have been linked to the incidence of schizophrenia, as have disorganised rather than the poorest neighbourhoods.²¹⁸

Levels of family and social support may also have an impact on the incidence of schizophrenia in Black/Black British people. The AESOP study found that parental separation and loss are associated with psychosis²¹⁹, and that parental separation, in particular paternal parental separation is more common in Black/Black British people than in their White British counterparts.

African-Caribbeans living in predominantly white neighbourhoods have been found to have a high incidence of schizophrenia. This has been called the ethnic density effect²²⁰ and may be another expression of social isolation, exclusion from social networks. People from Asian/Asian British ethnic backgrounds are comparatively less dispersed and less likely to be socially isolated²²¹, which may contribute to the relatively low rate of schizophrenia in this group.

Together Leicester, Leicestershire and Rutland were a Focus Implementer Site for Delivering Race Equality (DRE) in Mental Health Care. This initiative, driven by the National Institute for Mental Health in England, was aimed at achieving equality and tackling discrimination in mental health care. Many actions described in DRE had their roots in existing legislation and guidance such as the Race Relations (Amendment) Act 2000. DRE pulled them together and set them in a mental health context.

The DRE programme was based on three 'building blocks', more appropriate and responsive services, community engagement and better information. As part of this programme the DRE Group aimed to influence commissioning of services for people from BME ethnic backgrounds with mental health problems. This was done using evidence from the Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) and the Count Me in Census.

EMPIRIC found prevalence rates of common mental disorders of between 12% and 13% for men from Indian, Pakistani or Bangladeshi communities. This was not significantly different to the rates of mental illness in males from White/White British ethnic backgrounds. However, there were differences among females, with a higher proportion of mental illness in women from Indian and Pakistani backgrounds (23.8% and 26% respectively).

The Health Survey for England: the Health of Ethnic Minority Groups showed that rates of mental illness in Bangladeshi women were similar to those for other Asian women and higher than their White/White British counterparts. In this study, rates for mental illness in men of Bangladeshi backgrounds were also higher compared to men from other ethnic groups.

Rates of psychosis for Indian men (0.9%) were similar to those for men from White/White British ethnic backgrounds (1.0%); rates for Pakistani men were slightly higher, at 1.4%. Rates for Indian and Pakistani women were 1.3%, higher than the 0.7% found for women from White/White British ethnic backgrounds. Rates for both Bangladeshi men and women were 0.6%. None of these differences were found to be statistically significant. For the three Asian groups in the study, rates for 'migrants' were lower than for 'non-migrants' (people who were born in Britain or migrated here before the age of 11).

There were minor differences between the different ethnic groups on measures of social functioning, chronic strain and personality difficulties, with these correlating more to social class than to ethnicity. Participants from the Bangladeshi community reported slightly more difficulties with social functioning and chronic strain.

The participants in the study from Asian ethnic backgrounds, particularly those from Pakistani or Bangladeshi communities, were more likely to have poor physical health, and significantly less likely to have approached their GP about a stress-related or emotional problem in the previous six months, although Bangladeshi men and women were the most likely of all the groups to report having seen their GP in this time for a physical health problem. South Asian groups provided more informal care within their homes than the other ethnic groups.

Bangladeshi participants reported high levels of emotional and practical support from their close relationships, but also high levels of negative aspects. Those Bangladeshi participants who had higher scores on measures of common mental disorders also reported lower levels of social support.

The EMPIRIC study found prevalence rates of common mental disorders of 13.8% for males from Black/Black British ethnic backgrounds and 19.8% for their female counterparts. There were minor differences between the different ethnic groups on measures of social functioning, chronic strain and personality difficulties, with these correlating more to social class than to ethnicity.

In terms of psychosis, EMPIRIC found an estimated annual prevalence rate of 1.6% for Black/Black British men and 1.7% for Black/Black British women, compared to 1.0% for White men and 0.7% for White women. However, this difference was not found to be statistically significant.

Participants in the study who were from Black/Black British communities were less likely to be employed and less likely to be married or cohabiting, both of which were associated with higher rates of psychosis.

Participants from the Black/Black British ethnic backgrounds were more likely than their White/White British counterparts to have poor physical health. They were significantly less likely to have approached their GP about a stress-related or emotional problem, and despite having high

levels of contact with relatives and friends, also reported receiving less confiding, practical or emotional support.

The Count Me In census was a joint initiative between the Healthcare Commission, the Mental Health Act Commission and the National Institute for Mental Health in England aimed at promoting equality in health care. It was carried out annually between 2005 and 2009 as a way of generating a snapshot of all patients in mental health and learning disability facilities in England and Wales.

The period saw a decline in the total number of inpatients. Each census showed variations between the local and national picture. For instance, in 2008, 77% of inpatients were British and 23% were from black and minority ethnic backgrounds. Of these 10% were from Black or White/Black Mixed ethnic backgrounds and 3% were from South Asian ethnic backgrounds. In Leicester the proportions of inpatients were different; 80% were White British, 9% South Asian, 5% Black or Black British. The Asian/Asian British (Indian) population recorded at LPT numbered 28 out of a national figure of 426. This means that of all Indian inpatients recorded nationally at the time of the Count Me In census 2008 6.6% (95% CI 4.6, 9.3) were inpatients in LPT hospitals or facilities.

There was a strong association with age for LPT inpatients. 62% of the White British population who were inpatients on 31st March 2008 were aged over 50 years, the reverse of the numbers of inpatients from BME census categories, where 60% of inpatients were aged below 50 years.

An accurate analysis of rates of admission for people resident in Leicester was hindered by the fact that Count Me In covered Leicester, Leicestershire and Rutland (LLR). However, an analysis of the rates of admission for LLR is possible based on this data, covering four different groups: White, South Asian, Black African/British and Other.

Table 17 shows that the inpatient bed occupancy rate for Black African/British groups was significantly higher than average, with this group forming 1.2% of the local LLR population according to the 2001 Census, and 5.8% (95% CI 2.7, 12.2) of the inpatient population in Leicestershire Partnership Trust institutions on March 31st 2008.

Table 17: Comparison of Census Groups of LPT inpatients 2008 Count Me In Census with 2001 Census Population for LLR

Census Group	Count Me In 2008 Observed Inpatients	% Inpatients Count Me In Census 2008	95% CI		% Population Leicester, Leicestershire and Rutland 2001 Census
			Lower	Upper	
White	330	82.9	74.3	89	85.5
Asian or Asian British	35	8.8	4.7	16	10.7
Black or Black British	23	5.8	2.7	12.2	1.2
Other	8	2.1	0.6	7.2	2.6
Not Stated	2	0.5	0.1	4.6	
Total	398	100.1			

With regard to inpatients at LPT who were detained under the Mental Health Act in 2008, 37.9% were from a minority ethnic group. This proportion of inpatients was not significantly higher than the national rate of detained patients from minority ethnic groups, which was 30%. Table 25 shows that 41.2% of inpatients from minority ethnic groups were recorded as being detained under the Mental Health Act provisions, compared to 24% of inpatients from a White British ethnic background. There is therefore a strong association between detention and being a member of a minority ethnic group (P = <0.001).

Table 18: Frequency and Proportion of Inpatients in LPT sites detained under the Mental Health Act, shown as proportions of White British and Other Ethnic Groups (Source: Count Me In Census 2008).

Ethnic Group	Informal observed	Informal % within Ethnic Group	Detained observed	Detained % within Ethnic Group	Total	Strength of association	OR	95% CI Lower	Upper
White British	241	75.8	77	24.2	318				
Other Ethnic Group	33	41.2	47	58.8	80	P=<0.001	4.45	2.6	7.64
Total	274		124		398				

In effect, in 2008 a person from a minority ethnic group in LLR was 4.45 times as likely to have been detained under the Mental Health Act (95% CI 1.39, 3.78) as someone from the White British ethnic category. As a proportion within different ethnic groups, detentions were high among inpatients from an Asian/Asian British and Black/Black British backgrounds. Of the Asian/Asian British inpatients 19 of the 35 had been detained, a proportion of 54.3% (95% CI 38.2, 69.5). Amongst the inpatients from Black/Black British backgrounds the figure was 17 out of 23, or 73.9% (95% CI 53.5, 87.5).

Recent data, specific to the services provided by LPT to city residents shows that there has been some progress in meeting mental health needs of people from BME communities, whilst some inequalities remain. For instance, 2012/13 data shows that there was an over representation of people from Black/Black British and White/White British ethnic backgrounds among those Leicester residents who were detained under provision of the Mental Health Act.

With regard to access to specialist cognitive behavioural therapy in 2013/14 there was an over representation of people from White/White British backgrounds, an under representation of people from Asian/Asian British ethnic and people from Black/Black British ethnic backgrounds. However, access to IAPT services showed In 2013/14 there was a slight under representation of people from Asian/Asian British ethnic backgrounds, but no difference for those from White/White British or Black/Black British ethnic backgrounds.

VCS organisations provide support and advocacy for people from BME communities. This kind of support covers issues such as supporting people to gain access to statutory and community based mental health services, support for carers, advice about rights and entitlements and provision of alternative therapies and services. They offer culturally appropriate support in different settings, offering activities which are educational, therapeutic, social and cultural.

WRAP is a service offered by LASS in Leicester. It was supported by the Delivering Race Equality agenda to engage people from BME communities in dealing with mental health. WRAP offers individuals or groups tools to help deal with their wellbeing, identifying triggers which lead to feeling unwell, making a plan and sharing experiences with other participants. Sharing experiences is key to learning from individual differences and responses to triggers, which is the type of support that is preferred over being judgemental when people express problems.

Mental Health of Asylum Seekers, Refugees and New Arrivals

Inward migration means that the Leicester population is becoming more diverse. This section reviews the mental health needs of new arrivals, focusing mainly on asylum seekers and refugees, and the services available to meet their needs.

New arrivals to Leicester comprise at least 3 different groups. The first group is people from Somali backgrounds that arrived from the Netherlands, Sweden and Denmark about a decade ago. Generally members of this group received asylum in Europe and became EU nationals. The second group are economic migrants, mainly from Eastern Europe, especially a large Polish community. Finally there are asylum seekers and refugees who first began to arrive in the 1990s. This group comprises people from the Balkans, Iraq, Iran, Afghanistan, Kurdish people from Turkey and people from sub-Saharan Africa, predominantly Zimbabwe.²²²

Some key Terms²²³

A number of terms can describe new arrivals; these terms may determine individual entitlement to welfare, health and social care provision.

An asylum seeker is a person who has fled persecution and is waiting for a decision following an application for asylum, with the UK authorities, under the 1951 United Nations (UN) Convention on Refugees. A refugee is someone who has been found by the authorities to be at risk of persecution and whose asylum claim has been accepted. A failed asylum seeker has exhausted the available legal avenues, and has not met the legal criteria to become a refugee.

The UN High Commission for Refugees describes a migrant as someone who makes a conscious voluntary choice to leave their country of origin. Should they choose, they can safely return. An ordinary resident is someone living in the UK for a settled purpose. This usually means work or study. Economic migrants are people who leave their home country to seek work. This term could be applied to new arrivals who obtain work permits from the government to fill labour shortages in the UK.

Asylum Seekers and Refugees

Every year hundreds of people flee conflict and persecution to seek sanctuary in the UK. Many will have experienced trauma and loss, some will have been imprisoned, tortured, subjected to sexual violence or rape. Some will have witnessed acts of violence on others, including family and friends.

The health and wellbeing of asylum seekers is often poor because they may come from places where healthcare provision has collapsed and where malnourishment and communicable disease is exacerbated. Often the journey to the UK has a detrimental impact on individual health.

The health needs of asylum seekers may increase on arrival in the UK. The reasons for this include difficulty in accessing healthcare services, social isolation, lack of awareness of entitlement, problems in registering and accessing primary and community healthcare services and language barriers. In addition, there are physical and mental health issues specific to asylum seekers which, coupled with the impact of going through the complex asylum seeking process, places them at risk of destitution and inequalities. These experiences have a detrimental impact on the health and wellbeing of asylum seekers and refugees, resulting in the need for extra health and social care support.

New Arrivals in Leicester

Leicester City Council estimates that the Somali community comprises about 10,000 people, mainly resident in St Matthews and Highfields with some people living in Beaumont Leys. Many economic migrants are of working age and around 70% are from Poland, followed by Slovakia (13%), Portugal, Latvia and Lithuania. Estimates from National Insurance records suggest that there are 6,000-8,000 people from these communities, including 1,000-2,000 people from the Roma community in Slovakia. Some members of the Polish community live in Fosse ward, Evington and the Narborough Road areas. The members of the Slovak Roma community are mainly located in the Evington Road and East Park Road areas.

With regard to asylum seekers and refugees, Leicester is National Asylum Seeker Service (NASS) designated dispersal city. The maximum number of asylum seekers in Leicester at any one time is 800. If Asylum seekers are accepted as refugees then they are free to settle anywhere. In Leicester the Zimbabwean population is the largest refugees group; estimated to number 2,000-3,000 people.

Leicester is known to be home to significant numbers of failed asylum seekers and illegal immigrants. The details of these people are unknown, and they survive by sofa surfing and hand-outs from local, mainly faith groups and charities. It is estimated by Leicester City Council that there could be as many as 3,000 'hidden people' living in the city. It is thought that these people are mainly male and from countries such as Afghanistan.

Physical health

This needs assessment has shown that mental wellbeing is linked to physical health. New arrivals may experience a number of different physical health conditions. For people from African communities there are health issues regarding diet, hypertension, diabetes, female genital mutilation, women not accessing ante and post-natal care, substance misuse and smoking. For people in the Roma community there may be health and social care problems related to a reluctance of community members to engage with statutory service providers.

With regard to economic migrants, most are young, fit and healthy but their needs increase as they become more settled and start families, or bring their families to Leicester. At the moment the reduction in the number of jobs in certain sectors has led to an increase in homelessness amongst EU migrants in Leicester. In the winter of 2011-12 half the homeless people in Leicester were members of this group. By the time a person becomes homeless there are often a number of issues which have compounded their situation, including alcohol and drug dependency, smoking, poor diet, heart disease and mental ill health.

The most common physical health problems affecting asylum seekers include:

- **Communicable diseases:**²²⁴ Immunisation coverage may be poor or non-existent for asylum seekers from countries where healthcare facilities are lacking.
- **Sexual health needs:**²²⁵ UK surveillance programmes of sexually transmitted diseases (except HIV) do not routinely collect data on country of origin. Uptake of family planning services is low, which may reflect some of the barriers to accessing these services by women.
- **Chronic diseases:**^{226 227} Such as diabetes or hypertension may not have been diagnosed in the country of origin, perhaps due to lack of healthcare services.
- **Dental disorders** are commonly reported amongst refugees and asylum seekers.
- **Consequences of injury and torture:**²²⁸

- **Psychosomatic disorders:** Physical manifestations of mental illness, which may result from night terrors, sensitivity to noise.
- **Women's health:** Studies have shown poor antenatal care and pregnancy outcomes amongst refugees and asylum seekers. Asylum seeking, pregnant women are 7 times more likely to develop complications during childbirth and 3 times more likely to die than the general population. Uptake rates for cervical and breast cancer screening are typically very poor. Other concerns include female genital mutilation and domestic violence.
- **Disability:** Limited evidence exists on the prevalence of disability amongst refugees and asylum seekers, with estimates varying from 3–10%. There is little or no commissioning of services for asylum seekers with disabilities (e.g. landmine injuries).
- **Irregular or undocumented migrants:** (such as those who have failed to leave the UK once their asylum claim has been refused or those who have been illegally trafficked) also have significant health needs and are largely hidden from health services.

Evidence of risk to the mental health of asylum seekers and refugees

Upon arrival in the UK asylum seekers face the challenge of navigating the complex process of seeking asylum. When a person makes an application for asylum and apply for support, they will normally be given Section 95 support whilst their claim for asylum is being considered. When an asylum seeker has exhausted their appeal rights, but is unable to return home, he or she can apply for Section 4 (hard case) support for full-board.

During the application period they have limited support, and often find themselves destitute. Once they have been granted refugee status they face the challenge of building new lives in unfamiliar circumstances, often facing hostility, housing difficulties, poverty and loss of choice and control.

Compared to the general population the incidence of mental illness is higher among asylum seekers and refugees.²²⁹ The most frequently diagnosed conditions are related to trauma, psychological distress, depression and anxiety.²³⁰ However, these are not homogenous groups; some individuals may have normal reactions to abnormal events, for others reaching the UK may be indicative of resilience.

Whilst mental illness may be associated with the circumstances surrounding the departure of some people from their country of origin, there is evidence that for others, mental distress is associated with their circumstances in the UK,²³¹ where policy has had a negative impact on their mental health and wellbeing.

The following issues have a detrimental impact on the mental health of asylum seekers and refugees:

The process for claiming asylum in the UK can cause stress and insecurity: Application decisions can take a long time, during which people often live in fear that they could be detained and deported at any time.²³² This makes it difficult for people to settle and plan for the future.

Dispersal: Most asylum seekers have no choice where they live. Dispersal does not necessarily take into account community support, family or friends. Research shows how important these support networks are to integration and wellbeing.²³³ The dispersal areas are often deprived, with little experience of diverse communities, often resulting in social tension and racism.²³⁴

Accommodation: Poor housing has been shown to have a negative impact on mental health.²³⁵ Although this accommodation has improved there are concerns that it can be poor quality and

unsuitable in some cases, and those who are supported by friends or family often face overcrowding.

English Language Skills: Language is important for integration and participation in society.²³⁶ People who cannot speak English face challenges in engaging with communities and accessing support. A shortage of English classes and rules excluding asylum seekers from free classes until they have been waiting for a decision for at least 6 months, or have been accepted as a refugee, can make learning English challenging.

Work and Benefits: Asylum seekers are prohibited from working, and are therefore deprived of the opportunities for integration which employment can provide.²³⁷ As a result, many live in poverty, often on just over £5.00 per week. The inability to provide for themselves and their families or to contribute to society impacts negatively on self-esteem, confidence and mental health.²³⁸ The impact of poverty and long-term unemployment on health and mental wellbeing has been well documented.

Failed asylum seekers: It is government policy to withdraw housing and finance support from failed asylum seekers. Their only option is to apply for Section 4 support. Since April 2014 Section 4 applications are made by phone, which makes it hard for failed asylum seekers to receive support even if they satisfy formal requirements. Section 4 provides £36 weekly on a charge card, to be used in certain supermarkets, and basic accommodation on a no choice basis, which could be far from support networks. To qualify for this support people must meet certain criteria, including a commitment to return to country of origin as soon as it is safe and practically possible, proof of making travel arrangements, or proving that they are unable to return. Of these people, individuals with mental health problems are less likely to sign up to Section 4 support.

Destitution: Those who do not meet Section 4 criteria, or who do not want to apply because for fear of persecution if they are returned, find themselves without recourse to any benefits or the right to work. These people face destitution.²³⁹ In addition, some refugees and asylum seekers who are entitled to support, including many children, are also destitute.²⁴⁰ Although many may have experienced mental distress before they became destitute, it is clear that destitution exacerbates mental illness.²⁴¹

Healthcare restrictions: All asylum-seekers and refugees are entitled to primary healthcare free of charge, although refused asylum-seekers are registered at the discretion of the GP. In 2004 restrictions on free secondary healthcare were introduced. The impact of this policy for refused asylum seekers, who are often destitute and unable to return home is that secondary care is usually chargeable unless it is emergency treatment, family planning, compulsory mental health treatment or treatment for certain infectious diseases. As a result, many people now have limited access to healthcare, including non-compulsory secondary mental health services. The rising number of destitute asylum seekers putting increasing pressure on local authorities who have to fund support from local budgets. Furthermore, since a legal ruling in 2008 (*M. v Slough*), the threshold for eligibility has been raised, making it harder for those experiencing mental health problems, such as depression and trauma related psychological distress to gain support.

Detention: Asylum seekers can be detained at any point in the process. At any time about 3,000 people are held in detention centres around the UK. There is no time limit to detention. Amongst these people will be those with mental illness, children physical disabilities and people who have been tortured. Cohen reported high levels of distress and self-harm among detainees.²⁴²

Children and young people: In 2007 7,700 children arrived in the UK seeking asylum. Some of these children arrive with, or join, their family though many arrive alone as unaccompanied asylum-seeking children. Without support refugee children and young people are at risk of experiencing mental health problems. However, the UK asylum system has adverse effects on the mental health of these children and young people.

Recent research in Nottingham²⁴³ confirms some of these issues. Asylum seekers are those who have fled their country of origin in fear of their lives, this is by definition a situation which may negatively impact on a person's mental health. Many asylum seekers have post-traumatic stress disorders, having witnessed or experienced violence, murder, rape or torture. They come to the UK expecting to find a safe haven. However the asylum system is slow, and because there are long delays and uncertainties in seeing their cases resolved, many experience added stress and anxiety. In addition, impoverishment and destitution is very distressing. As a consequence many have experienced a double impact and present to services with mental health problems.

Asylum seekers have chaotic lives, many do not present with routine mental illness; for example clinical staff may not be aware of an individual's status as an asylum seeker or refugees and the implication which that has in terms of a person's life experience. The Nottingham evidence shows that asylum seekers and refugees are difficult patients because they:

- May not turn up as they cannot afford transport costs
- Have been detained, at the Loughborough Reporting Centre
- Have been forced to change accommodation or have no permanent address
- May not be able to speak adequate English to communicate by phone
- Have no money to buy a phone card
- May be depressed and cannot get to their appointments
- May not know how to get to a clinic
- May have been discharged if they did not attend an appointment

Once with a mental health practitioner an asylum seeker may encounter problems such as:

- Interpretation constraining assessment, such that a session is not long enough to cover all a person's problems
- The problems raised may not be able to improve sufficiently to fit with therapeutic outcomes
- They may encounter stereotypes, such "we can't see you until your life is more settled"; "you should go home"
- The therapist has limited knowledge of PTSD, trauma or of the asylum system and its effects on asylum seekers.

Asylum seekers in Leicester

Since 2001 Leicester has been a NASS dispersal city,^{244 245} with a maximum cluster limit of Section 95 and Section 4 asylum seekers of 800. Actual numbers have ranged from 450 in 2011 and 2012, to over 1000 in 2007. In 2013 numbers increased, such that in May 2014 there were 862 asylum seekers dispersed to Leicester; a 45% increase in dispersal numbers since 2012.

Home Office indications suggest that there may be a further increase in dispersal numbers before the end of 2014. Asylum seekers dispersal numbers do not include unaccompanied asylum seeker children, asylum seekers with negative decisions, those who are not supported, and those who's appeal rights are exhausted.

The 2014 demographic data show that most asylum seekers and refugees come from Zimbabwe followed by India, Iran, Afghanistan, Syria and Sri Lanka. Over 40 languages are spoken; 20% speak English, about 11% speak Arabic and around 6% speak Shona. The next most common languages are Tamil, French and Farsi.

Since 2010 the number of asylum seekers and refugees who have sought the support of the Red Cross is 2,850, ranging from between 668 and 765 per year, an average of about 713 people annually. It is estimated that a further 650 will seek BRC support in 2014-15.

Table 19: Asylum Seekers and Refugees seeking British Red Cross support in Leicester 2010-2014

Year	Number of Refugees
2010-11	739
2011-12	668
2012-13	765
2013-14	678
Total	2,850

The focus of the BRC Orientation and Support Service is on supporting destitute asylum seekers and refugees. About 75% of the 2,850 asylum seekers and refugees who have sought support from the BRC are destitute.

All asylum seekers are at risk of destitution, but for most the risk is greatest at the end of the process when they no longer receive support. Research shows that those who seek Section 4 support, or are too afraid to seek it or have been refused it, are most likely to be seen by the BRC. For refugees destitution arises usually because of bureaucratic delays in the issuing of national insurance numbers and bio-metric residency permits.

Destitute asylum seekers form a hidden underclass in Leicester, at risk of poor physical and mental health. The case study below is one example of the impact of the asylum seeking process and destitution on the mental health and wellbeing of an individual, and the support which was available to her.

Case Study

A victim of female genital mutilation (FGM) in Cameroon was refused an application for asylum. A consequence of this was that her National Asylum Seeker Support (NASS) was terminated. Under Home Office regulations she had not been permitted to work and had relied on state support.

The Home Office refused the application because it did not find credible the evidence that her injuries resulted from persecution in her country of origin. There were medical grounds for further legal application, supported by an immigration solicitor and based on the report of a specialist practitioner. Whilst visiting her solicitor she suffered a collapse, linked to stress and malnutrition, following withdrawal of support. Her solicitor referred her to the British Red Cross Refugee Support Service (BRC). She was taken to hospital. The BRC acted as advocate, facilitating communication with the hospital with the consent of the client.

On discharge from hospital she faced becoming homeless, so the BRC provided short term accommodation whilst applying for Section 4 support. There were delays in processing the Section 4 application; a common occurrence. As the BRC could only provide accommodation 3 nights, the

delay resulted in the person becoming homeless. She slept either on the floor at a friend's home or in a park. On one occasion, whilst sleeping in the park, she was assaulted. This compounded the stress of the situation and the Post-Traumatic Stress Disorder (PTSD) which had resulted from persecution she had suffered in her own country.

Eventually she received an appointment to see the medical practitioner; as this was in London, she was only able to attend with BRC support. The medical practitioner did not feel it appropriate to conduct an intrusive examination to compile evidence on FGM, because he believed her to have such poor mental health that she should be detained under the Mental Health Act.

The BRC provided clothes, food, toiletries and emotional support during this difficult period. In addition they provided practical help; referring her to a befriending group, as a way of combatting social isolation and dislocation, maintaining communication with her solicitor and medical practitioner, which was critical in keeping open her case, completing applications for health care to enable the client to get medication. Other advocacy for this client included referral of the case to her local MP to make representations on her behalf.

Once the solicitor had the evidence they needed, a fresh claim for asylum was submitted and consequently the BRC applied for NASS support. She had to relocate to Birmingham and has since become a volunteer helping people who face similar battles.

ASSIST in Leicester

ASSIST is an NHS healthcare practice which provides health care to asylum seekers and refugees in Leicester. It provides specialist mental health support. Many referrals are made to the practice by the BRC. These clients experience problems which are broadly similar to the issues discussed in this chapter, with high levels of Post-Traumatic Stress Disorders, psychosis, depression and anxiety. Many may have seen murder, rape and been tortured and imprisoned. It is also recognised that the asylum seeking system itself, and particularly the long waiting times experienced, can add to anxiety and depression.

Past ASSIST Annual Reports show evidence that clinical expertise in managing the psychological conditions associated with asylum seekers and refugees is crucial to provide the necessary support to manage the mental health of individual asylum seekers and refugees, whose environment is unpredictable. This expertise has led to the service developing a proactive approach to support and containment in the management of acutely distressed patients. The service offers integrated interventions which are more significant than those which are offered in mainstream general practice.²⁴⁶

In addition to supporting Ashton and Moore write that there is a need for understanding of the impact of trauma on the lives of asylum seekers, so that they are able to make new connections and construct new meanings. Recovery from their experiences may take a long time, understanding, consistency and continuity.

ASSIST estimates that between April 2013 and May 2014, of its 400 asylum seeker and refugee patients, 161 have moderate to severe psychiatric problems, 40% of its asylum seeker and refugee patients; a far greater proportion than an average general practice. In June 2014 the waiting time for an initial mental health assessment was 5 weeks.

Meeting the needs of asylum seekers and refugees also requires specialist mental health services, services for survivors of torture, and community advocacy projects led by organisations with an interest in refugees. As the Red Cross is a focal point for the most vulnerable asylum seekers, one

approach which commissioners should consider is to provide specialist psychological care at the Red Cross. This would be an example of integrated working, bringing mental health support to the vulnerable community. An additional approach would be to develop school based mental health projects for asylum seeker children who are emotionally vulnerable.

Homeless people in Leicester²⁴⁷

People who are homeless experience more health problems than the general population, but have less access to timely appropriate care. Homelessness can be defined as the lack of decent, secure and affordable housing.²⁴⁸ There are many reasons why people become homeless. Sleeping rough is associated with low income and with being marginalised. Many people who sleep rough would not accept a hostel bed, especially if they have had a bad experience in the past. Only 5% of people who sleep rough do so by choice;²⁴⁹ 80% of homeless people want a flat or house of their own; most want to live alone with some support.²⁵⁰ The majority of rough sleepers have a history of placement in foster care, children's home or in another institution.

There are at least 3 groups of people who are homeless:

- Those who are officially recognised as being homeless, including families with young children and vulnerable single homeless people.
- Rough sleepers and single homeless people living in hostels.
- The hidden homeless; people who sleep on friends' floors, in overcrowded and inadequate housing.

It is difficult to estimate the number of people who are part of the hidden homeless group. Beds are accessed through a single point of contact (SPOC).

Health of homeless people

The mortality rate for homeless people is between 3.8 and 5.6 times that of the general population. The average life expectancy of someone who sleeps rough is 47 years,²⁵¹ compared with 83 years for women and 79 years for men for the population of England. Compared to the housed population the homeless are 54 times more likely to die as the result of a violent assault, 35 times more likely to take their own lives, 30 times more likely to die as a result of the effects of drugs and alcohol and more than twice as likely to die as the result of an accident.

Mental and physical illness is both a cause and consequence of homelessness. Existing illness is made worse by homelessness and by poor access to timely, appropriate health care. Compliance with treatment is difficult for homeless people, whose lives are often chaotic, and whose health is often a lower priority than shelter, warmth and food.

Illness may reduce a person's ability to find employment, and thus reduces for some people the ability to find and retain accommodation. Homelessness causes ill health; lack of shelter results in exposure to extreme weather conditions; it increases the risks of accidents. Lack of privacy in communal dwellings can increase exposure to communicable disease; poor sanitary conditions can lead to disorders associated with poor personal hygiene; malnutrition reduces immunity to disease and lack of security increases exposure to violent attack.

All physical conditions are worse for people who are homeless. For instance, there is an increased risk for:

Respiratory problems: Rates of respiratory problems are twice as high for people living in hostels and 3 times as high for people sleeping rough compared to the general population.²⁵² Homeless people may be at particular risk of pneumococcal pneumonia.²⁵³ Evidence shows that homelessness is linked to drug resistant tuberculosis.²⁵⁴ These factors may be related to exposure to the elements, overcrowding and poor nutrition, lack of access to medical care and poor compliance.

Skin complaints: Rashes, infestations, wounds, ulcers, cuts and grazes are 3 times more prevalent among homeless people than the general population.²⁵⁵ These problems are initially related to poor access to hygiene amenities, and once established they may be difficult to treat because of limited access to health care and poor compliance.

Musculo-skeletal problems: These are 2 times as common among homeless people as the general population.

Gastrointestinal conditions: The rate of conditions, such as dyspepsia, ulcers, diarrhoea and vomiting is twice as high among homeless people as the general population. These conditions are associated with stress, poor diet and poor hygiene.

Neurological conditions: Neurological conditions may lead to deterioration in social functioning which is associated with homelessness. Factors such as exposure to violence and misuse of alcohol and drugs may have an impact on cognitive function of homeless people.

Homelessness and mental health

Mental illness is more common among homeless people. Serious mental illness, such as schizophrenia and psychoses, are present in 25-30% of those people sleeping rough or in hostels.²⁵⁶ A systematic review estimated the prevalence of psychosis among homeless people to be 11%, with higher rates among women, young people and the chronically homeless.²⁵⁷

Substance use and dependence amongst homeless people is high. In a survey of street homeless and hostel users in London 83% of interviewees reported using drugs, and 68% had used alcohol, in the month prior to the survey.²⁵⁸ Rates of co-morbidity of mental illness and substance misuse are also higher in the homeless population; most studies show a range of 10-20% of homeless people have both.²⁵⁹

Cases of deliberate self-harm and suicide are more frequent among homeless people. Emergency presentation of cases of self-harm in London showed that 15% were homeless.²⁶⁰ The Oxford Monitoring System for Attempted Suicide analysis of emergency departments showed that between 1988 and 2002 10% of presentations were of people from no fixed abode. These people were more likely to be male, have a history of mental illness and a substance use problem.²⁶¹

Health and social care for homeless people in Leicester

Recent research²⁶² into repeat homelessness in Leicester has found that:

- There is an increase in cases of people with moderate and severe level mental health problems who are homeless
- The experience of some people is that they have to 'get worse to get better'; that is their illness may not initially merit intervention until it deteriorates
- There are people who have mental health problems but are not in receipt of services because they have not been assessed or diagnosed with mental illness

The bureaucracy associated with homelessness, such as the need to produce documents, claiming benefits and form filling for services, has a detrimental impact on individuals; they are stressful for people who cannot understand or cope with correspondence. An additional problem is how to house people who are vulnerable to homelessness because of their behaviour or because they are perceived to be a risk to close neighbours; for example if placed in a house in multiple occupation.

Homeless health care is provided the Inclusion Healthcare Social enterprise. Specialist primary care for homeless people began in the 1990s, with GP provision at the Night Shelter and a drop in centre, followed by a Personal Medical Services Pilot for homeless people established in 2000.

Inclusion Healthcare has a range of primary care services, as well as support which is specialist for vulnerable people. The service registers homeless people, residents of two approved hostels, residents of two learning difficulties units, and women working in prostitution.

In addition to primary care Inclusion Healthcare offers specialist support for people in this vulnerable group who have mental ill health, alcohol and drug misuse problems, communicable disease, maternity care, musculo-skeletal problems and skin complaints. These services are currently delivered from Charles Berry House and the Dawn Centre. The latter venue is important, because in addition to a healthcare suite, the Dawn Centre has a Night Shelter and the YASC drop-in centre which has washing and laundry facilities, and the opportunity to consult with outreach teams.

The Homeless Mental Health Service (HMHS) consists of mental health nurses, a psychologist and a psychiatrist. Based at the Healthcare suite/Y support project at the Dawn Centre, it accepts referrals from homeless people themselves, aged over 16 years, and from services in contact with homeless people. It provides specialist mental health assessment for homeless people, supportive counselling, brief psychological therapy and access to mainstream mental health services.

In the past the majority of people seen by the HMHS previously came via hostels, so hostel closure has had a detrimental impact on these numbers and difficulty in locating people whose lives are chaotic. Hostels also provide the mental health service with the opportunity to observe people and to identify underlying mental health problems of which the client may be unaware of or unwilling to discuss.

Thus access to the service relies increasingly on self-referral, and as a result HMHS is concerned about how to engage with people who need their support, particularly:

- Early engagement – before homelessness occurs and when people have not presented at Housing Options. People who have accommodation, even though they may be at risk of homelessness are seen by Open Mind IAPT or Assertive Outreach
- People who are not eligible for council funded homelessness services
- Engaging people who haven't identified for themselves that they have mental health problems or people who can't /won't articulate these problems to services.

Additional issues which complicate access to the HMHS. For instance, meetings concerning high risk individuals no longer occur, and the LPT referral management service for Leicester prioritises Community Mental Health Teams rather than the HMHS. It is likely that these services are not flexible enough, and do not have the necessary expertise, to meet the needs of homeless people.

Lesbian, gay, bi-sexual and transgender (LGBT) people

LGBT health needs

It is likely that the LGBT community comprises 2-2.5% of the general population, somewhere between 6,000-7,500 people.²⁶³ According to Fish, lesbians, gay men and bisexual people form a population whose demographic characteristics are largely unknown. The LGBT population comprises people from every segment of the UK population including and their needs reflect the stratification of health and social care inequalities. Compared to the population generally LGBT people have greater exposure to the wider determinants of health, poorer experiences of hospital and residential care, poorer access to health and social care provision and are particularly subject to stigmatisation, discrimination and insensitivity.

With regard to mental health and wellbeing a systematic review of the international literature and meta-analysis on research on the mental health of 214,344 heterosexual and 11,971 LGBT people found:

- LGBT people have a two-fold increase rate of suicide attempts, 1.5 higher risk for depression and anxiety disorders, and higher risk of alcohol and substance misuse
- Lesbian and bisexual women are particularly at risk of substance dependence
- Gay and bisexual men are particularly at risk of lifetime prevalence of suicide attempt.

Other evidence points to the higher prevalence of mental health problems among LGBT people compared with the heterosexual population. 16% of lesbians and bisexual women (survey n=6,178) aged under 20 have attempted suicide. 34.4% of trans-sexual people say they have attempted suicide at least once as an adult; 20% reported a mental health disability. This increased prevalence is also associated with higher use of mental health services in LGBT populations. More evidence is required on the older LGBT population.

A birth cohort of 967 young people in New Zealand found that 87.6% were exclusively heterosexual. The remainder were either bisexual (9.6%) or homosexual (2.8%). Rates of mental health problems were:

- Major depression- Men 14.6% straight, 42.9% bisexual, 71.4% gay. Women 24.3% straight, 37.3% bisexual, 50.0% lesbian
- Anxiety disorder - Men 10.2% straight, 28.6% bisexual, 85.7% gay. Women 21.2% straight, 34.3% bisexual, 40.0% lesbian
- Suicide ideation - Men 10.9% straight, 28.6% bisexual, 71.4% gay. Women 9.7% straight, 20.9% bisexual, 30.0% lesbian
- Suicide attempts - Men 1.6% straight, 0% bisexual, 28.6% gay. Women 1.5% straight, 4.5% bisexual, 10.0% lesbian.

LGBT Open Mind IAPT Service in Leicester

Given that LGBT people are at significantly higher risk of mental disorder, suicide ideation, substance misuse, and deliberate self-harm, mental health care commissioners, providers, VCS groups and the Leicester, Leicestershire and Rutland Integrated Equalities Service felt that there was an urgent need for mental health services to develop LGBT sensitive services which would include:

- The incorporation of LGBT issues into diversity training for staff
- Improve access to therapeutic mental health services
- Improve mental health outcomes

In providing a LGBT specific service, Open Mind IAPT aims to reduce mental health inequalities experienced by LGBT people and improve access and outcomes in relation to their mental health and wellbeing. The service is a partnership between LPT and local LGBT provider services such as Trade, the LGBT Centre, and aims to include the wider LGBT community.

The service provides mental health support for people with depression, generalised anxiety disorder, mixed depression and anxiety, panic disorder, obsessive compulsive disorder, phobias, stress and low mood whilst also developing more helpful coping strategies and build emotional resilience as well as confidence and self-esteem. It also includes LGBT competency development training for Leicester based IAPT clinicians, incorporating learning outcomes such as:

- Understanding the mental health issues for lesbian, gay, bisexual & transgender people
- Know about the local area & how to get support
- Tips on how ask the question & monitoring sexual orientation

The project will inform long term development of an LGBT care pathway and consider how such a development could be aligned to improved access for LGBT people to primary healthcare and other services.

Although the service was officially launched in September 2013, it has been functioning since May 2013. Preliminary findings from a report to the project group, which includes looked at all Open Mind IAPT patients, suggested that:

- A higher proportion of LGB people (specifically Gay men) were found to have accessed services.
- Age group (years): Compared to the population of Leicester, there were more LGBT people aged 18 to 29 and 30 to 49 in referrals to and accessing services
- Compared to the Leicester population women were overrepresented and men were underrepresented amongst both those who entered treatment and amongst all referrals
- When sexual orientation subgroups were considered, Bisexual people were underrepresented amongst those who entered treatment
- A numerical trend for Lesbians to be overrepresented amongst those who entered treatment, but it was not possible to apply a statistical test as all Lesbians who were referred entered treatment.
- Overall, sexual orientation was not significantly associated with a particular reason for not entering treatment

As this is the early stage of the pilot study, the numbers of LGB people with initial and final anxiety and depression scores were low, hence statistical power for this group was low (resulting in a low ability to detect a significant drop in depression or anxiety score). However, initial indications are that effectiveness of treatment varies by sexual orientation with lesser efficacy for some LGB groups on some measures. The final, year-long evaluation may give a clearer indication on this point.

Transgender Pathway

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth. Trans and gender variant people are not necessarily gender dysphoric. Transgender people have higher rates of poor mental health, may experience increased drug and alcohol use, have higher than average rates of attempted suicide and self-harm. However, they are less likely to access health and social care services.

People with atypical gender identity development but not diagnosed with gender dysphoria should be supported on to a treatment pathway appropriate to their need by a Gender Identity Clinic (GIC). Some, but not all, patients may require formal psychiatric intervention to assist with psychiatric comorbidities and in such cases shared care may be appropriate.

Assessment, diagnosis and confirmation of gender dysphoria must be by a health professional who specialises in gender dysphoria and has general clinical competence in diagnosis and treatment of mental or emotional disorders, for example psychiatrists and psychologists.

NHS England may commission a specialised Gender Identity Clinic (GIC) service from providers able to deliver the range of multi-disciplinary services described in this document, and offer effective and high-quality care for gender dysphoria. Historically, such services have been single-centre, consultant-led, multidisciplinary teams but other models, for example multi-centre, multi-disciplinary clinical networks involving General Practitioners with special interest in gender dysphoria, are not excluded. However, it is a requirement that both single-centre and multi-centre clinical network providers have a multi-disciplinary team, deliver agreed individual patient care.

A recent study from the Scottish Transgender Alliance²⁶⁴ on trans mental health showed high rates of satisfaction with treatments. 70% of participants were more satisfied with their lives since transitioning. 85% were more satisfied with their body since undertaking hormone therapy, 87% were more satisfied after non-genital surgery and 90% after genital surgery.

Of those who have attended GICs, 60% were seen within a year, 32% wait 1-3 years, under 10% wait over three years for an appointment. 58% of the participants felt that waiting for treatment had a detrimental impact on their mental health or emotional wellbeing.

Many trans people had poor experiences of health care; 62% people who had used GIC services experienced one or more negative interactions, 63% of those who used general mental health services, and 65% of those in contact with general health services. For nearly 30% of participants respondents, a healthcare professional had refused to discuss a trans-related health concern.

Within mental health services, 29% of the respondents felt that their gender identity was not considered to be genuine, and was instead being perceived as a symptom of mental ill-health. 26% felt uncomfortable being asked about their sexual behaviours. 17% were also told that their mental health issues were because they were trans.

Carers

There is a separate needs assessment for carers in Leicester, but it is important to reiterate that without support the personal impact of caring can have a detrimental impact on mental health. Providing support and ameliorating the risks to the health and wellbeing of carers, are significant challenges for health and social care services. Carers have higher levels of stress and poorer physical health than the population generally.

The carers' needs assessment shows that in Leicester there are an estimated 30,000 carers. While not all need formal support, there is a large gap between need and service provision. For instance there are more recipients of adult social care than those with recorded carers' assessments. There is inconsistent recording of carers on general practice registers. There are 249 young carers known to social care services, but the census indicates that there are four to five times as many young carers in Leicester.

The ethnic background of known carers in Leicester is changing. Completed social service carers' assessments show that carers from Asian/Asian British ethnic backgrounds have increased since 2007/08, from 33.3% to 37.5%. Those from White/White British ethnic backgrounds have decreased from 61.8% to 54.7%.

Carers in Leicester report that they want more recognition and assessment of their needs, commensurate with the caring role. They require more respite care, more culturally specific services, accessible communication and signposting to helpful services and networks. Services for carers should be flexible; carers need more training and different types of respite care. Not all carers will require or want help, but an estimated 16,000 people have need of some support.

The main themes which emerge in the carers' need assessment were that service commissioners take steps to:

- Identify carers across Leicester by keeping and maintain registers in health and social care
- Ensure health and social care providers collaborate to improve the assessment and advice offered to carers; learning from and involving carers at every stage of planning and designing services and changing ways in which services are provided
- Ensure that there is consistent formal assessment of individual carer's needs by health and social care staff
- Increase the range and provision of respite services for carers
- Ensure carers are involved in commissioning decisions
- Improve monitoring and data collection from services who support carers.

For carers there is a sense that some things will make caring easier, such as access to counselling, flexibility in all aspects of life, such as at work, getting appointments for care recipients. Recognition of carers needs is also very important, as carers' own physical and mental health needs have to be fully addressed.

Veterans

A veteran is someone who has served in the armed forces for at least one day. There are around 4.6 million veterans in the UK. When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. The duty of care owed to service personnel can be found in the armed forces covenant²⁶⁵.

All veterans are entitled to priority access to NHS hospital care for any condition as long as it's related to their service, regardless of whether or not they receive a war pension. All people leaving the armed forces are given a summary of their medical records, which they are advised to give to their new GP when they register. Veterans are encouraged to tell their GP about their veteran status in order to benefit from priority treatment.

A minority of people leaving the armed forces need access to mental health services, while others might require it later in civilian life. Research indicates that armed forces personnel serving in Iraq or Afghanistan are no more prone to mental health issues than personnel not deployed to these areas. However, it is common to experience anxiety or nightmares after traumatic events and these can lead to psychological problems, such as post-traumatic stress disorder (PTSD), depression and anxiety. Symptoms can include being constantly anxious, being unable to relax, re-experiencing a traumatic event, avoiding anything that might trigger distressing memories or feelings.

PTSD can lead to problems in relationships and at work, including irritability, anger and substance misuse, particularly alcohol. While some symptoms, such as nightmares, are normal in the weeks following a traumatic event, symptoms that last longer than this can indicate a problem. Some people may not experience these symptoms until they have left the armed forces. These issues can be difficult for veterans, and the culture of the armed forces can make seeking help for a mental health problem difficult.

There are many treatments available to help people cope with the psychological impact of traumatic events, including trauma-focused CBT. There are many charities that provide services, advice and support for veterans, reservists and their family members. There are also a number of national support services for Veterans, as seen in the Table below

National support services for Veterans

Combat Stress

[Combat Stress](#) offers a range of services for veterans of the Royal Navy, Army, Royal Air Force and the Merchant Service, including:

- [Intensive in-patient treatment](#) delivered at Combat Stress treatment centres, is a 6 week PTSD Intensive Treatment Programme for veterans
- Moderate in-patient treatment is a 2 week treatment focusing on specific areas, such as anger management and alcohol
- Low level in-patient interventions of 1 week interventions

Combat stress operates a 24-Hour Helpline for the military community and families

The Royal British Legion

[The Royal British Legion Knowledge](#) database has details of services and sources of support at a local and national level for the Armed Forces community

Big White Wall

The [Big White Wall](#) provides support from trained counsellors available and supportive community for all Armed Forces personnel, veterans and families

Veterans Information Service

The [Veterans Information Service](#) is provided in partnership with the Ministry of Defence and Service Personnel & Veterans Agency (SPVA). As well as offering advice, information and the [Veterans Welfare Service](#), the SPVA provides pay, pension and support services to both military personnel and the veterans' community, directly serving around 900,000 members.

People with learning disabilities

This section of the needs assessment is a summary of some of the links between learning disabilities and mental health needs. The demographics of the population with learning disabilities are changing. The number of people with learning disabilities in the United Kingdom increased by 53% in the period between 1960 and 1995, an average increase of 1.2% per year. This increase is

thought to be because of the improving socio-economic conditions coupled with advances in health care. Another study projected a further increase of 11% for the period 1998-2008.

People with learning disabilities are amongst the most vulnerable members of society. They have a wide range of social and health care needs, and they may have coexisting conditions which contribute to need, such as physical or developmental disabilities, mental and physical ill-health and a range of behavioural problems. It is often the presence of these conditions that defines need for services. They also have needs which occur as a result of social exclusion, such as poverty, unemployment and lack of adequate accommodation. Children with mild learning disabilities may need specialist support in mainstream education. Adults may need the same support and access to benefits as others who are in socially excluded groups. Others with higher levels of disability may have a lifelong need of care. This care increasingly takes place in the community, with family members often the focal point. Thus service planning and commissioning must include the needs of carers. This is particularly important given that people with learning difficulties are increasingly reliant on carers who are ageing themselves.

Children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging can be, and have a right to be, given the support and care they need in a community-based setting, near to family and friends. Closed institutions, with people far from home and family, deny people the right care and present the risk of poor care and abuse.

The Winterbourne View review²⁶⁶ highlighted a widespread failure to design, commission and provide services which give people the support close to home, and which are in line with well-established best practice. In addition, there was a failure to assess the quality of care or outcomes being delivered at Winterbourne View and other hospitals.

Many individuals with learning disabilities need social care services, although, health services play a significant role to ensure that all needs are met. Disability may lead to the need for additional specialist support, benefits and services. However, it is important that generic services should always be accessible to people with learning disabilities. Service planning should be based on a partnership between health, social care, housing, education, carers and service users. The pattern of types of health need experienced by people with learning disabilities differ from the general population as do the main causes of death.

Often the needs of people with learning disabilities go unmet. To address such faults Mencap advocated that:

- Healthcare professionals need support, encouragement and guidance to make reasonable adjustments for patients with a learning disability
- Members of the public should be given the tools to persuade health professionals and healthcare authorities to make adjustments and treat people with a learning disability equally
- Organisations should implement the Getting It Right Charter, which promotes 9 key activities that all healthcare professionals should make to ensure that there is equal access to health. These are:
 - Using of hospital passports
 - Ensuring health care staff understand and apply the principles of mental capacity laws
 - Appointing hospital learning disability liaison nurses
 - Ensuring every person with a learning disability has an annual health check
 - Providing ongoing learning disability awareness training for all staff

- Listening to, respecting and involving families and carers
- Providing practical support and information to families and carers
- Providing information that is accessible to people with a learning disability
- Displaying the Getting It Right principles for everyone to see

Definitions

It is important to look at definitions of learning disabilities, not because of allocation of resources or to judge, but to underpin the classification of conditions. The term learning disability usually refers to a group of individuals with a history of developmental delay; a delay in, or failure to acquire a level of adaptive behaviour and/or social functioning expected for their age; and in whom there is evidence of significant intellectual impairment.

Systems which are used to classify people with learning disabilities generally combine a measure of intellectual functioning, such as intelligence quotient (IQ) with measures of behavioural functioning. The main classifications are listed under F& in ICD-10. An IQ score of 50-69 is defined as mild learning disability, 35-49 as moderate, 20-34 as severe and <20 as profound. Clinical judgement is also taken into account.

In England and Wales the Mental Health Act 1983 included the terms 'mental disorder', which includes arrested or incomplete development of the mind. It also included 'mental impairment' and 'severe mental impairment'. These are specific legal terms and are not synonymous with mental illness, learning disabilities or intellectual impairment.

The aetiology of intellectual impairment can be subdivided into those conditions which arise at conceptions and those which arise during pregnancy, in labour and after a child's birth. No aetiological cause is found in about 30% of cases of mild or severe learning disabilities. These factors include genetic, infective and environmental causes.

Incidence and Prevalence

The Register of people with learning disabilities, administered by Leicester University, was a valuable source of information and there is work aimed at improving the accuracy of general practice data. In April 2010 there were 1,611 Leicester residents on the register. The rate of people on the LD register, against the population of 347,774 registered with the General Practices in Leicester, is 4.62 per 1,000. This figure is slightly higher than the 3.8 per 1,000 nationally.

Table 19: People on the Learning Disability Register in Leicester (Source: University of Leicester)

	Freq	%	Lower	Upper
Sex				
Female	672	41.7	39.3	44.1
Male	939	58.3	55.9	60.7
Total	1611	100.0		
Ethnicity				
Asian	414	25.7	23.6	27.9
Black	42	2.6	1.9	3.5
Mixed	17	1.1	0.7	1.7
Not known	106	6.6	5.5	7.9
Other	9	0.6	0.3	1.1

White	1023	63.5	61.1	65.8
Total	1611	100.0		
Residential area				
City East	795	49.3	46.9	51.8
City West	816	50.7	48.2	53.1
Total	1611	100.0		

This table shows that there were more males registered with learning disabilities, and that people with learning disabilities are equally resident in both the eastern and western ward areas of Leicester. The 68% of people on the LD register from a White/White British ethnic background was an over representation when compared with the General Practice population of Leicester, which was 60.4%. Given that studies have indicated that the prevalence of learning disabilities among people from Asian/Asian British ethnic backgrounds is higher than the population generally, the proportion of people on the register from an Asian/Asian British ethnic background appears to be lower than expected at 27.5% compared with the Leicester Practice Population of 29.9%.

Mental disorders

The prevalence of mental illness and behavioural disturbance is higher in all ages in all age groups of people with learning disabilities than in the general population. There is evidence that the exact figures for this prevalence may be difficult to determine because of poor detection, misdiagnosis and the effects and side effects of medication.

The aetiology of mental ill health for people with learning disabilities is the same as in the general population. Social, environmental and biological factors are all involved. Psychiatric disorders are more prevalent in adults with learning disabilities than the population generally. Between 30% and 50% of people with learning disabilities may show a variety of behaviours which are precipitated by problems with communication and physical and mental illness. Rates of schizophrenia are three times higher than in the general population. Many disorders generally go undetected and therefore untreated. Appropriate services are often unavailable or inaccessible. In 2006 Hassiotis et al suggested that there is generally poor provision for children and the elderly who have co-morbidity of learning disabilities and mental illness.

Challenging behaviours

Challenging behaviours which are accompanied with learning disabilities have a large impact on both those with learning disability and their families. Felce et al found that challenging behaviour is associated with psychiatric morbidity among people with learning disabilities.

The use of pharmacological treatments, such as antipsychotics, mood stabilisers and antidepressants for people with challenging behaviour should be sparing and reserved for patients putting themselves and others at particular risk as a consequence of their behaviour. Matson and Neal suggest that psychological based interventions should be considered when appropriate.

Bhaumik et al reviewed 51 people leaving long stay hospital with a view to assessing changes in aggressive challenging behaviour and psychotropic drug use following resettlement. A person-centred approach was used. They found statistically significant reductions in scores on the Modified Overt Aggression Scale at the 6-month post-resettlement for people moving to supported living, residential homes, nursing homes and group as a whole with reductions seen in all four types of aggressive behaviour. The conclusion of the study was that strong and consistent reductions in observed aggressive challenging behaviour were found and that factors associated with relocation,

(improved quality of life, greater community participation and increased contact with friends and family) may have played a role in reducing anger and frustration leading to an observed decrease in aggressive behaviour.

A number of studies focused on self-inflicted injury. Cooper et al carried out a prospective cohort study in a general community setting and found point prevalence of self-injurious behaviour of 4.9%. The two-year incidence was 0.6% and two-year remission rate was 38.2%. They found lower ability levels, not living with family carers, having attention deficit hyperactivity disorder, visual impairment, and not having Down syndrome were independently related to self-harm. As a result they state that their findings suggest that self-injurious behaviour was not found to be as enduring and persistent as previously thought.

Danquah et al also identified a number of factors predictive of ongoing self-harm; they found that two factors, self-biting and verbal ability independently predicted continued self-harm. They suggested that biochemical mechanisms may also be a factor in chronic self-harm behaviour.

With regard to the carers of people with challenging behaviour, a number of themes emerged, including the varied relationships with local communities in acceptance and support and the largely negative relationships with services. Families from minority ethnic communities were more likely to report negative experiences.

Autistic spectrum

Autism is a lifelong developmental disability, which is often referred to as part of the autism spectrum or an autism spectrum disorder (ASD). The word 'spectrum' is a way of describing the fact that while everyone who has autism will share three main areas of difficulty, individual conditions will vary. For instance, whilst some people with an ASD will be able to perform a range of activities of daily living whilst others will require specialist support to perform them. The main features which are shared by people with an ASD are difficulties in social communication, interaction and imagination.

In autism there are qualitative impairments in reciprocal social interaction, which take the form of an inadequate appreciation of socio-emotional cues, these may include poor use of social signals and a weak integration of social, emotional, and communicative behaviours; and, especially, a lack of socio-emotional reciprocity.

Qualitative impairments in communications are universal. These take the form of a lack of social usage of whatever language skills are present; impairment in make-believe and social imitative play; poor synchrony and lack of reciprocity in conversational interchange; poor flexibility in language expression and a relative lack of creativity and fantasy in thought processes; lack of emotional response to other people's verbal and nonverbal overtures; impaired use of variations in cadence or emphasis to reflect communicative modulation; and a similar lack of accompanying gesture to provide emphasis or aid meaning in spoken communication.

The condition is also characterized by restricted, repetitive, and stereotyped patterns of behaviour, interests, and activities. These take the form of a tendency to impose rigidity and routine on a wide range of aspects of day-to-day functioning; this usually applies to novel activities as well as to familiar habits and play patterns. In early childhood particularly, there may be specific attachment to unusual, typically non-soft objects.

The specific manifestation of deficits characteristic of autism change as the children grow older, but the deficits continue into and through adult life with a broadly similar pattern of problems in socialization, communication, and interest patterns. For a diagnosis of autism to be made these developments must have been present in the first 3 years, although the syndrome can be diagnosed in all age groups.

There are over half a million people in the UK with an autism spectrum disorder, or approximately 1%. In a city, such as Leicester with a population of about 300,000 people, that would equate to about 3000 people with an ASD. 80% of individuals with ASD have significant intellectual disability. Conversely, autistic 'traits' are very common amongst people with intellectual disability: the full syndrome occurs in 17% overall and 27% of those with an IQ < 50. The information supplied by ICD-10 suggests that the disorder occurs in boys three to four times more often than in girls.

Asperger Syndrome

Asperger Syndrome (AS) is a neuro-biological disorder generally considered as belonging to the spectrum of autism. Patients with AS have intellectual capacity within the normal range with however a distinct profile of abilities apparent since early childhood. They can exhibit behaviour and marked deficiencies in social and communication skills. People with AS have difficulties in the same three areas highlighted above for ASD, namely social communication, interaction and imagination.

But whilst there are similarities with autism, people with AS have fewer problems with speaking and are often of average, or above average, intelligence. They do not usually have the accompanying learning disabilities associated with autism, but they may have specific learning difficulties. These may include dyslexia and dyspraxia or other conditions such as attention deficit hyperactivity disorder (ADHD) and epilepsy. People with AS sometimes find it difficult to express themselves emotionally and socially. For example, they may:

- Have difficulty understanding gestures, facial expressions or tone of voice
- Have difficulty knowing when to start or end a conversation and choosing topics to talk about
- Use complex words and phrases but may not fully understand what they mean
- Be very literal in what they say

People with AS may have difficulties with one or more of the senses (sight, sound, smell, touch, or taste). The degree of difficulty varies from one individual to another. Most commonly, an individual's senses are either intensified (over-sensitive) or underdeveloped (under-sensitive). For example, bright lights, loud noises, overpowering smells, particular food textures and the feeling of certain materials can be a cause of anxiety and pain for people with AS. People with sensory sensitivity may also find it harder to use their body awareness system. This system tells us where our bodies are, so for those with reduced body awareness, it can be harder to navigate rooms avoiding obstructions, stand at an appropriate distance from other people and carry out 'fine motor' tasks such as tying shoelaces. Some people with AS may rock or spin to help with balance and posture or to help them deal with stress.

Treatments and services for people with learning disabilities

Currently there are a range of service providers for people with learning disabilities, from universal services through to specialist health and social care. Specialist health care for people with learning disabilities is provided by Leicestershire Partnership NHS Trust. Other services involved in the

treatment of people with learning disabilities are the community dental services, physiotherapy and occupational therapy.

With respect to the mental health and wellbeing of people with learning disabilities commissioners need to ensure that services implement strategies to maximise the quality of identification and management of mental disorders for those people with co-morbidity of learning disabilities and mental illness.

It is expected that this service provision will expand joint working between Primary care services, Mental Health (AMH) and Learning Disability Services (LD) and the three local authorities. ASD specific care pathways based on NICE Guidance will ensure that service users receive clinical care which is appropriate for their needs; improving the services offered, increasing long term continuing health input thereby reducing risks and long term hospitalisation and inefficient commissioning.

The Autism Act 2009 committed the Government to publishing an Adult Autism Strategy to transform services for adults with autism. The Strategy was published on 3rd March 2012, named Fulfilling and Rewarding Lives: A Briefing on the National Adult Autism Strategy for England. Key actions from the strategy include the development of local Autism Teams, actions for improving access to diagnosis and post-diagnostic support and for better planning and commissioning of services, and improved training of frontline professionals in Autism.

In Leicestershire adults who may have an ASD are currently able to directly access from primary care a specialist assessment clinic. This assessment only clinic conducts up to two full assessments per week. The total number of referrals between October 2012 and September 2013 was 157, and is expected to grow by 20% per year. This Service does not actively manage or hold cases, or provide on-going health input.

Once diagnosed, the majority of these individuals receive little or no follow up from LPT services (unless they also have a Mental Health problem). LPT will continue to provide the assessment clinic within existing resources and support to those with other Mental Health problems. The new Service will provide specialist treatment and follow up for individuals who are currently not receiving a Service from LPT. It is expected that the new service will manage a caseload of 150 patients at any given time, which they will maintain until patients are ready for discharge to other services.

The assessment clinic has developed partnerships with Adult Mental Health and Social Care teams. However, it is not resourced to assess and care for the 1 or 2 complex ASD cases which may be seen annually. People in this category usually require individual packages of care and are often treated in out of area placements, with little prospect of repatriation to Leicester because of the lack of a funded LLR ASD care pathway. Acute inpatients with ASD (approximately 1 per acute inpatient AMH ward) typically have prolonged stays due to the lack of expert staff required for discharge planning.

Gaps, Findings and Recommendations

Mental illness disproportionately impacts on people from minority groups, whilst these groups have difficulty accessing appropriate services.

Leicester has a diverse population compared with England as a whole; 50% of Leicester's residents are from BME backgrounds compared with only 13% in England overall. Around a quarter of Leicester's population are of South Asian origin, 4% are Black/British, 3% mixed and 3% from other ethnic origins. The age profile of Leicester's BME population is relatively younger than the White population.

Distinct cultural differences in how mental health and wellbeing are thought about affect access to, and experience of, statutory services. The issues vary widely, both between and within BME groups by factors like age and gender. This means that there is no single 'BME mental health problem'. They may range from a person whose first language has no word to describe depression through to a person who has no trust of statutory services.

Recent data shows that there has been some progress in meeting mental health needs of people from BME communities, whilst some inequalities remain. For instance, 2012/13 data shows that there was an over representation of people from Black/Black British and White/White British ethnic backgrounds among those Leicester residents who were detained under provision of the Mental Health Act.

With regard to access to specialist cognitive behavioural therapy in 2013/14 there was an over representation of people from White/White British backgrounds, an under representation of people from Asian/Asian British ethnic and people from Black/Black British ethnic backgrounds. However, access to IAPT services showed in 2013/14 there was a slight under representation of people from Asian/Asian British ethnic backgrounds, but no difference for those from White/White British or Black/Black British ethnic backgrounds.

It is likely that the LGBT community comprises 2-2.5% of the general population, somewhere between 6,000-7,500 people. Compared to the population generally LGBT people have greater exposure to the wider determinants of health, poorer experiences of hospital and residential care, poorer access to health and social care provision and are particularly subject to stigmatisation, discrimination and insensitivity. LGBT people have higher rates of poor mental health. There is a need to develop specialist care for transgender people.

Commissioners should work with statutory and voluntary sector providers to address issues of access and outcome for people from minority communities.

The carers' needs assessment shows that in Leicester there are an estimated 30,000 carers. While not all need formal support, there is a large gap between need and service provision. For instance there are more recipients of adult social care than those with recorded carers' assessments. There is inconsistent recording of carers on general practice registers. There are 249 young carers known to social care services, but the census indicates that there are four to five times as many young carers in Leicester. There is a need for commissioners of mental health and social care to work with colleagues and key stakeholders to improve the mental health care of carers.

When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. The duty of care owed to service personnel can be found in the armed forces covenant. All veterans are entitled to priority access to NHS hospital care for any condition as long as it's related to their service, regardless of whether or not they receive a war pension. Veterans are encouraged to tell their GP about their veteran status in order to benefit from priority treatment. A minority of people leaving the armed forces need access to mental health services, while others might require it later in civilian life. Post-traumatic stress disorder, stress and anxiety are common problems experienced by veterans. Commissioners should ensure that the mental health care of veterans is commensurate with the obligations under the armed forces covenant.

People with learning disabilities are amongst the most vulnerable members of society. They have a wide range of social and health care needs, and they may have coexisting conditions which contribute to need, such as physical or developmental disabilities, mental and physical ill-health and

a range of behavioural problems. It is often the presence of these conditions that defines need for services. They also have needs which occur as a result of social exclusion, such as poverty, unemployment and lack of adequate accommodation. Health and social care commissioners should ensure that there is integrated care for people with learning disabilities.

Equalities, diversity and inclusion are key areas for commissioners. Commissioning should ensure that

- Work with key stakeholders to address the needs of people in minority communities, and ensure that they have access to the appropriate level of care and better outcomes.
- Integrate VCS organisations which represent minority communities into the care pathways
- Develop specialist care for transgender people
- Work with key stakeholders to improve the mental health and wellbeing of carers
- Ensure that the mental health care of veterans is commensurate with the obligations under the armed forces covenant
- Work together to consider the mental health of people with learning disabilities, when developing frameworks and care pathways
- Work together for local implementation of the Winterbourne View Report

Suicide

Suicide may be considered as an indicator of mental ill health because the majority of people who take their own lives suffer with a mental health problem. This chapter reviews the evidence concerning suicide and self-harm as it applies to Leicester.

The rate of death from suicide includes deaths from self-inflicted injury and deaths for which the cause of the injury was undetermined. Cases are decided by the coroner. From a medical and mental health perspective some verdicts, including open and misadventure, may have been viewed as suicide.

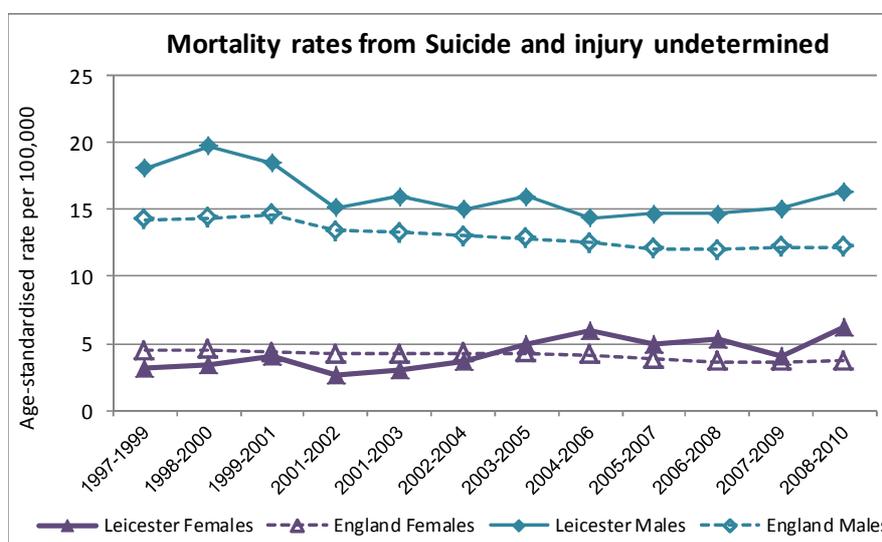
Evidence suggests that the act of a person taking their own life is often impulsive and dependent on different factors in addition to mental illness, such as the presence of a physically disabling or painful illness; alcohol and drug misuse; deprivation and the level of support that a person receives. Stressful life events such as the loss of a job, imprisonment, a death or divorce may also play a significant part. For many of those who take their own life it is the combination of factors which may be important. This chapter sets out some of the evidence about the rate of death from suicide in Leicester and some of the actions which may be taken to prevent people from taking their own lives.

Suicide and undetermined injury in Leicester

Each case is a tragedy for individuals, their families, friends and colleagues. In Leicester, on average, approximately 32 people take their own lives each year. The rate for suicides is calculated on a 3 year rolling average. In the period 2009-2011 there were 90 deaths from suicide and undetermined injury in Leicester, giving a rate of 10 per 100,000. As there are a small number of suicides each year in Leicester, an increase or reduction in the numbers can result in a large change in the rate. Furthermore, as deaths from suicide and undetermined injury disproportionately affect younger people, it is a cause for a high proportion of years of life lost.

In the 2011 audit of deaths from suicide and undetermined injury in Leicester, there were 25 registered cases. 16 of these died in 2011, 2 died in 2009 and 7 in 2010. A further 12 cases who died in 2011 have been registered in 2012; these will be reviewed in forthcoming audits.

Figure 30: Suicide and undetermined injury mortality rates, all ages



Of the 25 deaths, 18 (72%) were judged to be suicide and 7 received a verdict of undetermined injury (28%). The majority of registered cases of death from suicide and undetermined injury in 2011 were males (n = 20; 80%). The mean age of the 25 cases was 44.12 years. The youngest person was 25 years and the oldest 82 years. The most frequent age group was between 50 and 59 years (7 deaths). Ethnicity was recorded in 20 of the cases, 18 cases were in people from a White/White British ethnic background and 2 from Asian/Asian British ethnic backgrounds.

In 2011, female deaths from suicide or undetermined injury were generally older, a mean age 49.6 years, age range 33 to 57 years. 3 of the 5 female cases were aged 50-59. This is a change to previous years when the age of female cases has generally been lower. There were 4 cases in people aged 20-29, all of whom were male.

In the 20 cases where ethnicity was recorded, 4 were female and 16 male. The cases from White/White British ethnic backgrounds included 15 males and 3 females; there was 1 male and 1 female case from Asian/Asian British ethnic backgrounds.

The most frequent means of death from suicide and undetermined injury are hanging and overdose. In 2011 there were 13 cases of hanging, 5 were deaths from self-poisoning. There were 7 'other causes', which included jumping from a height, being knocked over by a train, drowning, exsanguination and burning. With regard to other factors associated with all 25 cases which merit consideration, 6 were recorded by the coroner as having taken alcohol at the time of death.

Where recorded, the substances taken in cases of suicidal death by overdose include; Zopiclone (a treatment for insomnia); Amitriptylene, Citalopram, Mirtazapine, Venlafaxine (treatments for depression); Phenobarbital (used in treatment of epilepsy); Chlordiazepoxide (used for short term treatment of anxiety and alcohol withdrawal) and Dihydrocodeine (a treatment for pain relief). This continues a trend, noted in 2010 towards overdoses of medications used in the treatment of depression and anxiety and away from overdoses of Paracetamol.

Home was the location of death for 15 cases. There were 2 other deaths which appear to have been at private properties, one of which was in Leicestershire. Locations of death for the 8 other cases included: Victoria Underground Station; the Grand Union Canal near Braunstone Gate, Leicester; a public park near Coleman Road, Leicester; the M1, south of Junction 21. Other cases died in hospital, 3 at the Leicester Royal Infirmary and 1 at Selly Oak Hospital, Birmingham. Of the cases whose place of death was recorded as a hospital, 1 person had jumped from a height from the Highcross Shopping Centre Car Park.

Of the 5 female cases there was 1 who died as a result of hanging, 1 as a result of an overdose. The 3 other cases included drowning, burning and jumping from a height. In previous years, overdose has been the leading means of death in female cases. 14 cases had their marital status recorded, 8 were married and 6 single. All 6 of the cases who were single were male. 2 of the 8 married cases were female.

Evidence

Suicide prevention is a major public health issue²⁶⁷; it is a target in the *Public Health Outcomes Framework*²⁶⁸ and is highlighted in the cross-governmental mental health strategy *No health without mental health*.²⁶⁹ More than 4,200 people took their own life in 2010. The *National Suicide Prevention Strategy for England* was launched in 2002 and renewed in 2012.

The likelihood of a person taking their own life depends on a number of factors, including:

- Gender; males are 3 times more likely to take their own life than females
- Age, people aged 35-49 have the highest suicide rate
- Mental illness
- The treatment and care that they receive after making a suicide attempt
- Drug and alcohol misuse
- Physically disabling or painful illnesses

Stressful life events may also have an impact, including:

- The loss of a job
- Debt
- Living alone, social exclusion or isolation
- Bereavement
- Family breakdown and conflict including divorce and mental illness within the family
- Imprisonment

For some people who take their own life, a combination of factors may be involved. Stigma, prejudice, bullying and harassment appear to increase a person's vulnerability to take their own life.

Durkheim²⁷⁰ suggested that suicide varies inversely with the degree of individuals' integration in social groups with which they engage. There is also an association between low socio-economic position and suicide rates²⁷¹. Suicide rates are generally higher in urban than rural areas. Low income, unemployment and low educational achievement are generally associated with higher suicide risk, although this may not be the case in psychiatric patients²⁷².

With regard to the risk factors associated with suicidal thoughts, the Office for National Statistics²⁷³ suggests that high risk factors include; a major financial crisis (29%), having a problem with the police or a court appearance (27%) and having looked for work for one month or over (23%).

Higher rates of lifetime suicidal **thoughts** were found among people who had been homeless (48%), ran away from home (45%), experienced violence in the home (44%) and had ever been expelled from school (41%). Over half of those who reported experience of sexual abuse also reported having had suicidal thoughts during their lifetime.

With regard to **attempted** suicide the ONS found that some of the major risk factors were:

- 12% of those people who had experienced a problem with the police or a court appearance, 10% of those who had experienced a major financial crisis and 8% of those who had looked for work for one month or more had attempted suicide at some time in their life.
- Between 22% and 26% of people who reported running away from home, being homeless, having experienced sexual abuse and having experienced violence in the home had attempted suicide at some time in their life.
- Women with a severe lack of social support were over five times more likely than those with social support to have attempted suicide in their lifetime (16% compared with 3%) and twice as likely to have attempted suicide than men (8%).

- 12% of all respondents with a primary support group of three or less had attempted suicide in their lifetime, compared with only 3% with a social group of nine or more people.
- Amongst the general population 13% reported having suicidal thoughts, 4% have attempted suicide and 2% deliberate self-harm at some time in their lives.²⁷⁴ Most of the variation in suicide rates by occupation can be explained by socio-economic factors. However there is an excess risk in occupations with easier access to means, such as farmers (who have access to firearms) and health professionals (where there is an increase rate of self-poisoning).²⁷⁵

Evidence from reviews of the risks and protective factors for suicidal behaviour suggests that there are higher rates of suicide in certain groups:²⁷⁶

Mental Illness: Review evidence shows that mental health disorders are found in at least 90% of cases of suicide, more than 80% of whom are untreated at the time of death.²⁷⁷ This includes the range of mental illnesses and a history of psychiatric treatment in general. In schizophrenia and borderline personality disorder suicide risk appears to be elevated around the time of first diagnosis. For bipolar disorder and schizophrenia the elevated risk was found to be associated with other risk factors, such as a history of suicide attempts, other psychiatric diagnoses, drug or alcohol misuse, anxiety, recent bereavement, severity of symptoms and hopelessness.

The primary diagnoses among the cases of suicide in England and Wales in the period 2003-05, who were in contact with mental health services in the year before their death were: affective disorder (46%), schizophrenia or other delusional disorder (18%), personality disorder (9%), alcohol dependence (7%) and drug dependence (2.5%).²⁷⁸

The National Confidential Inquiry into 6,367 suicides in current or recent mental health patients in England and Wales between April 2000 and December 2004²⁷⁹ found:

- Psychiatric inpatients and people who had just been discharged from inpatient care are at very high risk of suicide. There were high rates among people who absconded or were in transition from ward to community
- High rates of co-morbidity of mental illness and substance misuse among cases of suicide

In another study the ONS found that 70% of a sample of people with a diagnosis of a psychotic illness had thought about suicide at some time in their lives and 45% had attempted suicide. In addition, 21% had harmed themselves without intending to commit suicide.²⁸⁰ High levels of neurotic symptoms have also been shown to be associated with suicide attempts.²⁸¹ Approximately 25% of people who completed suicide in the UK had been in contact with mental health services in the year before death; this represents around 1,500 people per year in the UK.²⁸²

Self-harm: There are many types of self-harm, occurring in different contexts and with different motives for the individuals involved. Although self-harm is a manifestation of emotional distress, it may not reveal an intention to die.²⁸³ However, people who self-harm have a much greater risk of dying by suicide compared with those who do not.^{284 285} Cooper et al found self-harming behaviour to have an approximately 30-fold increase in risk of suicide, compared with the general population.²⁸⁶

Substance Misuse: Alcohol intoxication may trigger suicidal impulses in vulnerable people, and substance abuse may enhance vulnerability through depression and social isolation. Intoxicants are also often part of the suicidal act. Substance misuse increases the risk of suicide attempt and death by suicide. The risk associated with opioid use and mixed intravenous drug use was found to be

greater than that for alcohol misuse. The risk of suicide associated with alcohol misuse is greater among females.

Epilepsy: There is an increased suicide risk associated with epilepsy, which varies across different types and with the degree of severity of the effects of the illness. People with temporal lobe epilepsy, or those who have had temporal lobectomies or surgical resections, have a greater risk of suicide.

Personality traits: There is evidence of higher suicide risk in people with a range of personality traits including hopelessness, neuroticism, extroversion, impulsivity, aggression, anger, irritability, hostility, anxiety, attention deficit hyperactivity disorder (ADHD) and eating disorders such as anorexia nervosa and bulimia and low problem solving skills.

Occupation: Unemployment is linked to elevated risk of suicide. Generally occupational social class and suicide and deliberate self-harm are inversely linked; the lower the social class, the higher the risk of suicidal behaviour. However, there are exceptions in that the highest proportional mortality rates for suicide were found in certain occupational groups, such as medical doctors and farmers. Within the medical profession female doctors have a higher risk of suicide than their male counterparts.

Poverty: Poverty and deprivation are linked to suicide risk at an ecological level. Areas with greater levels of socio-economic disadvantage have higher suicide rates.

Sexuality: Lesbian, gay and bisexual people are at increased risk of self-harm and suicide. Anxiety, depression, alcohol and substance misuse have been found to be at least 1.5 times more common in LGB people. Higher rates of mental ill health could be partly attributable to social hostility, stigma, discrimination, social exclusion and difficulty in accessing mainstream mental health care services faced by LGB people.

Ethnicity: Given the diversity of Leicester there is a need to obtain as much information as possible about the ethnic backgrounds of people who die as a result of suicide or undetermined injury. However, ethnicity is not recorded on death certificates in the UK so accurate data is not available, although a recent study found that there was high rate of cases of suicide in older females of south Asian ethnic backgrounds.²⁸⁷

Students: Students in higher education represent a unique group in which to describe the epidemiology of mental illness. They broadly fall into the age group of 17–25 years. This age span encompasses the transition from adolescence to adulthood. It is a high-risk period for onset of illnesses such as schizophrenia and bipolar disorder, anorexia nervosa, and illness related to substance misuse.²⁸⁸ Eisenberg et al estimated the prevalence of any depressive or anxiety disorder to be 15.6% for undergraduates and 13.0% for graduates.²⁸⁹

The rates of suicide and deliberate self-harm among children and young people have increased dramatically over the past 20 years.²⁹⁰ Between 1990 and 1999, there were 1,482 full-time student deaths from suicide or undetermined causes in England, Wales and Scotland, 1,111 were males, 371 were females.²⁹¹ Risk factors appear to focus on times when students are under stress.

The wider risk factors for mental disorders and the student population include financial poverty and lack of social support. According to the report Mental Health of Students in Higher Education, self-injury among students is associated with symptoms of depression and anxiety, cigarette smoking,

suicidal thoughts, symptoms of eating disorders and, in the case of men, growing up in a low socioeconomic status household.²⁹²

Prisoners: The number of suicides in prison in England and Wales has increased in recent years.^{293 294} Prisoners are predominantly socially disadvantaged young men, a group in whom the suicide rate has increased in society generally.²⁹⁵ The prevalence of important risk factors for suicide, such as mental illness and drug and alcohol misuse, is higher in prison than in the community.²⁹⁶ The prison environment itself may increase suicide risk.²⁹⁷

Protective Factors

McLean et al²⁹⁸ found that resilience factors are better predictors of suicidal behaviour than the degree of exposure to stressful life events. A number of factors appear to protect people from taking their own lives, including:

Coping skills: Problem-solving skills may be protective against suicidal behaviour among those who have attempted suicide. Nevertheless, there is conflicting evidence on the interplay between the suicide risk factor of hopelessness and problem-solving-based coping skills. One study showed that problem solving may mediate against hopelessness among adults who have attempted suicide; another demonstrates that hopelessness can mediate against the protective effect of problem-solving-based coping.

Reasons for living: High levels of reasons for living, future orientation and optimism protect against suicide attempt among those with depression. There is some evidence that those who have previously attempted suicide can develop coping strategies to protect themselves against future suicidal behaviour.

Physical activity and health: There is some evidence that an attitude towards sport as a healthy activity and participation in sporting activity is protective against suicidal behaviour among adolescents. A perception of positive health may be protective against suicide among females who have experienced sexual abuse.

Family connectedness: Good relationships with parents can protect against suicide risk, especially in adolescents, including those who have been sexually abused. Positive family relationships also provide a protective effect for adolescents including those with learning disabilities.

Having children living at home is protective against suicide for women; however, another study indicates that this protective effect may not exist among women who are HIV-positive.

Marriage is generally a protective factor against suicide. Marriage may have a protective effect against socio-economic inequalities related to suicide, particularly for men. It is important to consider other confounding variables including the finding that married men were less likely than non-married men to have problems with drugs, sex, gambling and having used or currently using psychiatric medicine.

Supportive schools: Supportive school environments, including access to healthcare professionals, are important protective factors among adolescents including those who have experienced sexual abuse, those with learning disabilities and those who are from the lesbian, gay, bisexual or transgender community.

Social support: Social support in general is protective against suicide among a range of population groups.

Religious participation: Evidence suggests that religious participation may be a protective factor against suicidal behaviour. However, this can vary according to the level of secularisation within a country or community, and social and cultural integration.

Moral sanctions against suicide promoted by members of a religious community may have wider protective effect on the non-religious members of a community where the religious members are in the majority. Other factors, such as the observance of traditional cultural rituals, may have a stronger protective effect.

Impact of economic recession

Barr et al²⁹⁹ conducted a study to determine whether the English regions worst affected by the economic recession in the United Kingdom in 2008-10 also had the greatest increases in suicides. They estimated that the UK recession has led to about 1,000 excess suicides in England: 846 among men and 155 among women.

The analysis indicated that increases in male unemployment were associated with about 40% of the increase in male cases in England during the recession. Those areas with greater rises in unemployment also experienced higher rises in suicides; this rate was significant only among men.

The study linked a small reduction in suicides in 2010, with a slight recovery in male employment. It also suggested that women seem less likely to harm themselves in response to unemployment, suggesting an increased degree of resilience among women.

Means

Research indicates that the likelihood of a person taking their own life will, to some extent, depend on the ease of access to, and knowledge of an effective means. One reason for this is that suicidal behaviour is sometimes impulsive. If a lethal method is not immediately available then a suicidal act may be prevented.

The most frequently used methods of suicide are hanging and self-poisoning by overdose. There are sometimes high risk locations, such as car parks, bridges and railway stations.

Suicide Prevention Strategy

The Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group comprises of a number of key stakeholders across the statutory and voluntary sector to audit local cases of death from suicide and undetermined injury, to raise awareness of the risks of death from suicide and to influence best practice to reduce the number of local cases. The group aims at local implementation of the cross cutting Suicide Prevention Strategy for England³⁰⁰, which set out 2 overall objectives:

- A reduction in the suicide rate in the general population in England; and
- Better support for those bereaved or affected by suicide.

The strategy identifies six key areas for action to support delivery of these objectives:

- Reduce the risk of suicide in key high-risk groups

- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring.

NICE Guidance on Self-harm

The NICE Guidance on [Self-harm](#) (CG16) (2004) outlines the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.

In November 2011 a number of recommendations were replaced with recommendations from [Self-harm: longer-term management](#) (NICE clinical guideline CG133).

The NICE clinical guideline on self-harm covers:

- the care people who harm themselves can expect to receive from healthcare professionals in hospital and out of hospital
- the information they can expect to receive
- what they can expect from treatment
- what kinds of services best help people who harm themselves

It highlights key areas for implementation, which are:

Respect, understanding and choice: People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

Staff training: Clinical and non-clinical staff in contact with people who self-harm should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Triage: All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. This assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness. If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many people, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

Treatment: People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.

Assessment of needs: All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

Assessment of risk: All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological

characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Gaps, Findings and Recommendations

The rate of death from suicide includes deaths from self-inflicted injury and deaths for which the cause of the injury was undetermined. Cases are decided by the coroner. From a medical and mental health perspective some verdicts, including open and misadventure, may have been viewed as suicide. Coroners' verdicts are often 18 months after a death has occurred, there is a need therefore for real time surveillance to ensure that key learning from incidents are shared in a timely fashion. .

Evidence suggests that the act of a person taking their own life is often impulsive and dependent on different factors in addition to mental illness, such as the presence of a physically disabling or painful illness; alcohol and drug misuse; deprivation and the level of support that a person receives. Stressful life events such as the loss of a job, imprisonment, a death or divorce may also play a significant part. For many of those who take their own life it is the combination of factors which may be important. There is a need therefore to raise awareness of the issue of suicide and to audit and learn from cases where people have taken their own lives.

Each case is a tragedy for individuals, their families, friends and colleagues. There is a need to support those who are bereaved by a case of suicide.

In Leicester, on average, approximately 32 people take their own lives each year. The rate for suicides is calculated on a 3 year rolling average. In the period 2009-2011 there were 90 deaths from suicide and undetermined injury in Leicester, giving a rate of 10 per 100,000. As there are a small number of suicides each year in Leicester, an increase or reduction in the numbers can result in a large change in the rate. Furthermore, as deaths from suicide and undetermined injury disproportionately affect younger people, it is a cause for a high proportion of years of life lost. Most deaths occur as a result of hanging or overdose; most occur in a person's own home. The rate is higher among males.

The incidence of self-harm is different, in that it occurs equally among males and female and the population affected is generally younger. Commissioners should ensure that the current guidance on self-harm is being implemented by key stakeholders.

It is recommended that commissioners consider:

- Work with key stakeholder to develop real time surveillance of information to enable better review and response to deaths from suicide.
- There should be continued efforts to raise awareness about suicide and self-harm amongst the general public and professionals.
- There should be support for those who self-harm or who are affected by acts of self-harm.
- The NICE guidelines on self-harm should be followed so that individuals who self-harm receive an assessment of need and access to relevant support.
- Support people who are bereaved by suicide
- Local trends in suicide continue to be audited in order to inform local delivery and actions

Offenders

This needs assessment has shown there to be links between poor mental health and the wider determinants of mental health and wellbeing. The report *Psychiatric Morbidity among Prisoners*³⁰¹ indicated that approximately 90% of prisoners have a psychotic, a neurotic or a personality disorder or suffer with a substance misuse problem which has an effect on their mental health. Prisoners are also likely to have with more than one problem concurrently, with remand prisoners more likely to suffer with multiple problems. As a Category B Local Prison, for male prisoners, HMP Leicester has a large throughput of prisoners, including those on remand, making mental healthcare in the prison a major challenge. Studies also show a higher level of need for mental health services, and worse outcomes, for offenders in the community than in the general population.

The risk of suicide is heightened particularly for those on remand or new to a prison; those who have been in prison for less than one month have higher rates of suicidal thoughts. The rate of suicide amongst offenders in general is approximately 4 times that in the general population, with death most likely to occur within 12 weeks of release from prison.

Initiatives to improve mental healthcare for prisoners and offenders include the development of mental health in-reach teams and the transfer of prison healthcare to the NHS. There has also been guidance concerning how to improve mental health provision for offenders in general and in particular to improve access to mental health services for 16 and 17 year olds, as people in this age group are responsible for the majority of youth crimes and for the more serious crimes.

Evidence from the literature

Offenders are a high-risk group for social exclusion and mental ill health. There are high rates of mental illness and suicide among this group. Certain groups within the prison population, such as women, young offenders and those with learning difficulties or disabilities, are at even greater risk of poor health outcomes³⁰².

Substance misuse has a particular impact on the health and wellbeing of people in the criminal justice system. With regard to alcohol consumption, for example, Robertson et al³⁰³ and Bennett³⁰⁴ found that between 22% and 25% of detainees were under the influence of alcohol on arrival at police stations. Stark and Gregory³⁰⁵ found that 69% of people who were arrested had a positive urine sample test for at least one drug.

However, Franklin³⁰⁶ found that forensic medical examiners were reluctant to enquire about alcohol use and a general reluctance to prescribe medication which could help offenders who misuse substances³⁰⁷. Singleton et al³⁰⁸ identified drug dependency in 43% of male and 52% of female remand prisoners and in 34% of male sentenced and 36% of female sentenced prisoners.

Reports emphasise the potential harm to a person's mental health which could be caused by these factors. Singleton et al³⁰⁹ showed that mental illness is over represented in the prison population. Approximately 90% of prisoners were shown to have at least one mental ill health problem, a figure which includes alcohol abuse and drug dependency. The study shows the significance of particular themes within psychiatric morbidity. 7% have severe and enduring mental health problems, and nationwide 1,000 prisoners per year are transferred to secure mental health accommodation.

There are differences between remand and sentenced prisoners. For instance the prevalence of personality disorder was 78% of male remand prisoners compared with 64% of male sentenced prisoners. Neurotic disorders were prevalent in 59% of male remand prisoners and 79% of the

female remand prison population. In contrast, the prevalence of neurotic disorders was less amongst sentenced prisoners (40% of male and 63% of female).

There are higher rates of co-morbidity of mental illness and substance use amongst prisoners and offenders when compared with the population in general. Singleton et al³¹⁰ found that 12-15 % of sentenced prisoners have 4 or 5 co-occurring mental disorders, with higher prevalence rates among older people, women and ethnic minority groups. Dual diagnosis³¹¹ significantly increases the problems faced by prisoners in accessing services.

Despite the evidence showing a high prevalence of mental ill health amongst prisoners and offenders, the treatment which is delivered is of a variable quality and services are not integrated. Reed et al³¹² showed that the quality of services for mentally ill prisoners was below the standard set in the NHS. A study by Wolff et al³¹³ shows that this is not a problem confined to Britain. Yet this problem is one which has been recognised for some time. The former Chief Inspector of Prisons, Sir David Ramsbotham said in the 1990s that,

“Prisoners should be entitled to the same level of health care as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated, counselled and nursed to the same standards demanded within the National Health Service”³¹⁴.

It was as a consequence of such inequality that responsibility for commissioning health services for the prisoner population transferred to the NHS.

As there is less evidence concerning the health of prisoners in the period following release from prison there has been a move to redress the balance by focusing upon offender healthcare rather than simply the healthcare of prisoners³¹⁵. Given that services are not co-ordinated following release, set against the improvement in the delivery of prison healthcare, policy makers have suggested that there is a possibility that health needs could in fact worsen after a prisoner is released^{316 317}. On release, for example, there is increased opportunity for drug and alcohol use.

If there is no co-ordination of services on release, former prisoners may experience difficulty in gaining access to mainstream health services. Recently released offenders favour the use of crisis services, such as Emergency Departments, and do not have access to preventative healthcare or health promotion activities³¹⁸.

Of the evidence concerning post-release and issues concerning the health of offenders being managed in the community, Solomons and Rutherford³¹⁹ note a lack of information about mental ill health, whilst Brooker et al³²⁰ suggest that the contention that offenders in the community have poor health is largely anecdotal, with community trends extrapolated from research conducted in prisons³²¹. Nadkarni et al³²² were not aware of any studies of mental health morbidity amongst residents of probation and bail hostels, although they suggest that this population could share the uncertainty of prisoners on remand and could therefore have higher levels of psychiatric morbidity than the population in general.

The impact of not meeting the mental health needs of prisoners is further shown in the findings of Verger et al³²³ who studied the mortality of 1,305 French prisoners following release from prison in 1997. They found that the mortality rates from non-natural causes were significantly higher in the 15-34 and 35-54 age groups than the general population. Standardised rates of suicide are also higher amongst prisoners than the general population.

Keene et al³²⁴ identified that 13.6 % of the total probation population were in contact with a local mental health trust. The proportion was higher amongst female offenders (19.6%). It also showed that there was little co-ordination of services in meeting the mental health needs of this population. Only 53% of offenders who were assessed as having poor mental health were in contact with mental health services, whilst there were 445 probationers who had not been assessed as having mental health problems did have contact with a local mental health trust.

Long term conditions also have an effect on offenders. Mair and May³²⁵ conducted interviews on a sample of 1,213 offenders and ex-offenders on probation caseloads, part of which concerned health status. They noted that self-reported physical and psychological problems were higher in the study group than in the general population. With regard to the physical health of offenders, there were high rates of musculoskeletal and respiratory problems. A high proportion of the offender population also reported an expectation of having a long term health problem lasting at least 6 months (49%). 46% of male probationers between 16-44 years of age reported long term illness or a disability compared to 26% in a matched age group in the general population. They concluded that there is clear evidence of a higher incidence of self-reported health problems in the population of probationers which is similar to the high rates amongst prisoners. Both offender groups self-reported health problems which exceed those found in the general population.

Fazel et al³²⁶ suggest that rates of physical ill health are higher among older prisoners. They interviewed 203 men from 15 prisons, with the result that 83% reported a chronic illness. The most common illnesses were psychiatric, cardiovascular, musculoskeletal and respiratory. The group concluded that rates of chronic morbidity in older prisoners are higher than those reported in studies focusing on younger prisoners, and those found in surveys of the general population of a similar age.

Against this background of vulnerability some argue for the development of integrated or specialist services to meet the needs of offenders. Evidence from Manchester³²⁷ suggests that community sentenced young offenders benefit from nurse led programmes in health promotion. The secondment of nursing staff into Youth Offenders Teams can have an impact in offering primary care to a group of people to whom it would not normally be readily available. Maeve³²⁸ showed the benefit of extending nursing care into the community following release, suggesting that nursing has a unique position in the development of interventions which may help individuals during and following imprisonment.

An integrated approach to the healthcare of prisoners could also be effective with regard to communicable disease. UK prison healthcare programmes look to health protection against blood borne viruses which may be acquired through sexual activity or substance misuse. These include health protection programmes for Hepatitis A, B and C and health promotion about the risks of HIV. Allwright et al³²⁹ showed that in Irish prisons drug use and tattooing were risk factors for new prisoners. Wexler et al³³⁰ showed that health education can protect against infection. Seal et al³³¹ suggested that such programmes are also needed to support prisoners in the post-release period. The importance of health promotion to the issue of offender health has been recognised by the Department of Health³³², which showed that of those who inject drugs 20% had Hepatitis B and 30% Hepatitis C. In addition 80% of prisoners were found to smoke.

An integrated programme of health and social care services, for incarcerated offenders, those offenders preparing for release and those who are in the community, should also cover issues such as housing, employment and leisure. For example, Kushel et al³³³ found that despite high levels of health risks among all homeless and marginally housed people, those for ex-prisoners were even higher and that efforts to combat homelessness should cover release programmes.

HMP Leicester

HMP Leicester is a Category B Local Prison for adult males. Local prisons hold prisoners who have been remanded in custody by the courts. In addition, prisoners are often held in local prisons when they are first sentenced or if they are sentenced for a short term of imprisonment. Table 20 shows the frequency, proportion and expected number of prisoners to have a problem linked to mental ill health, based on an average daily population of 355 prisoners. It shows that the majority of prisoners are likely to suffer with mental health problems, with high rates of drug and alcohol dependency, suicide ideation or self-harm and homelessness.

Table 20: Frequency and proportion of mental illness, drug and alcohol dependence, suicide and homelessness in a sample of prisoners at HMP Leicester

	Frequency	Proportion %	95% Confidence Interval		Range based on ADP = 355
			Lower	Upper	
Total prisoners studied	94	100			
Have mental ill health problems	57	60.6	50.5	69.9	179-248
Have drug dependency	49	52.1	42.1	61.9	149-219
Have alcohol dependence	28	29.8	21.5	39.7	76-141
Suicide ideation/Self-harm	23	24.5	16.9	34.0	60-121
Homeless	16	17	10.8	25.9	38-92

Open Mind IAPT and Probation Trust

Leicestershire Partnership Trust and Leicestershire and Rutland Probation Trust are currently working together to deliver psychological therapy to offenders in the community. The objectives of this initiative are learn about ways care for people with chaotic lifestyles, joining health and Criminal Justice delivery to service users in a way that makes sense.

Preliminary reports, based on outcomes from referrals in the first 12 months of the project suggest that the whilst IAPT service users usually have mild to moderate common mental health disorders, those clients who are offenders in the community generally present with more severe problems. 67% had moderate-severe GAD7 scores, 54% moderate- severe PHQ9 scores and 75% moderate – severe, or worse in phobia and or social adjustment on assessment.

46% of clients referred to the service entered treatment, whilst 41% did not attend the first appointment, indicating the chaotic lifestyle of the client group. There is a recovery rate of 34%.

Anecdotal evidence from Offender Managers and self-reports from service users, imply that results are better than the figures suggest. Further analysis indicates that those who engaged made progress.

Case Study

A 34 year old male with a 24-month suspended sentence for a violent offence against an individual. He was an ex-veteran and a recovering alcoholic. Although he had no previous convictions, he admitted past aggressive incidents. His therapy issues included unresolved childhood issues, past experience of emotional and physical abuse. There were problems with his parents and unconscious sibling rivalry, poor attachment, sense of abandonment, difficulty establishing trust, and struggle to

form and maintain meaningful relationships.

He was found to have low self-esteem, low self-worth, diminished confidence; manifesting as depression and anxiety. He did not have insight into his anger.

With regard to treatment there was an emphasis on building therapeutic relationship using validation, empathic attunement and inquiry. It was essential to inquire about who failed to provide the developmentally necessary functions that should have been fulfilled by a responsible 'caretaker'

The work with attunement validated the client's needs and feelings, and this work then became the foundation for repairing the failures of previous relationships – in effect a corrective emotional experience.

- "I knew I had to look inside myself to understand why I made certain choices and behaved in certain ways".
- "Stepping back and looking at the way I thought and behaved made me start to recognise patterns of behaviour that led to negative emotions".
- "I have got to start valuing myself more and find emotional fulfilment in work".
- "I'm starting to learn, believe and hope for things, which I haven't done in years".
- "I can't say I am anywhere near perfect in trying to stop these patterns, but recognition is a big deal and I know I have a choice".

Commissioning services for offenders

The commissioning process for meeting the needs of offenders is complex. In addition to local health and social care commissioners, Leicestershire Police and HMP Leicester, the commissioning architecture includes the NHS England Area Team and the Police and Crime Commissioner. It will also include the probation structures which are currently emerging following the publication of *Transforming Rehabilitation - a Strategy for Reform*, by the Ministry of Justice in 2013.

This strategy includes provision of rehabilitation services to offenders sentenced to less than one year in prison, giving offenders continuous support by one provider from custody to community, driving innovation by focussing more strongly on outcomes and giving opportunities for those delivering services to work more flexibly to delivery "what works".

The existing structure for delivering services will end in 2014. In place of the current Probation Trusts, there will be a new, smaller, public sector National Probation Service to deliver core services of assessment, management of high risk of harm cases, services to victims, Courts and the Parole Board, plus other facilities such as structured sex offender treatment programmes and enhanced supervision delivered in Approved Premises.

The Police and Crime Plan³³⁴ from the Police and Crime Commissioner for Leicester, recognises the importance of the mental health agenda for offenders. **Strategic Priority 16 in the plan is to improving the response, service and outcomes for those with mental health needs.**

It suggests that Leicestershire Police are considering how they and partners can provide the best, most appropriate and timely service for people living with mental health conditions; and secondly, to reduce repeat demand from people in crisis living with mental health conditions.

In early 2013, the police refreshed their mental health strategy. This focus of the local Health and Wellbeing Boards on prevention and the coming together of key stakeholders, promises to help

create an excellent platform from which partners can agree common areas of concern. This can then result in a joint plan of work to achieve mutually agreed outcomes.

Responding to, and dealing with, incidents relating to mental health crisis, despair, and vulnerability occupies a significant proportion of front line police officer time both locally and nationally. Over a twelve month period, Leicestershire Police dealt with more than 8,000 such incidents, which amounts to 22 incidents a day, and 15% of all police incidents. Of these, 384 relate to reports of people 'missing from home', with many involving some of the most vulnerable people in our society, including young people in the care of the local authority or people with dementia. There is a clear need therefore for health and social care to work with the police to develop shared frameworks for mental health and wellbeing care pathways.

Gaps, Findings and Recommendations

The commissioning architecture for the mental health of prisoners and offenders is complex, and includes local health and social care bodies, NHS England and the Police and Crime Commissioner. This requires greater monitoring and collaboration when developing the mental health care pathway for prisoners and offenders.

Approximately 90% of prisoners have a psychotic, a neurotic or a personality disorder or suffer with a substance misuse problem which has an effect on their mental health. Prisoners are also likely to have with more than one problem concurrently, with remand prisoners more likely to suffer with multiple problems. As a Category B Local Prison, for male prisoners, HMP Leicester has a large throughput of prisoners, including those on remand, making mental healthcare in the prison a major challenge.

Studies also show a higher level of need for mental health services, and worse outcomes, for offenders in the community than in the general population. There is a need to develop improved care pathways for offenders in the community and on release from prison, with particular focus upon health and social care services.

Initiatives to improve mental healthcare for prisoners and offenders include the development of mental health in-reach teams and the transfer of prison healthcare to the NHS. There has also been guidance concerning how to improve mental health provision for offenders in general and in particular to improve access to mental health services for 16 and 17 year olds, as people in this age group are responsible for the majority of youth crimes and for the more serious crimes. However, more work is needed to ensure that frameworks and accessible pathways are developed for prisoners and offenders. It is recommended that commissioners consider:

- Develop improved care pathways for offenders in the community and on release from prison, with particular focus upon health and social care services, in particular those which relate to mental health. This should include improved access and co-ordination with Probation Services and successor organisations.
- Initiate greater monitoring of services and arrangements for offenders with mental ill-health.
- Consider the mental health needs of offenders and addressed collaboratively by the Health and Well-being Board.
- Develop accessible pathways into alcohol and drug treatment for offenders in the community, building on treatment which has been undertaken in prison.

Dual diagnosis

The co-existing problems of mental ill health and substance misuse represent a difficult challenge for mental health services. Elements of care, such as diagnosis and treatment are difficult and service users represent high risk of relapse, readmission to hospital, self-harm and suicide. Substance misuse among people with mental health problems is usual rather than exceptional; treatment for substance misuse problems often improves mental health; and the healthcare costs of untreated people with dual diagnosis are likely to be higher than for those receiving treatment.

People with co-existing mental illness and substance misuse disorders have high rates of physical ill health. The provision of integrated care for people with a combination of mental health problems and substance misuse requires an effective links across health, social care, and the voluntary sector and criminal justice services.

Mental health and risk taking behaviour

Risk behaviours: There is a strong social gradient in health so that relative deprivation is a catalyst for a range of negative emotional and cognitive responses to inequity³³⁵. People with severe mental health problems are more likely to have poor diets, engage in less exercise, smoke heavily and be dependent on alcohol thus increasing the risk of illness such as cardiovascular disease.

Dual diagnosis: Dual diagnosis is not a diagnosis in itself; rather it refers to individuals who have both mental health and substance misuse disorders. Often the terms dual diagnosis and co-morbidity are used interchangeably. Dual diagnosis and co-morbidity do not cover the spectrum of mental illness. Individuals who have dual diagnosis are vulnerable and have complex needs. Compared to people with mental ill health alone, those with dual diagnosis have a poorer prognosis, they have high rates of health service use, including high use of emergency departments and inpatient care. This is combined with high levels of social care needs, which are exacerbated by isolation.

According to Banerjee et al³³⁶, in comparison to those who have a mental health problem alone, people with dual diagnosis are more likely to have:

- Increased likelihood of suicide
- More severe mental health problems
- Homelessness and unstable housing
- Increased risk of being violent
- Increased risk of victimisation
- More contact with the criminal justice system
- Family problems
- History of childhood abuse
- More likely not to receive care
- Less likely to be compliant with treatment

Alcohol: Mental illness increases the risk of alcohol problems: common mental illness doubles the risk of alcohol dependency and severe mental illness triples the risk³³⁷. Alcohol misuse and mental disorders exacerbate each other. Anxiety, depression, low self-esteem and lack of success in attaining life goals are associated with drinking among adolescents³³⁸. Alcohol abuse by young people increases the risk of depression by a factor of six, and there is a reciprocal relationship between depression and alcohol abuse³³⁹.

Effects of alcohol on mental health: Mental disorders such as depression, anxiety and psychosis increase the risk of misusing alcohol. Excessive alcohol consumption may increase risk of suicide and dementia. Evidence suggests that the risk of hazardous drinking increases following two or more stressful life events³⁴⁰. For example, experience of sexual and physical abuse in childhood is significant in the development of alcohol problems in women (although not in men with similar traumatic experiences)^{341 342}. A third of suicides in young people are associated with alcohol intoxication; 65% of adult suicides are associated with excessive drinking³⁴³. Heavy drinking may be a factor in one in four cases of mental health and wellbeing³⁴⁴.

Drugs: According to the *Dual Diagnosis Toolkit* drugs can be described as any substance that, by its nature, alters the structure of functioning of a living being. Although this definition is broad, and can include everyday socially accepted drug use, such as caffeine, it is useful because it can help in the understanding of drug use and the challenges involved in changing patterns of behaviour.

The *Toolkit* uses work by Drugscope to define drug use and misuse. The former refers to drug taking which, although it is associated with risk, is not necessarily wrong or dangerous. The latter implies use other than medicinal, which is harmful or done in a wrong way. It refers to use which is dependent or part of a pattern of problematic or harmful behaviour.

There are a number of factors which could affect substance use, for example, environment/culture, a person's mood and the plasticity of the drug. In addition the legal status of the drug does not necessarily reflect how harmful it can be. Estimates suggest that there are 3.8 million dependent alcohol drinkers in England and Wales, which is 6 times the number of people dependent on Class A drugs. Harm does not always reflect the damage to the drug user it also reflects the broader effects of substance use in society, such as the links between alcohol, drugs and crime.

It is estimated that there are around 33,000 people in Leicester who are hazardous drinkers, 11,000 people are harmful drinkers and about 3,500 are dependent on alcohol³⁴⁵. The misuse of alcohol contributes to chronic ill health and a range of social problems.

With regard to the type of substance use, the *Toolkit* highlights the following:

Experimental drug use may be part of an overall pattern of development, such as a person getting drunk for the first time. However, evidence suggests that the number of people experimenting is increasing and the age at which they experiment is gradually decreasing.

Recreational drug use can be applied to legal and illegal substances. It is considered to be regular and controlled, and can be stopped at any time.

Polydrug use is the utilisation of more than one drug by an individual, either as part of a cocktail or one after another.

Dependency describes the compulsive use of a drug or drugs either to feel good or to stop feeling bad. It is often attributed to physical or psychological factors. Psychological dependency implies a strong desire to use a drug in spite of negative consequences or with the knowledge that to take it could be harmful. Physical dependency suggests the need to use a drug to avoid the physical discomfort of the symptoms of withdrawal. It results from the frequent, heavy use of drugs such as heroin, tranquillisers and alcohol. Such symptoms can reinforce the dependent behaviour. Generally psychological and physical dependence are due to the biological effects of drugs on the nervous system.

The use of volatile solvents, such as glues and gases, to achieve psychoactive effects is generally restricted to a small number of young people of school age, with its use intermittent and brief. Data suggests that lifetime prevalence rate of volatile solvent use to be 3% across people aged 16-59 and 6% across those aged 16-24³⁴⁶. 2 per cent of young people aged 16-19 report using solvents in the previous year and 1% in the previous month.

International studies have shown that prolonged use of cannabis can lead to respiratory, psychological and interpersonal problems^{347 348}. In addition affective and behavioural symptoms may follow the cessation of chronic cannabis use^{349 350}. The majority of participants sampled in chronic cannabis use studies appear to meet the clinical criteria for dependence. Those seeking help for cannabis problems are likely to have withdrawal symptoms during periods of abstinence. In the UK, the most prevalent substance in the broad group of hallucinogenic amphetamines is MDMA; 'Ecstasy'. Although there is widespread use of Ecstasy, few people present to specialist treatment services with Ecstasy related problems. On rare occasions the use of such amphetamines and cocaine can lead to subarachnoid and intra-cerebral haemorrhage. There have also been studies which have reported that long term neuro-degeneration may result from amphetamine use. Other studies have suggested that the regular use of Ecstasy can lead to the user experiencing withdrawal problems, such as mood and concentration problems.

With reference to the psycho-social needs associated with drug use the Stimulant Needs Assessment Project interviewed 541 cocaine and amphetamine users, of whom 33% had used Ecstasy in the previous month. Polydrug use was the norm amongst the sample, with cannabis, heroin and LSD use being reported in the previous month. In the sample 20% considered that they needed help in managing and controlling their use of stimulants and related problems.

Up to 50% of people with illicit drug use problems in specialist treatment programmes are heavy alcohol users and have alcohol related problems^{351 352}. Excessive alcohol and tobacco smoking are established aspects of the lifestyles of some clients in the methadone maintenance treatment (MMT)³⁵³. Evidence also suggests that the MMT clients who are alcohol dependent are more likely to have psychological problems and family and relationship difficulties when they undertake treatment.

Mental ill health linked to drug use

Anxiety disorders are the most common form of mental health problems, which affect around 14% of the population. Anxiety, worry and fear are felt by most people. However they become a problem when a person experiences them with a severity which makes it difficult for them to function. Post-Traumatic Stress Disorder is a particular anxiety disorder which results from a traumatic experience or witnessing life threatening events. With respect to dual diagnosis, anxiety disorders can be brought on by alcohol and drug use, whereas alcohol and drugs may be used by people to cope with the symptoms of mental illness.

With respect to PTSD, for example, Chilcoat et al³⁵⁴ suggest that there are at least three hypotheses to explain the relationship with dual diagnosis. These are: self-medication of PTSD symptoms; the high risk of exposure to traumatic events by people who are drug users and that substance users are at greater risk of PTSD following a traumatic event.

PTSD has been linked to polydrug use. Hien et al³⁵⁵ found that in a sample of 49 women and 47 men seeking methadone treatment for opiate dependence, 30% of the women reported as history of sexual abuse and 2% of the men. 25% of the sample reported childhood physical abuse. Of these

60% of the people reported that the first episode of abuse occurred before the onset of substance use. According to Brady et al³⁵⁶, PTSD preceding cocaine use is more likely in women than men.

Brady³⁵⁷ reports that bipolar disorder has the greatest risk for co-existence with alcohol or drug use than any of the common mental health disorders. Cocaine is noted for its use in maintaining and intensifying the high of bipolar affective disorder rather than alleviating the symptoms of depression.

Patients with bipolar disorder have a high prevalence of substance abuse. In a study of 204 patients with bipolar disorder (Goldberg et al., 1999) 34% had past substance use. The substances used were alcohol (82%), cocaine (30%), cannabis (29%), hypnotic/amphetamine (21%) and other opiates (13%). Those with a history of dependency on substances were more likely to be male who have been divorced, separated or widowed. In addition they were more likely to have a history of non-compliance with medication and suicidal ideation. Those with mania were more likely to use alcohol and have a history of poor medication compliance.

In a study by Feinman³⁵⁸ those whose substance use began after the onset of bipolar disorder had the earliest mean age of symptoms of mental ill health (13.3 years) and the highest incidence of suicide.

There is a large body of evidence concerning the link between substance use and schizophrenia. Studies suggest that inpatient populations have a higher prevalence of dual diagnosis than outpatients. Fowler et al³⁵⁹ found that of 194 outpatients with schizophrenia those with current or lifetime dependence disorders were single young males whose accommodation was unstable. In addition they were associated with high rates of criminal behaviour. The rates of substance use or dependence in the last 6 months amongst this group were 26.8% and the lifetime rate was 59.8%.

Ries et al³⁶⁰ found that people with schizophrenia are three times more likely to abuse alcohol and six times more likely to abuse drugs than the population in general. Patients who were admitted for treatment with schizophrenia as part of dual diagnosis were more likely to be male, younger, and homeless and to have a history of assaulting. On admission those with dual diagnosis were significantly more suicidal. At discharge the dual diagnosis group had less severe hallucinations and delusions. Those with dual diagnosis had shorter inpatient stays and better responses to treatment, possibly as a result of the removal of substances as part of the care which had been delivered.

Prevalence and services in Leicester

The co-existing problems of mental ill health and substance misuse represent a difficult challenge for mental health services. Elements of care, such as diagnosis and treatment are difficult and service users represent high risk of relapse, readmission to hospital, self-harm and suicide.

Substance misuse among people with mental health problems is usual rather than exceptional. People with co-morbidity of substance misuse and mental ill health have a poor prognosis. There is a reciprocal relationship between the two issues. The most consistent predictor of a poor outcome for those receiving treatment for substance misuse is the presence of psychopathology. Substance misuse is a predictor of poor treatment outcome for mentally ill patients.

However, drug treatment outcomes can improve if mental disorders are treated, but treatment is often sub-optimal with clients often falling between services. Whilst there is a group of link nurses with a special interest in dual diagnosis at Leicestershire Partnership Trust, there has never been a formal dual diagnosis team. Once leadership is placed with mental health providers, formal links

and frameworks of practice may be developed. This may encourage integrated working with effective links across health, social care, and the voluntary sector and criminal justice services.

In the UK is estimated that 33% of psychiatric patients with serious mental illness have a substance misuse problem. In general evidence suggests that the prevalence of dual diagnosis is between 30% and 50% of psychiatric caseloads.

When estimating the prevalence of dual diagnosis for the purpose of this needs assessment, the 30%-50%, has been used. The figures are presented in the table below. This uses baseline figures for the working age adult population of Leicester which suggest the following:

Table 21: Estimated prevalence of dual diagnosis in Leicester

Population	Estimated prevalence in the population	Estimated number in Leicester	Estimated number of Dual Diagnosis based on prevalence assumptions	
			30% rate	50% rate
Dependent Drinkers		3,500	1,050	1,750
Solvent use	6% aged 16-24: 2007 mid yr est. 49,235	3,000	900	1,500
Illicit drug use	12% aged 15-59: 2007 mid yr est. 188,933	22,671	6,800	11,335
Class A drug use in last year	3% aged 15-59: 2007 mid yr est. 188,933	5,700	1,710	2,850
Cannabis use in last year	9% aged 15-59: 2007 mid yr est. 188,933	17,000	5,100	8,500
People with severe mental illness	2%-4%	3,500-7,000	1,050-1,750	2,100-3,500
Stress related mental illness or emotional problems		22,800	6,840	11,400
Common mental health problems team	3413 assessments 2006-7	3,413	1,023	1,706
Eastern Leicester PCT/City West PCT estimates for treated mental disorder	Annual figure: 18000	18,000	5,400	9,000
Quality and Outcome Framework data (QOF)	3200 people on registers	3,200	960	1,600
LPT caseload for Adult Mental Health services	Total reported for 2007: 4364	4,364	1,309	2,182
People claiming Incapacity benefit/Severe disablement Allow ance due to mental/behavioural disorders	36.9% of total in 2006 in East Midlands. Leicester total benefit claimants approx 16000	5,900	1,770	2,950
Specialised crisis support per year	1500 estimated from Crisis Resolution Team and assessments under Mental Health Act	1,500	450	750
Personality disorder	5.4% men 3.4% women	4,500 men 3000 women	1,350 men 900 women	2,250 men 1500 women
Prisoners at HMP Leicester	355 average daily population	205	96	160
Men and women who have suffered domestic violence	3,540 women 1670 men	1100 women 150 men	330 women 45 men	550 women 75 men
Sex workers with depression and PTSD		335	100	167
Gypsies and travellers	780	280	84	140
Asylum Seekers and refugees	3,000	2,000	600	1,000
Homeless	976	380	114	190
Physically disabling condition	10,000		3,000	5,000
Carers	10173	2700	810	1350

Common mental health problems affect between 29,000 and 33,000 people. The estimated number of people experiencing a severe mental health problem is between 3,500 and 7,000 people, and approximately 1,600 people have psychosis.

The number estimated to be seeking help from primary care is between 18,000 and 23,000 people, and Crisis Team referrals amount to 1,500 people. The Mental Health register from the Quality Outcome Framework for Leicester is currently about 3,200.

For example approximately 90% of Prisoners in a prison, such as HMP Leicester are likely to be suffering with mental ill health problems.

3,540 working age adult women, 1,670 men in Leicester will have experienced physical domestic violence in last year; 440 working age women will have experienced a serious sexual assault in the last year. Around 1100 female survivors, 150 male survivors of domestic violence will have mental or emotional problems in a year.

It is estimated that there are up to 135 sex workers with PTSD and 200 with depression.

It is likely that there are between 1,000 and 2,000 refugees or asylum seekers with depression, 1,700 with anxiety, and between 800 and 2,000 of this group of people with Post-traumatic stress disorder.

There were 380 single homeless people with mental health problems in 2003.

In 2006 there were around 10,000 people with disabling physical health condition or physical or sensory disability in Leicester.

Of the 10,173 unpaid carers providing more than 20 hours care per week (ONS, 2001) there were 2700 carers with mental health problems.

Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. This client group presents clear increased risks to their own and to public safety, with documented risk of increased crime, death and family breakdown. Individuals with these dual problems deserve high quality, patient focused and integrated care which is delivered within mental health services and treats both elements of their dual diagnosis. Providing an integrated dual approach to their treatment is essential to achieve sustainable improvement.

Gaps, Findings and Recommendations

The co-existing problems of mental ill health and substance misuse represent a difficult challenge for mental health services. Elements of care, such as diagnosis and treatment are difficult and service users represent high risk of relapse, readmission to hospital, self-harm and suicide. Substance misuse among people with mental health problems is usual rather than exceptional; treatment for substance misuse problems often improves mental health; and the healthcare costs of untreated people with dual diagnosis are likely to be higher than for those receiving treatment. People with co-existing mental illness and substance misuse disorders have high rates of physical ill health. The provision of integrated care for people with a combination of mental health problems and substance misuse requires an effective links across health, social care, and the voluntary sector and criminal justice services.

People with dual diagnosis often receive sub-optimal care because of concerns about the need to treat either mental health or substance misuse. Whilst commissioners should ensure that all staff in mental health and substance misuse teams are trained and equipped to work with co-morbidly issues, governance frameworks should be developed to ensure that mental health teams should take the lead in cases of dual diagnosis.

It is recommended that commissioners consider:

- Ensure that mental health teams take the lead in cases of dual diagnosis.
- Ensure that all staff in mental health and substance misuse teams are trained and equipped to work with dual diagnosis with appropriate support and supervision.
- Develop integrated governance, roles and responsibilities of the different agencies involved are defined by clear local protocols.

Thematic Index

Topic	Page Number
A	
Acknowledgements	26,27
ADHD	74
Adult Social Care Outcomes Framework	51
Anti-depressant medication	109
Anxiety disorder	76,103
Assertive Outreach	123,124
Autistic Spectrum	149
B	
Background	17
Benefits Changes	37-39
Black and minority ethnic groups	20,34,35,136
Bullying	78
C	
Carers	143
Child and Adolescent Mental Health Services	3,7,13,14,40,69-89,
Charter for mental health	4,17,18
Childhood experience	7,12,
Childhood mental health	21-22,
Children's Trust	11,
City Mayor Delivery Plan	41,
Clinical Commissioning Group	47
Closing the Gap (Health and Wellbeing Board)	44
Closing the Gap (Mental Health)	45
Commissioning	9,10,11,19,170
Community Engagement	57,
Community Mental Health Teams	118
Context of mental ill health in Leicester	34-38,
Complex Care	119
Continuing health Care	113
Creativity and co-production	57
Crisis Care/Acute Care	114
Crisis Care Concordat	43
D	
Debt	12,
Dementia	13,
De Montfort University	9,92,
Depression	34,
Deprivation	31
Domestic Violence	80,
Dual Diagnosis	3,13,16,,30,45,169
E	
Early help and Prevention Offer	83
Eating disorders	73,75
Economic Action Plan	17

Employment	20,55
Equalities	3,10,16,24,25,30,139-156,
Equality Duty	26
Exercise	53
F	
Foresight Report	54
G	
H	
HMP Leicester	169
Huntingdon's Disease	124,
I	
IAPT	24,111,166
Inequalities	34
J	
Joint Commissioning Strategy on Mental Health in Leicester	49
K	
L	
Learning disabilities	51.145
Lesbian, Gay, Bisexual and Transgender (LGBT)	13,25,141,
Liaison Psychiatry	117
Libraries	57
Life Course Approach	22
LLR 5 Year Strategy	48
Long Term Conditions (diabetes, cancer, CVD)	19,
Looked After Children	12,
M	
Mental health in Leicester	4,
Mental Health Facilitators	112
Mental Health Promotion	3,5,13,25,52
Mental Health Specialist Nurse	112.
Models of Service Delivery	20
N	
NHS England	11,
NHS Outcomes Framework	51
No Health without Mental Health	41,
O	
Obesity	53
Obsessive Compulsive Disorder	78,105,
Offenders	3,12,16,26,30,166-171,
Older People	3,10,15,24,29,53,129
P	
Parents	80
Parity of esteem	7,102,
PAWS	65
Perinatal maternal mental health	3,6,13.61-69
Personalised Care	10,11,12,
Place of Safety	119
Police and Crime Commissioner	4
Policy Background	38-52

PoNDER	65
Post-Traumatic Stress Disorder	76,103,
Preventing Suicide in England	41,
Primary Care	7,96,110-111,136,
Public Health Outcomes Framework	51
Q	
R	
Recession	7,37,161,
Recommendations	13,52,68,89,97,129,135,137,153,163,169,175
Recovery	21
Risk taking behaviour	18,
S	
Self-harm	81,160,164,
Services in Leicester	68,69,81-91,109-127,141,144,153,169,175
Social Determinants of Health	12,
Stepped Care/Tiered Care	10-11,18,80,104
Student Mental Health	3,9,15,23,29,32,89,161
Substance Misuse	131,160,172-178
SUCRAN	17,125
Suicide Prevention	3,12,16,26,154,
T	
Triage Car	116
THINK Family	85,
U	
Unemployment	12,
University of Leicester	9,93
V	
Valuing People	51
Veterans	11,144
A Vision for Adult Social Care	39
Voluntary and Community Sector	85,105
W	
Ward areas	19,36-38,79-80,
Welfare Changes	19,40,
Winterbourne View	51,147,154
Work	56,
Working Age Adults	3,9,15,23-24,29,98-130
X	
Y	
Z	
Other	
5 Ways to Wellbeing	25,57
1001 Critical Days	43

Appendices

Appendix 1: ICD-10F

Mental illness in ICD-10 F is concerned with five major categories (F2–F6) that are likely to contain ‘severe mental disorders’. All of the categories have subdivisions, making some 60 disorders in all, each with its own clinical provenance and each often interacting in various ways with one or more of the others.

The Categories are as follows:

- [F0: Dementia, including symptomatic mental disorders]
- [F1: Mental and behavioural disorders due to psychoactive substance abuse]

F2: Schizophrenia, schizotypal and delusional disorders

- F20.0 Paranoid schizophrenia
- F20.1 Hebephrenic schizophrenia
- F20.2 Catatonic schizophrenia
- F20.3 Undifferentiated schizophrenia
- F20.4 Post-schizophrenic depression
- F20.5 Residual schizophrenia
- F20.6 Simple schizophrenia
- F21 Schizotypal disorder
- F22.0 Delusional disorder
- F23.0 Acute polymorphic psychotic disorder
- F23.1 With symptoms of schizophrenia
- F23.2 Acute schizophrenia-like psychotic disorder
- F23.3 Other acute delusional psychotic disorder
- F24 Induced delusional disorder
- F25.0 Schizoaffective disorder, manic type
- F25.1 Schizoaffective disorder, depressive type
- F25.2 Schizoaffective disorder, mixed type

F3: Mood (affective) disorders

- F30.0 Hypomania
- F30.1 Mania without psychotic symptoms
- F30.2 Mania with psychotic symptoms
- F31.0 Current episode, hypomanic
- F31.1 Manic without psychotic symptoms
- F31.2 Manic with psychotic symptoms
- F31.3 Moderate or mild depression
- F31.4 Severe depression without psychotic symptoms
- F31.5 Severe depression with psychotic symptoms
- F31.6 Current episode, mixed
- F31.7 Currently in remission
- F32.0 Depressive episode, mild severity
- F32.1 Moderate severity
- F32.2 Severe depressive episode without psychotic symptoms
- F32.3 With psychotic symptoms
- F33.0 Recurrent depressive disorder, current episode mild severity
- F33.1 Moderate severity
- F33.2 Severe without psychotic symptoms

- F33.3 With psychotic symptoms
- F33.4 Currently in remission
- F34.0 Cyclothymia
- F34.1 Dysthymia
- F38.0 Other single affective disorders
- F38.1 Other recurrent affective disorders

F4: Neurotic, stress-related and somatoform disorders

- F40.0 Agoraphobia
- F40.1 Social phobias
- F40.2 Specific (isolated) phobias
- F41.0 Panic disorder (episodic paroxysmal anxiety)
- F41.1 Generalised anxiety disorder
- F42 Obsessive–compulsive disorder
- F43.0 Acute stress reaction
- F43.1 Post-traumatic stress disorder
- F43.2 Adjustment disorders
- F44.0 Dissociative amnesia
- F44.1 Dissociative fugue
- F44.2 Dissociative stupor
- F44.3 Trance and possession disorders
- F44.4 Dissociative motor disorders
- F44.5 Dissociative convulsions
- F44.6 Dissociative anaesthesia and sensory loss
- F44.7 Mixed dissociative (conversion) disorders
- F44.8 Other dissociative (conversion) disorders
- F45.0 Somatisation disorder
- F45.1 Undifferentiated somatoform disorder
- F45.2 Hypochondriachal disorder
- F45.3 Somatoform autonomic dysfunction
- F45.4 Persistent somatoform pain disorder
- F48.0 Neurasthenia (fatigue syndrome)
- F48.1 Depersonalisation–derealisation syndrome

F5: Behavioural syndromes associated with physiological disturbances and physical factors

- F50 Eating disorders
- F51 Non-organic sleep disorders
- F52 Sexual dysfunction
- F53 Mental and behavioural disorders associated with the puerperium
- F54 Psychological disorders associated with disorders classified elsewhere
- F55 Abuse of non-dependence-producing substances

F6: Disorders of adult personality and behaviour

- F60.0 Paranoid personality disorder
- F60.1 Schizoid personality disorder
- F60.2 Dissocial personality disorder
- F60.3 Emotionally unstable personality disorder
- F60.4 Histrionic personality disorder
- F60.5 Anankastic personality disorder
- F60.6 Anxious (avoidant) personality disorder
- F60.7 Dependent personality disorder

- [F7: Mental retardation]
- [F8: Disorders of psychological development]
- [F9: Behavioural and emotional disorders with onset in childhood and adolescence]

The term 'disorder' is used throughout ICD-10 F instead of 'disease' to emphasise that none of the diagnostic groups has yet been definitively described in terms of underlying brain or other somatic dysfunctions or pathologies. The categories are simply the current standards for reference and comparison.

The term 'symptom' is used in two distinct ways. One applies only to a dysfunction, usually rare (e.g. 'hallucination'), that is defined as part of a specific disorder. The other is applied to isolated subjective complaints, such as 'worrying' or 'panic', that appear in isolation or in groups that do not conform to World Health Organization definitions of disorder.

The five diagnostic ICD-10 F groups under consideration are briefly described below, together with some of the commoner sub-categories.

A note about the course of each of the main disorders is also provided.

As emphasised in the previous section, each of the following ICD categories can occur in conjunction with any of the others. For example, affective and neurotic disorders are commonly comorbid with schizophrenia, as is drug and alcohol misuse.

F20–25, schizophrenia, schizotypal and delusional disorders

The term 'psychotic' is commonly used to describe the abnormal subjective experiences and accompanying behaviours listed below.

Diagnosis depends largely on the patient's account of mental experiences, such as the first four in the list, which can be extremely severe in their initial impact. The three 'negative' items are very common in schizophrenia, but rarely sufficient for a diagnosis in themselves because they can occur in other disorders.

The key 'positive' symptoms of schizophrenia are:

- thoughts experienced as echoed, inserted, withdrawn or broadcast
- delusions of control, influence or passivity
- other delusions with bizarre and culturally inappropriate content
- hallucinatory voices, e.g. commenting on the subject's thoughts

The key 'negative' symptoms of schizophrenia (overt organic disease absent) are:

- incoherence or poverty of speech
- catatonic behaviours
- apathy, slowness, lack of initiative, social withdrawal

Recognised subgroups of schizophrenia include:

- paranoid disorders (20.0)
- hebephrenic disorders (20.1)
- catatonic disorders (20.2)

Separate groups include the following:

- F21, schizotypal
- F22, persistent delusional
- F23, acute and transient psychotic
- F24, induced delusional (including *folie a deux*)
- F25, schizoaffective disorders

F30–34, mood (affective) disorders

The affective disorders include the following:

- F30, manic episode;
- F31, bipolar affective disorder;
- F32, depressive episode;
- F33, recurrent depressive disorder;
- F34, persistent mood disorder, including cyclothymia and dysthymia.

The basic disturbance in all categories is a change in mood to depression or apathy (with anxiety very common) and/or to elation. The two moods can occur together or alternately, and overall activity is affected accordingly. At their most severe, depression, mania and the mixed 'bipolar' disorders are manifested in ideas (sometimes with delusional force, though usually with content congruent to mood) that may be expressed in self-harm or grandiosely dissociative behaviour.

Common symptoms of mania may include depressed and elated mood, loss of interest and enjoyment, loss of social inhibitions, reduced energy, activity, concentration or over-activity and poor concentration. Other symptoms among these disorders are low self-esteem, guilt, pessimism, inflated self-esteem, grandiosity, ideas or acts of self-harm or suicide. They could also include inadvertent harm to self/others, diminished sleep and appetite, mood-congruent hallucinations, severe psychomotor retardation or stupor, flight of ideas, pressure of speech.

Cyclothymia (34.0) is a persistent instability of mood, involving numerous periods of depression and mild elation. Dysthymia (34.1) is a chronic depression of mood that does not meet the criteria for F32 or F33.

The course of depression can vary from a brief episode (particularly if in response to stress that resolves rapidly) to a long and severe 'melancholia'. Bipolar disorders tend to be intermittent, but the pattern can recur over a lifetime.

F40–48, neurotic, stress-related and somatoform disorders

F40, phobic anxiety disorders

- Agoraphobia: fear of open spaces, crowds, trains, planes, leaving home, etc.
- Social phobias: fear of scrutiny by other people.
- Specific (isolated) phobias: fear of specific situations such as particular animals, heights, thunder, darkness, dentistry, etc.

F41, other anxiety disorders

- Panic attacks, rising rapidly to a climax and then gradually decreasing in severity.
- Generalised anxiety disorder.

F42, obsessive–compulsive disorder (OCD)

- Obsessional thoughts, ruminations and actions, despite conscious resistance.

F43–48, include stress, conversion, dissociative and somatoform disorders.

- Anxiety disorders tend to follow the pattern of any stress that provokes them, but can occur sui generis and be intermittent or long-lasting. Concomitant depression is common. OCD is also often long-lasting

F50–55, behavioural syndromes associated with physiological disturbance

This sub-chapter covers the eating disorders anorexia and bulimia, sleep disorders (non-organic), sexual dysfunctions and disorders associated with the puerperium.

F50.0–50.8, anorexia nervosa and bulimia

- Over-valued dread of fatness, leading to body weight deliberately maintained at least 15% below normal, with consequent widespread endocrine disorder.
- Associated with overeating and attempts to mitigate this by extreme purging, vomiting, etc. F51–53, sleep and sexual disorders.

Prolonged anorexia leads to under-nutrition resulting in endocrine and metabolic changes, particularly with onset before puberty and in older women up to the menopause. Bulimia often, but not always, follows an earlier episode of anorexia.

F60–68, disorders of adult personality and behaviour

The abnormal behaviour pattern tends to appear in late childhood and then to persist. Several areas of functioning are involved. Problems are not limited to periods of mental illness.

Appendix 2: Voluntary Organisations in Leicester

Group Name	Beneficiary Area	Main Beneficiary	Neighbourhood
Active Wesley Hall	City	People with mental health needs	Spinney Hill/Stoneygate
Adhar Project	City and County	People with mental health needs	Spinney Hill/Stoneygate
Advance	City, County and Rutland	People with learning difficulties	Castle/Knighton
Advance Employment	City, County and Rutland	People with mental health needs	City Centre
African Caribbean Citizens Forum (ACCF)	City and County	People from BME communities	City Centre
Age UK Leicester Shire & Rutland	City and County	Older people	Castle/Knighton
Ajani Women and Girls Centre Ltd	City	Women	Spinney Hill/Stoneygate
Akwaaba Ayeh	City and County	People with mental health needs	Spinney Hill/Stoneygate
Al-Anon Family Groups UK and Eire	National	People with addiction problems (alcohol, drugs)	* N/A
Alpha Tutorials	City	The general public / everyone	Belgrave/Latimer/Rushey Mead
Alternative Day Care	City	Older people	
Alzheimer's Society Leicestershire & Rutland	City and County	Older people	* N/A
Ambassadors for Health			
Anchor Centre (LCPT)	City	People with addiction problems (alcohol, drugs)	City Centre
Anna's Hope	East Midlands Region	Children	
Art of Living Foundation Midlands	East Midlands Region	The general public / everyone	* N/A
Asian Mental Health Group	City		Evington/Coleman/Charnwood
Aspergers Syndrome Support Group	City, County and Rutland	Carers / parents	Castle/Knighton
Aspiro	City and County	People with mental health needs	City Centre
Asra Housing Group	City and County	The general public / everyone	Braunstone/Western Park/Westcotes
Assist Project	City	Asylum seekers / refugees	City Centre
Association of Shared Parenting	City	Carers / parents	Spinney Hill/Stoneygate

Ayurveda & Alternative Therapies Self Help Group	City	People from BME communities	Belgrave/Latimer/Rushey Mead
b-inspired	City and County	People with a financial need (inc poverty)	Braunstone/Western Park/Westcotes
Baby Gear	City and County	Carers / parents	Castle/Knighton
Bangladeshi Social Association	District	People from BME communities	* N/A
Barnardos CareFree Young Carers Services	City and County	Children	* N/A
BEAT - Beating Eating Disorder	National	People with particular health needs	* N/A
Beechwood Day Services	City	People with mental health needs	Evington/Coleman/Charnwood
Belgrave Bhaiyo	City and County	Young people	* N/A
Bethany (Adullam Homes HA)	City	Homeless people	Braunstone/Western Park/Westcotes
Brahma Kumaris World Spiritual University	National	The general public / everyone	Belgrave/Latimer/Rushey Mead
Braunstone Childcarers Forum	Neighbourhood	Carers / parents	Braunstone/Western Park/Westcotes
Bridge House Project	City and County	Women	* N/A
BTCV (Leicester)	City, County and Rutland	The general public / everyone	Braunstone/Western Park/Westcotes
Carers Outreach and Development Service	City	Carers / parents	Castle/Knighton
Carr-Gomm	City	Socially excluded / vulnerable people	Freemen/Eyres Monsell/Aylestone
Celibrate	National	The general public / everyone	Freemen/Eyres Monsell/Aylestone
Centre for Conscious Awareness	National		Beaumont Leys/Abbey
Chand Senior Community Society	Neighbourhood	Socially excluded / vulnerable people	Belgrave/Latimer/Rushey Mead
ChildLine	East Midlands Region	Children	* N/A
Cinnamon Trust	National	Older people	* N/A
CLASP - The Carers Centre	City, County and Rutland	Carers / parents	Spinney Hill/Stoneygate
Co-Counselling International (CCI)	National	The general public / everyone	* N/A
Cohesion Youth Community and Sport Development	City	Young people	Spinney Hill/Stoneygate
Communities in Partnership (CIP)	City and County	The general public / everyone	Beaumont Leys/Abbey

Community Allotment Pavilion Project	Ward		New Parks/Fosse
Community Integrated Care (CiC)	City	People with learning difficulties	Castle/Knighton
Community Law Service	City		Castle/Knighton
Community of Grace	City	Homeless people	Spinney Hill/Stoneygate
Contact Student Volunteers - University of Leicester	City	Other charities, voluntary or social enterprises	Castle/Knighton
Coping with Cancer in Leicestershire and Rutland	City, County and Rutland	People with particular health needs	* N/A
Corner Plot	District	The general public / everyone	* N/A
Creative Support	National	People with learning difficulties	Spinney Hill/Stoneygate
Crossroads Care East Midlands	East Midlands Region	Carers / parents	* N/A
Cruse Bereavement Centre (Leicester)	City	The general public / everyone	Belgrave/Latimer/Rushey Mead
Disability Solution			Evington/Coleman/Charnwood
East Midlands Centre of Excellence for Teacher Training	City and County		
East Park Activity Group	City	People with learning difficulties	Evington/Coleman/Charnwood
East West Community Centre Limited	City	Older people	Braunstone/Western Park/Westcotes
Faith in People with HIV	City, County and Rutland	People with particular health needs	Spinney Hill/Stoneygate
Family Action	National	Children	City Centre
FareShare Leicester	National	People with a financial need (inc poverty)	City Centre
FHA Floating Support Focus Group	City	Socially excluded / vulnerable people	Castle/Knighton
First Step	City and County	Victims of crime and their families	City Centre
Fit 4 Work	City, County and Rutland	The general public / everyone	City Centre
Foundation Housing Association	City and County	People from BME communities	Castle/Knighton
Futureminds	East Midlands Region	Children	* N/A
Gamblers Anonymous	City		Belgrave/Latimer/Rushey Mead
Genesis	City	People with mental health needs	City Centre
GLAD	City		New Parks/Fosse

Gorse Hill City Farm	City	The general public / everyone	Beaumont Leys/Abbey
Greater Humberstone Community Development Ltd	Ward		Humberstone/Thurncourt/Hamilton
Green Team (The)	Neighbourhood	Young people	Spinney Hill/Stoneygate
Headway Leicestershire, Leicester and Rutland	City, County and Rutland	People with physical disabilities or special needs	Evington/Coleman/Charnwood
Healthy Community Lifestyle Promotions (HCLP)	City and County	The general public / everyone	Freemen/Eyres Monsell/Aylestone
Hodan Somali Community Group	City		Evington/Coleman/Charnwood
Indian National Club (UK)	City and County		* N/A
Insight Counselling Service (Leicester)	City	The general public / everyone	Spinney Hill/Stoneygate
Inspired (2009) CIC	National	People with mental health needs	
International Disaster Volunteers (IDV)	National	The general public / everyone	* N/A
International Punjab Society (Midlands)	East Midlands Region	People from BME communities	* N/A
Jasmine House Leicester Rape Crisis	City, County and Rutland	Women	Castle/Knighton
Juniper Lodge	City, County and Rutland	Socially excluded / vulnerable people	Evington/Coleman/Charnwood
Just Services Limited	City	People with physical disabilities or special needs	
Khushi	City	People with mental health needs	City Centre
La Leche League Leicester	City	Women	* N/A
LAMP Leicestershire Action for Mental Health Project	City, County and Rutland	People with mental health needs	City Centre
LASS (Leicestershire AIDS Support Services)	City, County and Rutland	People with particular health needs	Castle/Knighton
Laura Centre (The)	East Midlands Region	Carers / parents	Castle/Knighton
Learning for the Fourth Age	City and County	Older people	Spinney Hill/Stoneygate
Leicester City West Carers			Braunstone/Western Park/Westcotes
Leicester Counselling Services			
Leicester Hearing Voices Group	City	People with particular health needs	Belgrave/Latimer/Rushey Mead
Leicester Holme Project	City	Homeless people	Castle/Knighton

Leicester Lesbian Gay Bisexual & Transgender Centre (LGBT)	City and County	Lesbian, gay, bisexual or transgender people	City Centre
Leicester Parents Support Group			City Centre
Leicester YMCA	City	Homeless people	Castle/Knighton
Leicestershire & Rutland Probation Trust	City, County and Rutland	Offenders, ex-offenders and their families	City Centre
Leicestershire & Rutland Victim Support (East Midlands office)	East Midlands Region	Victims of crime and their families	Castle/Knighton
Leicestershire & Rutland Youth Offending Service (Duplicate)			
Leicestershire Autistic Society (Market Harborough)	City, County and Rutland	People with physical disabilities or special needs	* N/A
Leicestershire Centre for Integrated Living (LCIL)	National	People with physical disabilities or special needs	City Centre
LeicesterShire Citizens Advice Bureau - Leicester City	City and County	The general public / everyone	City Centre
Leicestershire Community Projects Trust (LCPT)	City, County and Rutland	People with addiction problems (alcohol, drugs)	City Centre
Leicestershire Employment For Autism Today (LEAT)	City and County	People with particular health needs	Spinney Hill/Stoneygate
Leicestershire Food Links	City, County and Rutland	The general public / everyone	* N/A
Leicestershire MS Therapy Centre	City and County	People with particular health needs	Freemen/Eyres Monsell/Aylestone
Leicestershire Partnership NHS Trust (Bradgate Mental Health Unit)	City and County		New Parks/Fosse
LeicestHERday Trust		Women	City Centre
Limblex Ex-Servicemen's Assoc			* N/A
Linwood Pregnancy Testing & Counselling Service	City		Freemen/Eyres Monsell/Aylestone
Living Gods Church			City Centre
Making Friends Group	City and County	People with learning difficulties	Humberstone/Thurncourt/Hamilton
Manic Depressive Group	City, County and Rutland	People with mental health needs	Braunstone/Western Park/Westcotes
Mantle Community Arts	City, County and Rutland	Young people	* N/A
Maya Group	City	People from BME communities	New Parks/Fosse
Mentoring and Befriending Foundation (East Midlands)	East Midlands Region	Other charities, voluntary or social enterprises	* N/A
Midlands Co-operative Society Ltd	City, County and Rutland	The general public / everyone	Freemen/Eyres Monsell/Aylestone
Mind	District		* N/A

Monday Club Leicestershire Ltd (The)	City and County	People with learning difficulties	Belgrave/Latimer/Rushey Mead
Musical Youth	City and County	Young people	Freemen/Eyres Monsell/Aylestone
Network For Change Ltd	City, County and Rutland	People with mental health needs	Spinney Hill/Stoneygate
New Dawn Asian Mental Health	City and County	People with mental health needs	Evington/Coleman/Charnwood
New Dawn Family Support Service	City, County and Rutland		* N/A
New Futures Project (The)	City, County and Rutland	Socially excluded / vulnerable people	Castle/Knighton
New Testament Church of God	Neighbourhood	Children	Spinney Hill/Stoneygate
NIA Day Centre			Castle/Knighton
Norton House	City and County	People with mental health needs	New Parks/Fosse
Open Door Leicester	City and County	Young people	Braunstone/Western Park/Westcotes
Papworth Trust	City	Older people	* N/A
Parent and Carer Council	City, County and Rutland	The general public / everyone	New Parks/Fosse
Pathways Centre (The)	District	The general public / everyone	* N/A
Patient Reference Group (Cross Street)	Neighbourhood		Belgrave/Latimer/Rushey Mead
Pets As Therapy (Prince Risborough)	National	The general public / everyone	* N/A
Quetzal	City, County and Rutland	Women	Beaumont Leys/Abbey
Rawal Community Association	City	People from BME communities	Castle/Knighton
Reaching People	City and County	The general public / everyone	* N/A
Reality	City	People with learning difficulties	Evington/Coleman/Charnwood
RECOVERY	City	People with mental health needs	Spinney Hill/Stoneygate
Rehabilitation Partnership Ltd (The)	City	People with physical disabilities or special needs	* N/A
Relate Leicester, Leicestershire & Rutland	City, County and Rutland	The general public / everyone	Castle/Knighton
Remit User Group	City	People with mental health needs	City Centre
Rethink (Leicestershire Rutland & County Carers Services) (Head Office)	East Midlands Region	People with mental health needs	* N/A

Riverside Midlands	City	Socially excluded / vulnerable people	Castle/Knighton
Ruach Care	East Midlands Region	People with mental health needs	
Sabras Radio			Belgrave/Latimer/Rushey Mead
Saffron Community Health Alliance	City	The general public / everyone	Freemen/Eyres Monsell/Aylestone
Saffron Support for Elderly People	City and County	Older people	Freemen/Eyres Monsell/Aylestone
Samaritans of Leicester	City, County and Rutland	The general public / everyone	Spinney Hill/Stoneygate
SAMARPAN Meditation UK			Evington/Coleman/Charnwood
Sanatan Manavta Day Care Centre	City and County	Older people	Belgrave/Latimer/Rushey Mead
Savera Resource Centre	City and County	People with mental health needs	Belgrave/Latimer/Rushey Mead
Schizophrenic Support Group	City and County	People with particular health needs	Castle/Knighton
Selective Mutism Info & Research Assoc (SMIRA)	National	Carers / parents	Spinney Hill/Stoneygate
Shelter Housing Aid & Research Project (SHARP)	City, County and Rutland	Homeless people	City Centre
Shree Prajapati Association Leicester	National	The general public / everyone	Belgrave/Latimer/Rushey Mead
Shree UK Luwar Gnati Mandal			Belgrave/Latimer/Rushey Mead
Society for the Protection of Unborn Children (SPUC) - Rutland & Melton branch	East Midlands Region	Children	* N/A
Soldier's, Sailor's, Airmen and Families Association - Forces Help (The) (SSAFA)	National	People with a financial need (inc poverty)	City Centre
Somali Community Care	City	People from BME communities	City Centre
Somali Community Integration and Health Awareness			Beaumont Leys/Abbey
South Leicestershire College	District	The general public / everyone	* N/A
St Francis Community Centre	District	Women	* N/A
St Matthews Community Solution Centre	Neighbourhood	People from BME communities	Spinney Hill/Stoneygate
St Peters Community Centre	City	Older people	Spinney Hill/Stoneygate
Street Pastors (Leicester & Leicestershire)	City and County	The general public / everyone	Braunstone/Western Park/Westcotes

Strides Leicester	City	People with mental health needs	Beaumont Leys/Abbey
Sudanese Darfur Association			Spinney Hill/Stoneygate
Taybah Culture, Community & Education Centre	City	Faith communities	Evington/Coleman/Charnwood
Tomonari	City and County	People with mental health needs	* N/A
Trade - LGB Health	City, County and Rutland	Lesbian, gay, bisexual or transgender people	City Centre
Trent Dementia Services Development Centre	City and County	Older people	City Centre
Wesley Hall Community Centre	City	The general public / everyone	Spinney Hill/Stoneygate
Workers' Educational Association (East Midland District)	City	The general public / everyone	Castle/Knighton
Y Advice & Support Centre (YASC)	City	Homeless people	City Centre
Yoga/Reflexology Group	City	The general public / everyone	* N/A
YU-Matter	City and County	People with mental health needs	

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