Mental health in Leicester:

JOINT STRATEGIC NEEDS ASSESSMENT (Adults)

A Joint Strategic Needs Assessment (JSNA) is a statutory process by which local authorities and commissioning groups assess the current and future health, care and wellbeing needs of the local community to inform decision making.

The JSNA:

Is concerned with wider social factors that have an impact on people's health and wellbeing such as poverty and employment.

Looks at the health of the population with a focus on behaviours which affect health, such as smoking, diet and exercise.

Provides a view of health and care needs in the local community

Identifies health inequalities

Indicates current service provision

Identifies gaps in health and care services, documenting unmet needs

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Leicester City Council

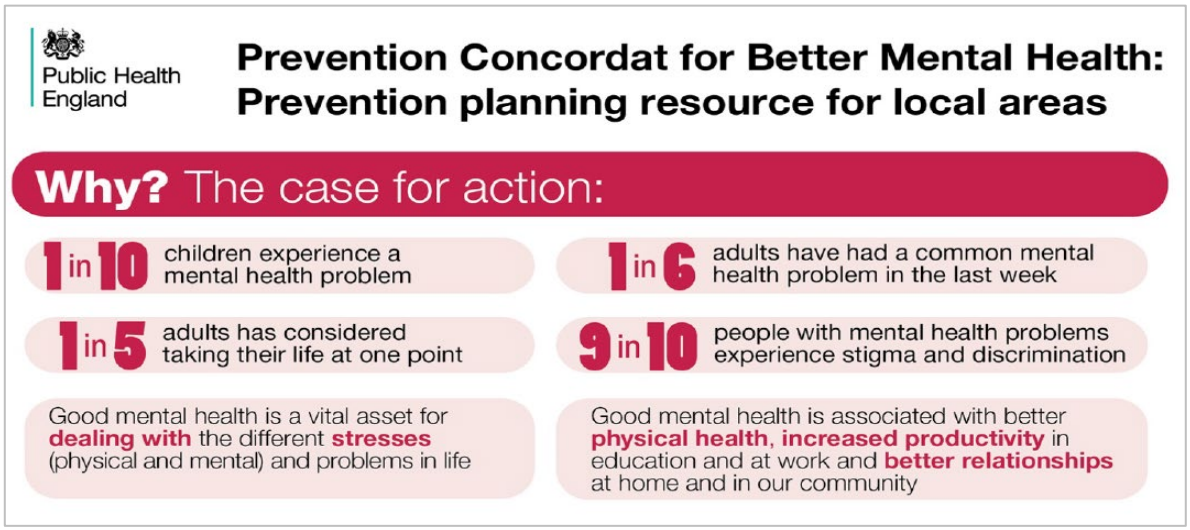
1. CONTENTS

1 INTRODUCTION

Mental health is a state of wellbeing in which individual potential can be realised. People with good mental health can cope with normal life stresses, work, and contribute to the community.[1] In contrast, mental illness refers to morbidity associated with mental, neurological and substance misuse disorders; approximately 1 in 4 people in England will experience a mental health problem each year.[2]

No other health condition matches mental illness in terms of prevalence, persistence, and breadth of impact.[3] In part this is because many mental disorders which begin in childhood have lifetime health consequences. It is also because mental illnesses are linked with adverse social and environmental factors.[4]

Figure 1. The case for action



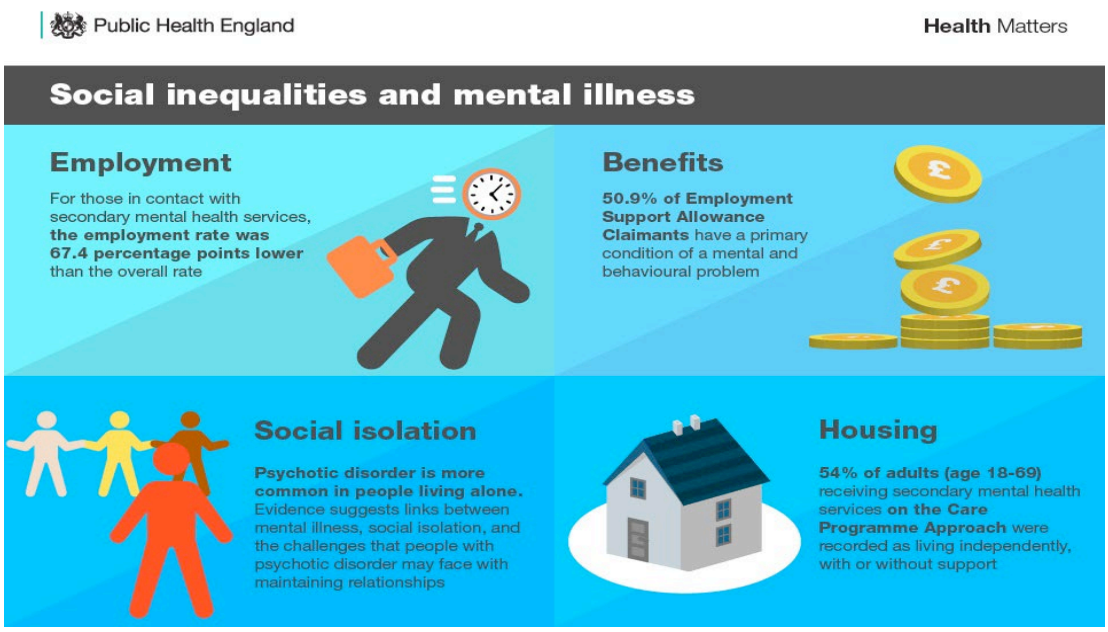
Source: *PHE Prevention Concordat for Better Mental Health*

Mental illnesses are usually described as either neurotic or psychotic. Neuroses are severe forms of emotional experiences such as depression, anxiety, or panic; sometimes labelled common mental health problems. About 1 in 6 people report experiencing a common mental health problem in any given week in the UK. Psychoses can alter a person's perception of reality; this may include hallucinations such as seeing, hearing, smelling, or feeling things that no one else can. These disorders are much more rare.[5]

The adverse social factors linked to mental illness include unemployment, lower educational attainment, poorer material circumstances and increased risk-taking behaviour.[6] For example, Smoking is responsible for a large proportion of the excess mortality of people with mental health problems; it is estimated that a third of all cigarettes are smoked by

people with a mental health problem.[7] Mental illness exacerbates these inequalities, resulting in increased mortality and physical morbidity as well as poorer economic, health and social outcomes. Among people who contact Citizens Advice, people with mental health problems have a greater number of practical problems such as fuel poverty, risk of homelessness and unemployment.[8]

Figure 2. Social inequalities and mental illness



Source: *Public Health England; Health Matters*

2 THE IMPACT ON THE POPULATION

Reduced life expectancy: People with serious mental health problems die prematurely. The life expectancy of someone with a serious mental health problem, such as bipolar disorder or schizophrenia, is 15 to 20 years less than the general population. This is mostly from preventable physical health problems such as cardiovascular disease and cancers.[9]

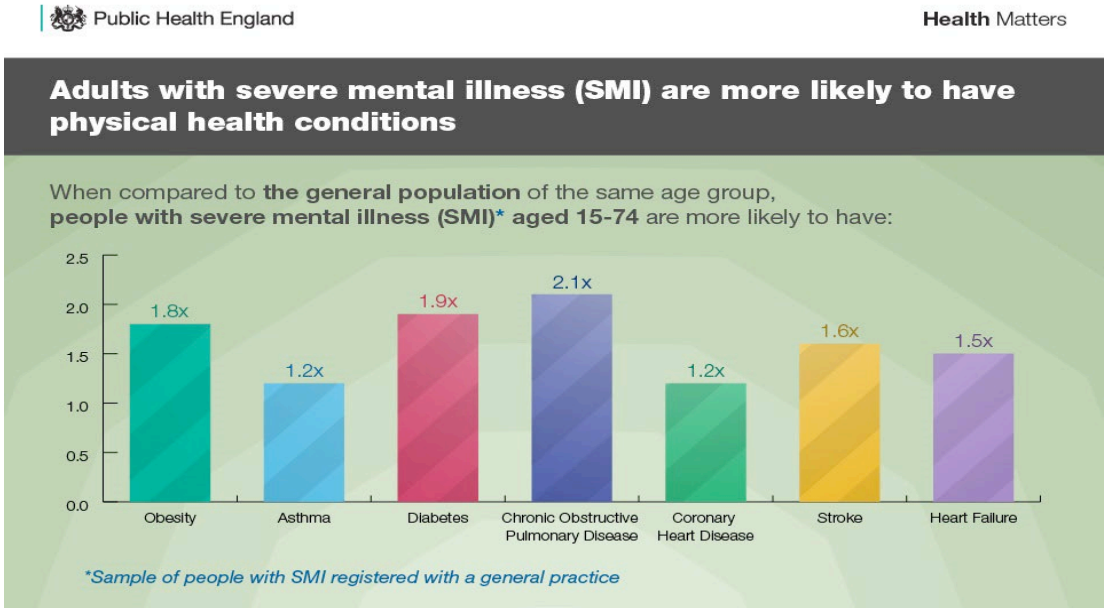
Poor physical health (see figure 3 below): People with common mental health disorders are more likely to engage in behaviours that are detrimental to overall health, such as poor diet, physical inactivity, heavy smoking and drug and alcohol misuse. Older adults who are depressed are more likely to have existing physical health conditions and more likely to develop physical health conditions. Depression is particularly associated with specific physical illnesses; cardiovascular disease and diabetes.[10]

Discrimination and stigma: Stigma is a common experience for people with mental health problems. It may compound inequality, by reducing employment opportunities and weakening supportive social networks. For some people, stigma is compounded by

additional discrimination on the grounds of ethnicity, illness , cultural background or sexuality.

Social exclusion: People with mental illness are often excluded from important areas of social life, including civic participation and social interaction. Social exclusion can have an adverse effect on diet and is linked to detrimental health behaviours such as smoking and increased alcohol consumption.

Figure 3. Mental illness and physical health



Source: *Public Health England; Health Matters*

Reduced access to quality medical care: People with mental illness are less likely to access care for both physical and mental health problems, indicative of the continuing lack of parity between mental and physical health.

Suicide and self-harm: On average, 30 people a year take their own lives in Leicester. While some people who die by suicide have a mental health problem, most are not known to services or have ever reached out for support. The rate of suicide is around 4 to 5 times higher among males than females; this trend is consistent over time.[11] On a national level, evidence has shown that most people who die by suicide had not been in contact with a GP or a health professional.[12] This emphasises the need to raise awareness about actions supporting of mental wellbeing and for timely access to appropriate mental health care.

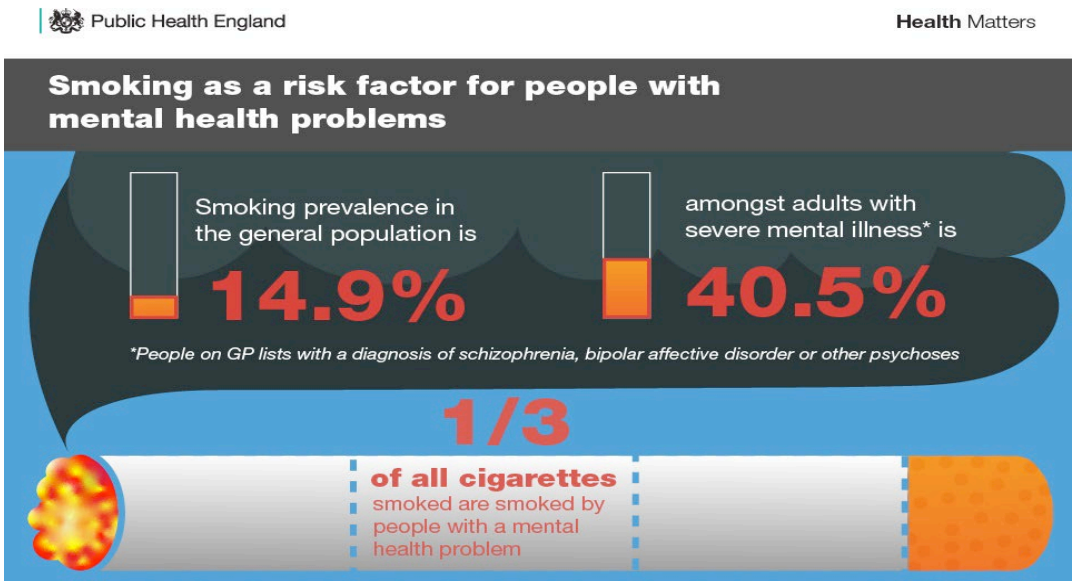
Alcohol misuse: Excessive consumption of alcohol is associated with poor mental health. The risks of hazardous drinking increase following stressful life events. There are an estimated 589,000 people who are dependent on alcohol in England and about a quarter of them are likely to be receiving mental health medication; mostly for anxiety and depression,

but also for sleep problems, psychosis, and bipolar disorder.[13] In Leicester there is an estimated 4295 dependent drinkers and 85% are not in treatment.[14]

Smoking (see figure 4 below): Rates of smoking are higher for people with mental disorder compared with the general population and as the severity of mental health conditions increases, smoking prevalence is higher. Rates are very high for people who are mental health inpatients, and in prison. Smoking is a significant cause of morbidity and the largest cause of health inequality for people with mental disorder.[15]

Obesity (see figure 3 above): Mental illness can increase the risk of obesity, which is more common in people with depression, bipolar disorder, panic, and agoraphobia.

Figure 4. Smoking and mental illness

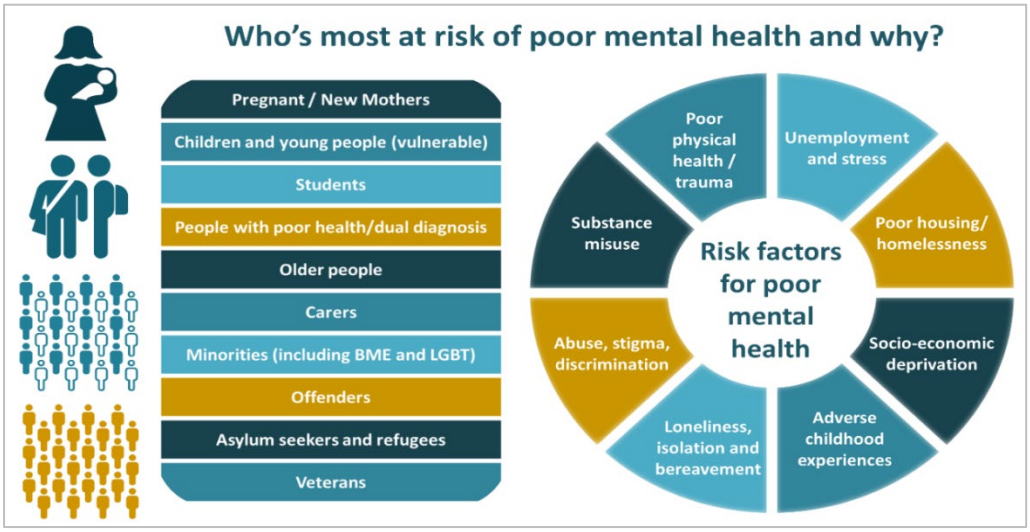


Source: *Figures 2, 3 & 4 Health Matters: Reducing health inequalities in mental illness*

3 WHO'S AT RISK AND WHY?

Mental health problems can affect anyone. For most, there is a complicated combination of factors at play. Figure 5 (below) shows some of the common risk factors for poor mental health, listing population groups disproportionately affected by poor mental health.

Figure 5. Risk factors and mental health



Risk factors for poor mental health are high in Leicester. Table 1 (below) shows how residents of Leicester experience many poor mental health risk factors more severely than England.

Table 1. Poor mental health risk factors

Indicators – Poor mental health risk factors	Leicester	England
Children living in deprivation (IDACI): % in most deprived 20% areas nationally (2019)	**24.2%**	17.1%
Children in care: Children looked after as a rate per 10,000 under 18 year olds (2022)	71	70
Children on child protection plans: Rate per 10,000 children under 18 (2021)	***37.6***	42.8
School pupils with social, emotional and mental health needs: % of pupils (2021)	**3.3%**	3.0%
First time entrants to the youth justice system: rate per 100,000 10-17 year olds (2021)	**188.2**	146.9
16-17 year olds not in education, employment or training (2021)	**9.0%**	4.7%
Living in 20% most deprived areas: % of population (2019)	**35%**	20%
Fuel poverty: % of households (2019)	**19.1%**	13.4%
Employment and support allowance claimants: % of 16-64 year olds (2021)	**5.2%**	4.3%
Admission episodes for alcohol-related conditions (broad): directly standardised rate per 100,000 population (2020/21)	**1906**	1500
First time offenders: Rate per 100,000 population	**268**	166
Domestic abuse-related incidents and crimes; per 1,000 16+ population (2021/22) / *Data relates to Leicestershire police*	24.1	30.8
Proportion of opiates and/or crack cocaine users not in treatment (2020/21)	57.8%	52.1%
Older people living in deprivation (IDAOPI): % of population aged 60+ (2019)	**29.8%**	14.2%

Significantly higher than England	***Significantly lower than England***	No significant differences

Source: *PHE Mental Health JSNA tool (2023)*

3.1 GROUPS AT RISK

Perinatal maternal mental health: This refers to women's mental health during pregnancy up to the time immediately after childbirth. The incidence of some conditions, such as anxiety, is not significantly changed in the perinatal period. However, perinatal obsessive-compulsive disorder and puerperal psychosis are specifically associated with pregnancy and childbirth. Perinatal mental illness impacts on the health and wellbeing of women, children and families and affects between 10 and 20% of women during pregnancy or within the first year after having a baby.[16]

Adverse childhood experiences: Mental health problems are higher among children who experience poverty, low educational attainment, domestic violence, and bullying. Children who experience abuse have an increased risk of illnesses such as depression and post-traumatic stress disorder in adulthood; looked after children have an increased risk of suicide attempt; to have multiple adverse childhood experiences is a major risk factor for many health conditions.[17]

Other vulnerable children are those with a parent who will have some degree of mental illness. 68% of women and 57% of men with a mental illness are parents.[18] These are most likely common mental health problems, some will have long-term mental health problems, as well as alcohol or drug problems and personality disorders few children live with a parent who has a severe mental illness.

Local survey data revealed in the city 1 in 5 children and young people worried about having enough money and about having enough to eat.[19] These children are more at risk of developing a mental health problem.

Being a student: While education is generally protective against mental illness the stresses associated with being a student can precipitate mental distress and may cause relapse into poor mental health. This occurs at the challenging time as young people progress from adolescence into adulthood, when there is already a higher-than-average risk of developing mental illness. There are about 32,000 students at the two universities in the city.[20]

In employment: Work generally sustains mental wellbeing, with benefits such as increased income, social contact, and productivity. However, it can be a source of stress, with people experiencing high demands and lack of control in their work environment. Working in insecure, low paid occupations is also a risk to mental health. People with mental illness are more likely to experience discrimination in the workplace.

Older people: As people live longer protecting their mental health and wellbeing will become more problematic. Depression is the most common mental disorder in people aged

over 65 years. Dementia (please see Dementia JSNA Chapter), delirium and substance misuse are also linked with poor mental health in older people and schizophrenia affects about 1% of the older population.

Mental illness in old age is affected by deprivation, bereavement, isolation, and physical illness. National data shows older people poverty in Leicester is significantly higher than England. The last census recorded about 12,000 single person 65+ households in Leicester and predicted loneliness to be higher in St Matthews & St Peters, City Centre, Braunstone, New Parks, and Mowmacre & Stocking farm.[21]

Having a long-term condition such as diabetes, arthritis, asthma, cardiovascular diseases, and cancers is associated with higher risk of poor mental health. Long term conditions can lead to significantly poorer health outcomes and reduced quality of life. People with long-term conditions disproportionately live in deprived areas and have access to fewer resources of all kinds.

Carers: Carers are more at risk of mental health problems, such as anxiety and depression than the general population, and are less likely than the population generally, to ask for support. According to the latest available 2021 Census there are an estimated 26,500 carers in Leicester. Local Health and Wellbeing Survey (Leicester Health and Wellbeing Survey 2018) data showed that over 30,000 Leicester adults have a caring responsibility.

Being from Black and Minority Ethnic (BME) backgrounds: For a city as diverse as Leicester the impact of mental illness on people from minority ethnic backgrounds is of paramount importance. Data shows higher rates of common mental health disorders and psychotic disorders have been found in people from minority ethnic backgrounds. There are disproportionate rates of people from BME populations being detained under the Mental Health Act. Decades of research have shown ethnic inequalities in access to, and experience of, mental health services. These inequalities will be discussed later in this chapter.

Lesbian, Gay, Bisexual and Transgender (LGBT) People: Evidence suggests that people who identify as lesbian, gay, bisexual and/or transgender (LGBT) are at a higher risk of experiencing poor mental health.[22] This higher prevalence could be associated with factors, such as discrimination, isolation and homophobia. Compared to the general population LGBT people also have greater detrimental exposure to the wider determinants of health, poorer experiences of hospital and residential care, and poorer access to health and social care provision. It is estimated that about 8,000 people aged 16 and over are lesbian, gay, or bisexual in Leicester.[23]

Offender mental health and wellbeing: Prisoners have been shown to have significantly higher rates of mental health problems compared to the general population. Remand

prisoners are likely to have 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.[24]

The burden of mental health illness is higher for Leicester than in comparator prisons. Up to 60% of the prisoners self-report mental health problems, and during 2020 about 135 men at any time were receiving mental health services. The case load of moderate to severe illness was usually between 60 and 70 and there were 455 incidents of self-harm in the year 2020. There is full staffing of mental health nurses, and full involvement with reception, casework and properly timetabled ACCT reviews. An appointed psychiatrist attended one day a week before COVID-19 lockdown restrictions were imposed, ensuring continuity of care. Consultations were held digitally for three months, but then resumed as face-to-face in clinic.

Studies show a higher level of mental health need and worse outcomes for offenders in the community than in the general population. Despite this increased need, access to health and social care is generally worse for offenders, either in the community or on release from prison.

Asylum seekers and refugees: Mental illness is more prevalent among asylum seekers and refugees. Several factors have a detrimental impact, for instance experience of trauma, the process of claiming asylum and detention, separation from family, unemployment, and inadequate housing. Patient data at the Leicester Assist Practice (a practice that provides healthcare for refugees and asylum seekers) suggests there are about 1,500 registered patients resident in Leicester[25].

Veterans: When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. All veterans are entitled to priority access to NHS hospital care for any condition if it is related to their service. 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.

Homeless People: 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.

Co-occurring mental ill health and substance dependence is common amongst people who sleep rough. Alcohol and drugs may be used to self-medicate poor mental health, and substances may also be used in conjunction to aid sleeping, pain, and cold temperatures.

There is evidence that people who rough sleep with co-occurring needs experience barriers to services. It is common for people with mental health needs to have difficulties accessing

treatment for co-existing alcohol or drug use, a particular problem for those diagnosed with serious mental illness, who may also be excluded from alcohol and drug services due to the severity of their mental illness[26].

People with dual diagnosis: A person with dual diagnosis has both mental ill health and an alcohol or drug problem. The interaction of the conditions can worsen both. Elements of care, such as diagnosis and treatment are difficult. Service users have 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. 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.

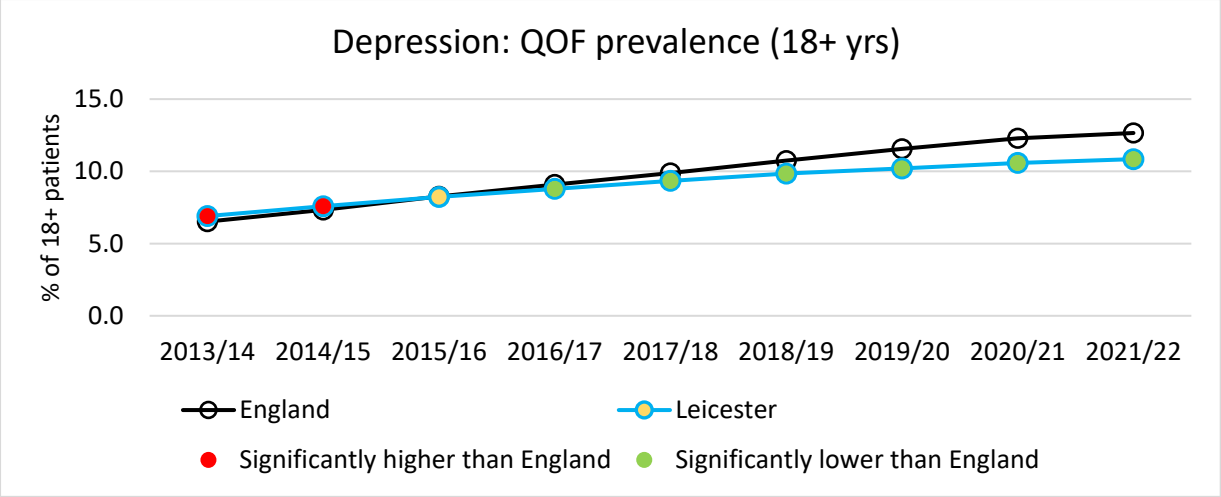
For an in-depth analysis of the groups at risk of poor mental health in Leicester see http://www.leicester.gov.uk/media/178811/mental-health-jspna.pdf

4 THE LEVEL OF NEED IN THE POPULATION

Mental illness can affect anyone. Figure 6 (below) shows local estimates of poor mental health need amongst children, working age adults and older people. The trend chart shows the percentage of people aged 18+ experiencing depression and compares against England. Since 2013/14 depression prevalence has increased from about 7% to above 10% both locally and nationally.

Figure 6. Mental illness in Leicester (including Depression prevalence trend)

- **Approximately 100 children (<18 yrs) are admitted to hospital each year for mental health conditions**
- **About 57,000 people of working age (16+) and 5,000 aged 65+ experience common mental health problems**
- **About 10.2% of the population (33,500) have reported depression. The actual estimate is likely to be higher.**
- **1** in **4 people** will **experience** a **mental health** problem of some kind each year. Stigma is still widespread and people are not receiving support from services.

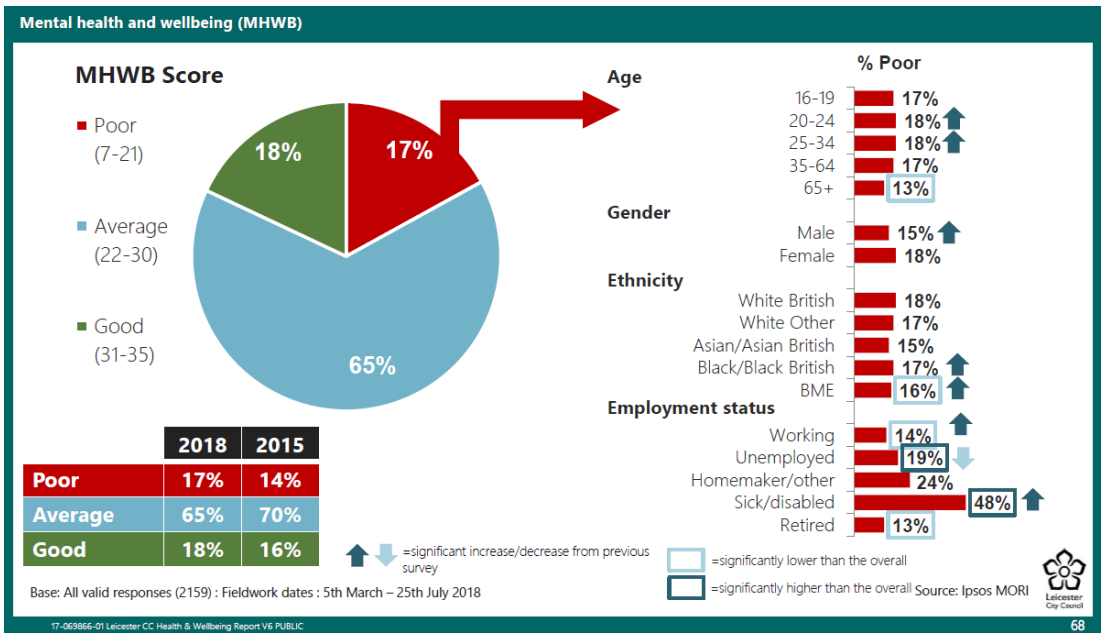


Source: *Office for Health Improvement and Disparities, Fingertips 2023*

4.1 POOR MENTAL WELLBEING IN THE LEICESTER HEALTH AND WELLBEING SURVEYS

The Leicester Health and Wellbeing Survey 2018[27] provides a snapshot of health and wellbeing issues for the Leicester population (aged 16 and over). It includes questions on mental wellbeing, resilience, and social isolation. It identified that one in six (17%) adults (16+) had a poor mental wellbeing (see figure 7 below). This is an estimated 47,000 residents in Leicester. This was also a significant increase since the previous survey in 2015; this increase can be seen in certain groups: 20–34-year-olds, men, BME residents, working residents, and those who do not work as they are sick/disabled.

Figure 7. Poor mental wellbeing amongst Leicester residents (16+)



Source: *Leicester Health and Wellbeing Survey 2018*

In some areas of the city the poor mental wellbeing is significantly higher than the overall Leicester rate of 17%. Rates of poor mental wellbeing are higher in some of the most deprived areas in the city (see figure 8 below). The Survey also identifies associated risks for those with poor mental wellbeing, such as significantly higher rates of A&E visits, physical inactivity and social isolation (see figure 9 below).

Figure 8. Poor mental wellbeing score in Leicester

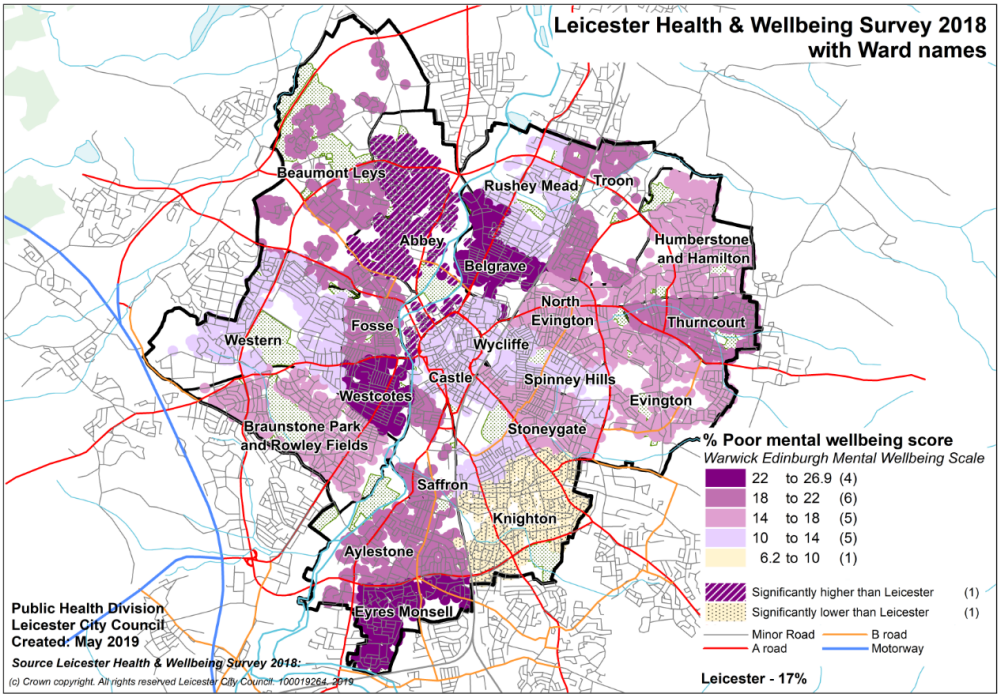


Figure 9. Mental wellbeing and associated risks amongst Leicester residents (16+)

The table below shows some of the "groups and behaviours" and their correlation with mental wellbeing groups

Mental Wellbeing Group	In good health	Visit GP in last 12 months	Visit A&E in last 12 months	<30 mins exercise per week	High BMI (overweight/ obese)	Five a day+ Fruit and veg portions	Socially isolated	Current smoker	Run out of money
Poor mental wellbeing: 17% of Leicester adults	**58%**	82%	**26%**	**18%**	**59%**	**15%**	**22%**	**32%**	**27%**
Average mental wellbeing: 65% of Leicester adults	77%	77%	20%	9%	48%	21%	*5%*	18%	11%
Good mental wellbeing: 18% of Leicester adults	*84%*	72%	*14%*	10%	52%	*27%*	*3%*	*14%*	*6%*
Leicester overall	75%	77%	20%	11%	50%	21%	8%	20%	13%

Significantly better than Leicester | **Significantly worse than Leicester**

Source: Ipsos MORI

Source: *Leicester Health and Wellbeing Survey 2018*

The more recent Leicester Children's Health and Wellbeing Survey 2021/22 revealed that over a third (36%) of children worried about the mental health of a family member. Children also reported worrying about alcohol or drug use at home (12%) and adults pushing/hitting at home (14%). About one in twenty children worried about all three of these issues.[28]

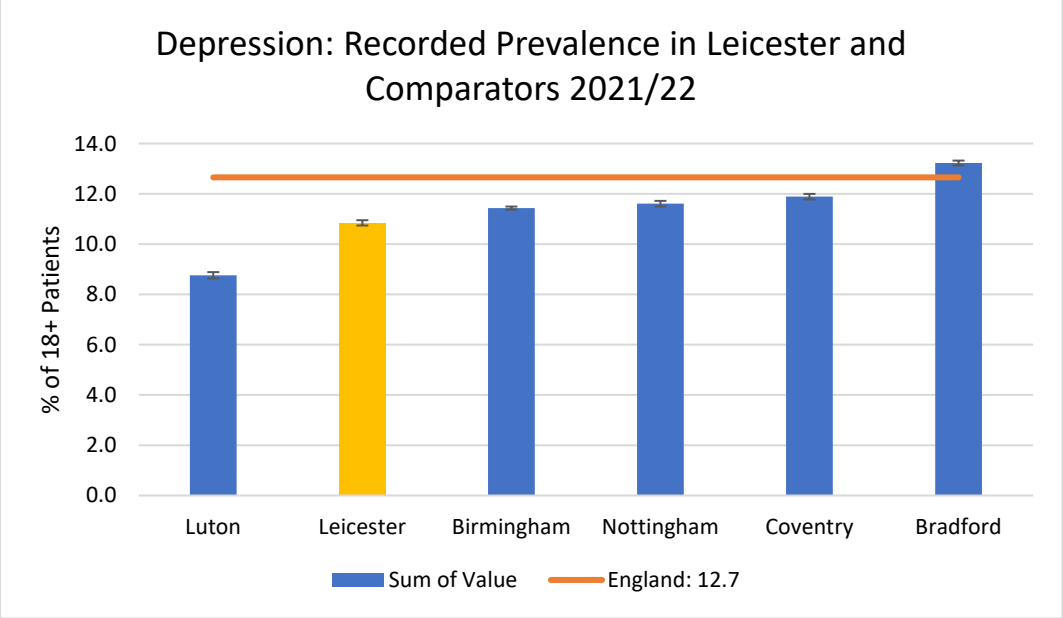
4.2 ESTIMATES OF THE LEVEL OF NEED AMONGST DIFFERENT GROUPS

Pregnant/New Mothers: On average there are about 5,000 births in Leicester in a year, we should expect at least 10 cases of post-partum psychosis; 10 cases of chronic serious mental illness; 120 cases of severe depressive mental illness; 385-580 cases of mild-moderate depressive illness/anxiety; 120 cases of post-traumatic stress disorder and 580-1,155 cases of adjustment disorders and distress.[29]

20.6% of working age adults (16+) had symptoms of common mental health problems. Applied to the Leicester population this equates to about 57,000 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 (19.1% and 12.2% respectively). The estimated number of people with serious mental health problems is estimated to be less than 1 in 100. Analysis shows that those who suffer from depression or bipolar disorder are more likely to reside in the most deprived areas.

Figure 10 (below) shows the percentage of people aged 18+ years experiencing depression in Leicester and similar areas with comparison against England. In 2021/22 Leicester reports a significantly lower prevalence of depression diagnosis compared to England and some of our similar authorities.

Figure 10. Depression prevalence in Leicester and comparators



Source: *OHID, Fingertips 2023*

Older people: Depression is the most common mental disorder in people aged over 65 years; affecting an estimated 7,000 older people in Leicester. Schizophrenia affects about 1% of the older population; equating to about 400 people in the city.[30]

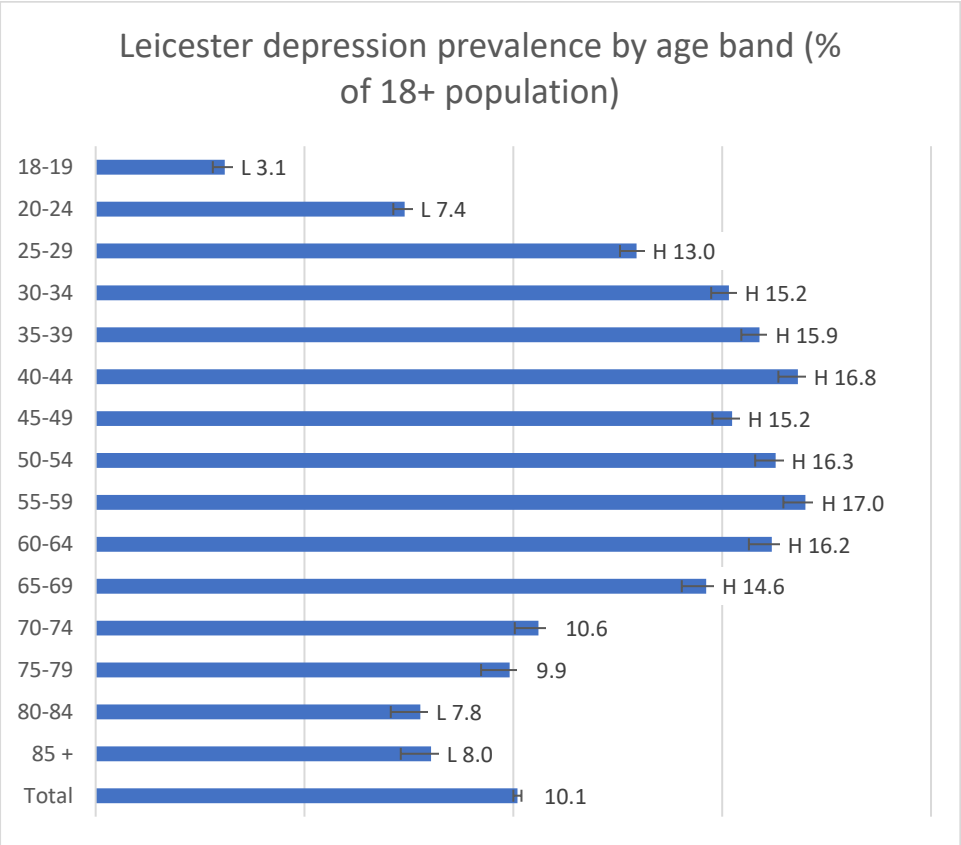
The latest estimated proportion of the population aged 65+ in Leicester who have a common mental disorder (CMD), where CMD is defined as any type of depression or anxiety is 12.7%; significantly above that for England overall at 10.2%.

The recorded prevalence of dementia is also significantly higher in Leicester than for England overall, with 4.8% prevalence among those aged 65+ (England 4.0%). However, it is estimated that many cases of dementia in the community remain undetected. In 2021, the estimated diagnosis rate for dementia was 76.4% (ie 76.4% of all patients estimated to have dementia have a recorded diagnosis of dementia). This is significantly higher than England (61.6%) and has been a consistent trend since 2017.

4.3 DEPRESSION AND MENTAL HEALTH PATIENTS ON PRACTICE REGISTERS

Leicester GP disease registers include about 37,000 patients with depression six out of every ten Leicester patients with depression is female and as a percentage of the population females are significantly more likely to have depression compared to males. About one in ten of the Leicester adult population and in age bands from 25 to 69 deprivation prevalence is significantly higher.

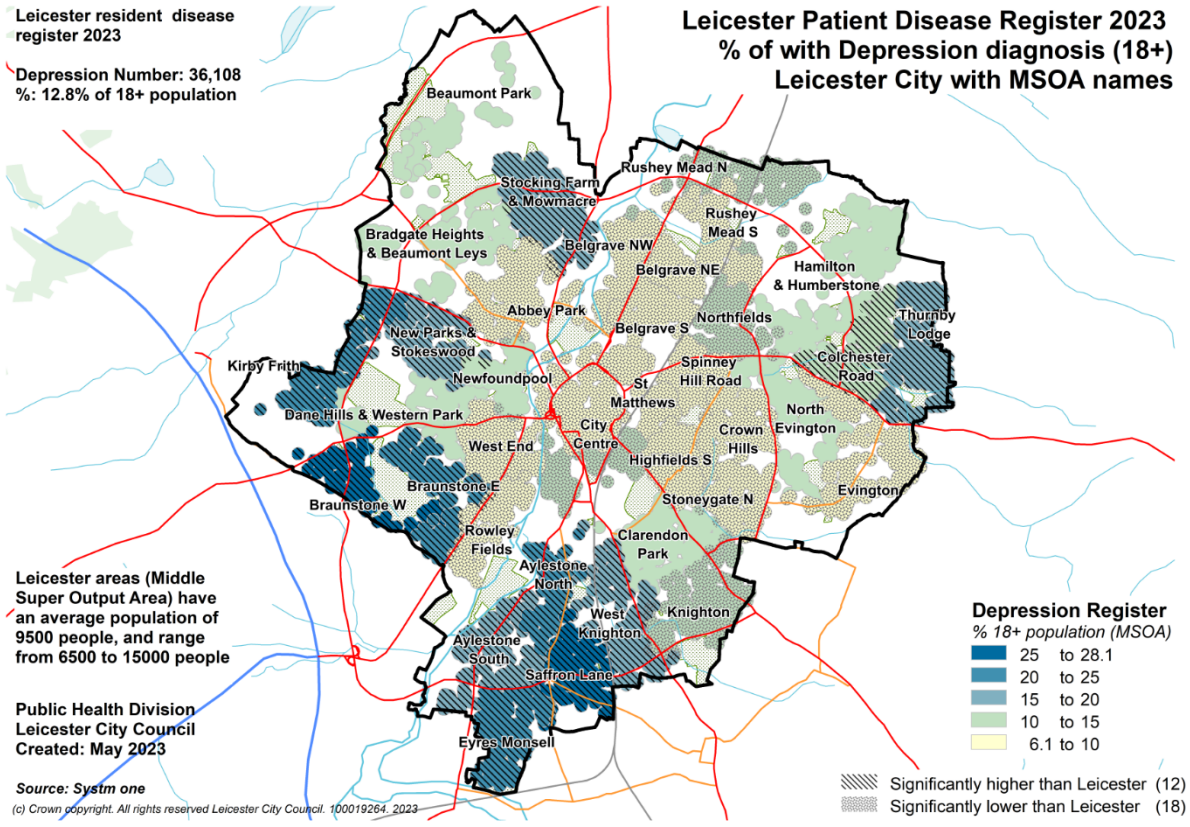
Figure 11. Leicester Patient Register: depression by age band (% of 18+ population) (2023)



Source: *System One 2023*

There are significant differences in the percentage of the adult population with depression by city neighbourhood. In some areas of the city depression is more common in the adult population. In areas of Braunstone, New Parks, Saffron, Eyres Monsell, and Thurnby Lodge about one in five adults have a diagnosis of depression. These are some of the most deprived neighbourhoods in the city.

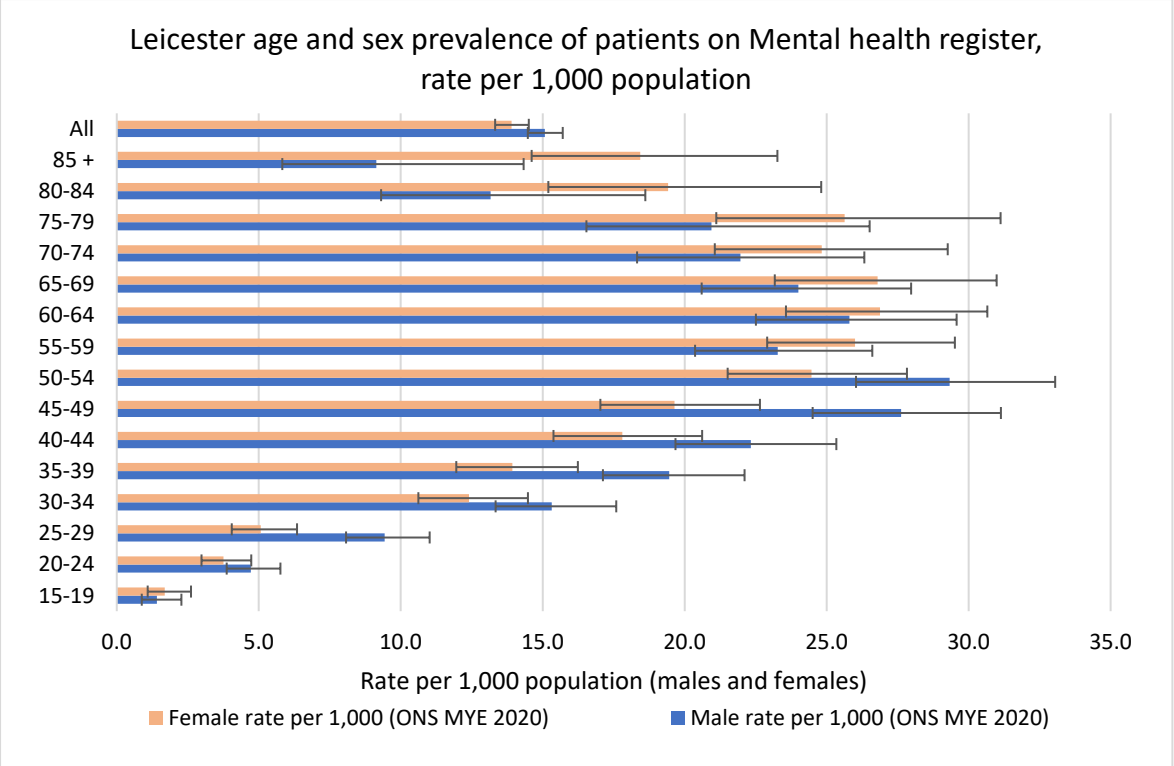
Figure 12. Leicester Patient Register: depression by MSOA (2023)



Leicester GP records include about 4,700 patients on the mental health register for conditions such as schizophrenia, bipolar disorder, and other psychoses. This is about 1% of the GP list. Figure 13 (below) shows the prevalence of patients on the mental health register by age and sex. Overall, it shows that males are slightly more likely than females to be on the register, however this differs dependent on age band. In younger age bands (20-54 year old) males have higher rates on the mental health register, and in older age bands (55-85+ year old) females are more likely to be on the register.

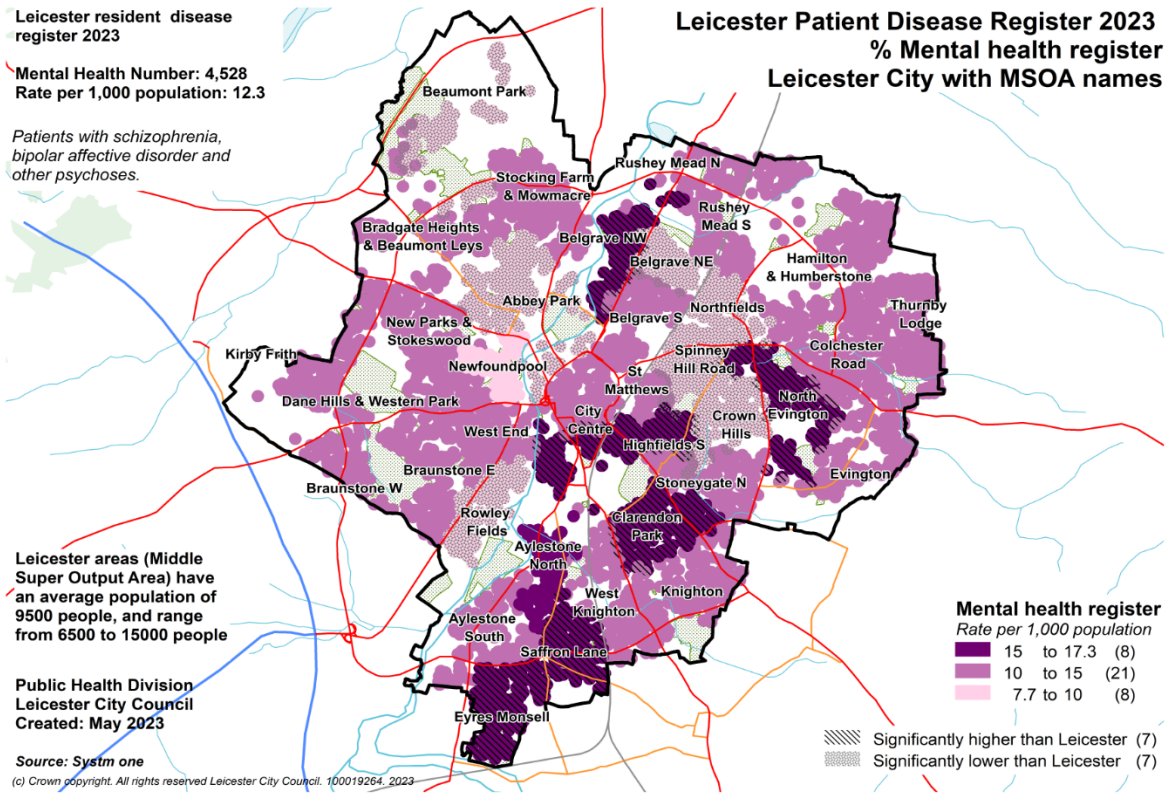
Leicester residents on the Mental Health register are distributed across the city. MSOA neighbourhood level analysis (figure 14 below) shows higher rates of mental health patients in Belgrave, North Evington, Highfields, Clarendon Park, Eyres Monsell, and Saffron. This is a different pattern to the spread of depression patients.

Figure 13. Leicester patients on Mental Health Register



Source: *NHS System One 2020*

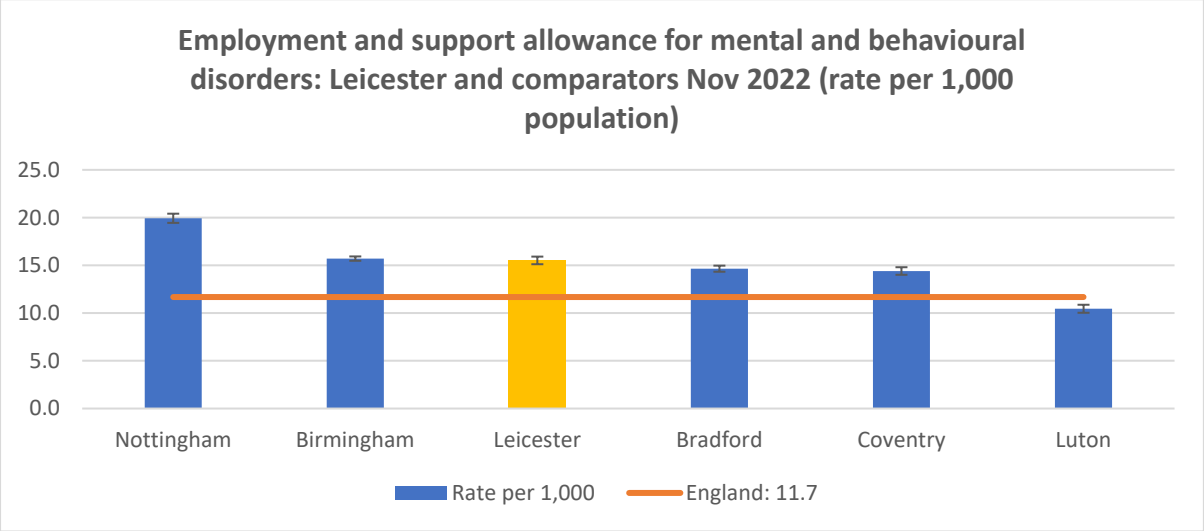
Figure 14. Leicester Mental Health Patient Register by MSOA (2023)



4.4 CLAIMANTS FOR MENTAL AND BEHAVIOURAL DISORDERS

The figures (below) show the rate of employment and support allowance claimants for mental and behavioural disorders.

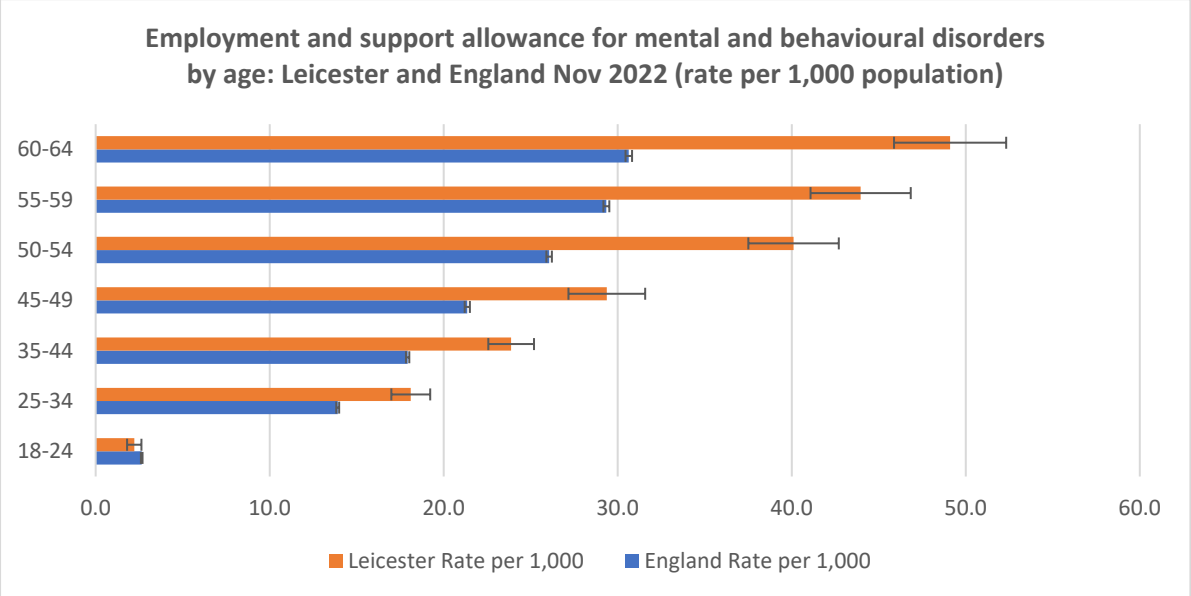
Figure 15. ESA claimants for mental and behavioural disorders



Source: *DWP Stat X-Plore 2023*

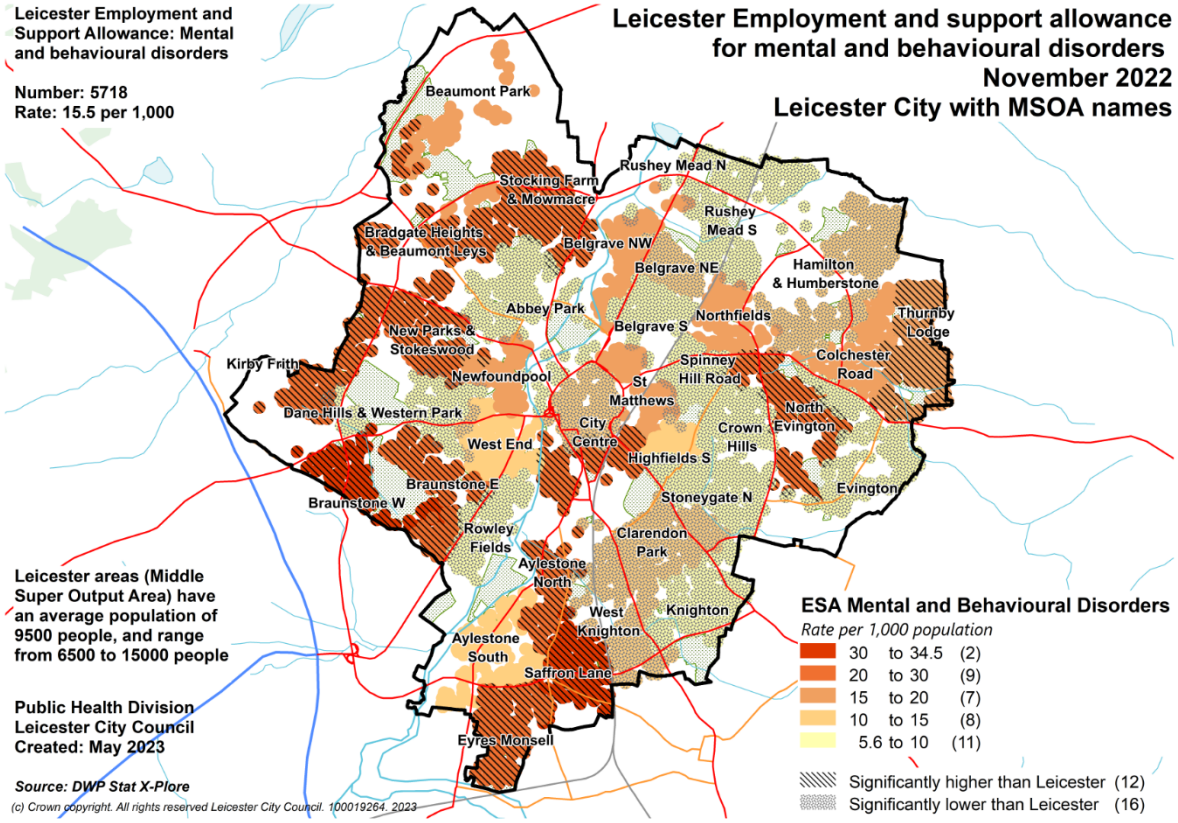
Figure 15 (above) shows Employment and Support Allowance (ESA) claimants for mental and behavioural disorders is significantly higher in Leicester compared with the national average. Figure 16 (below) shows that by age band Leicester older working age adults are significantly more likely to be ESA claimants compared to people of a similar age in England.

Figure 16. ESA claimants for mental and behavioural disorders by age band



Source: *DWP Stat X-Plore 2022*

Figure 17. Employment and Support Allowance Claimants for mental and behavioural disorders by Leicester MSOA (2022)



ESA claimants' data is available at a lower geography (figure 17 above) and shows there are higher rates of claimants for mental and behavioural disorders in some of the most deprived areas of the city including Braunstone, Eyres Monsell, Beaumont Leys, New Parks, Mowmacre and Stocking Farm, Saffron, and St Matthews. This does not fully align with patients on the mental health register, for example Belgrave and Highfields report significantly higher rates of patients on the mental health register but are not high for claimants of mental health disorders.

4.5 MENTAL HEALTH RELATED HOSPITAL ADMISSIONS

There have been on average about 1,400 hospital admissions a year with a primary diagnosis of a mental and behavioural disorder over the period 2012-2021. Table 2 (below) shows different diagnoses for hospital admissions. About a quarter of mental health primary diagnosis admissions are mental and behavioural disorders due to use of alcohol, and just over one in ten of admissions are because of a schizophrenia diagnosis.

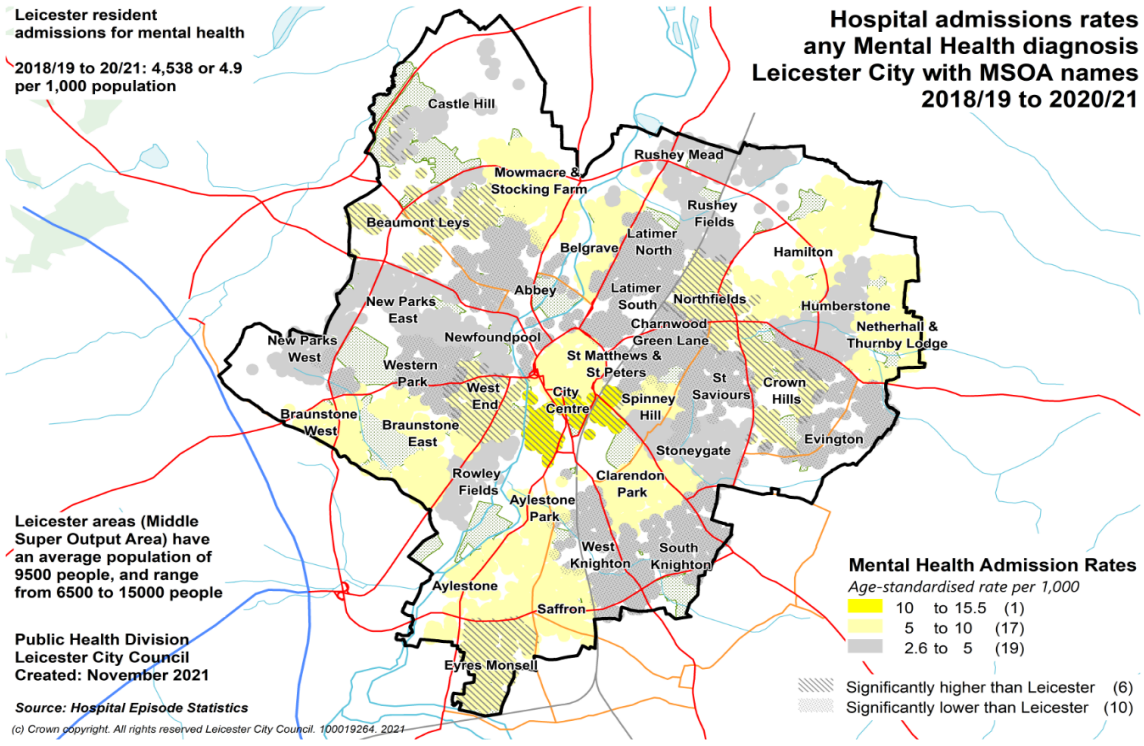
Table 2. Hospital admissions: primary diagnosis for mental and behavioural disorders

Hospital admissions with a primary diagnosis (2016/17-2020/21)	Number	%
Mental and behavioural disorders due to use of alcohol	1693	23%
Schizophrenia	915	13%
Delirium not induced by alcohol and other psychoactive subs	710	10%
Depressive episode	460	6%
Bipolar affective disorder	418	6%
Other anxiety disorders	385	5%
Specific personality disorders	373	5%
Acute and transient psychotic disorders	280	4%
Schizoaffective disorders	278	4%
Mental & behavioural disorders due multiple/psychoactive drug use	225	3%
Other Mental Health and Behavioural Disorders	1493	21%
Total	**7230**	

Source: *HES data 2022*

In recent years the number of admissions for mental health disorders has increased, in 2016/17 there were about 1,300 hospital admissions and in 2020/21 there were over 1,600 hospital admissions. For the 3-year period between 2018-2021 there were 4,538 hospital admissions for mental health disorders, this is the equivalent of 5 per 1,000 Leicester residents. Figure 18 (above) shows mental health related hospital admissions. Some of our most deprived areas, including the City Centre South, Beaumont Leys and Eyres Monsell report significantly higher rates than the Leicester average for hospital admissions.

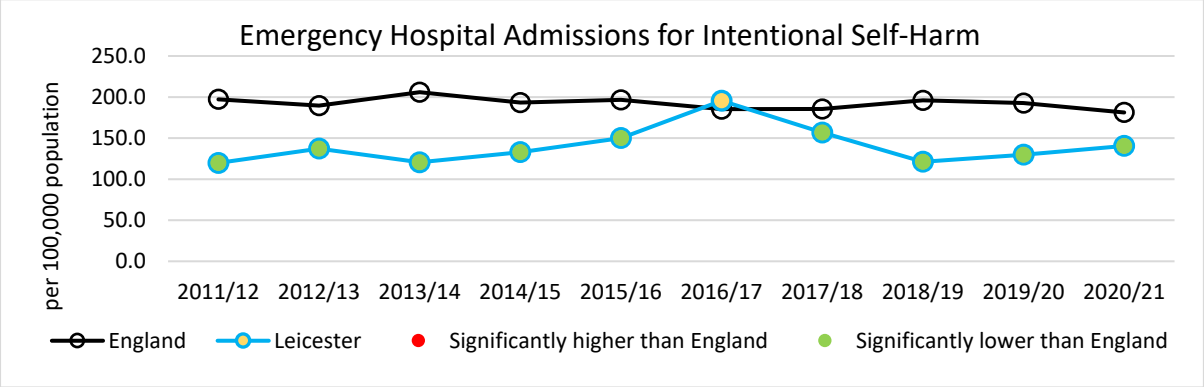
Figure 18. Hospital admissions for mental health conditions (primary diagnosis) 2018/19 to



4.6 INTENTIONAL SELF HARM AND SUICIDE

Self-harm describes behaviour which is a way of dealing with very difficult feelings, painful memories or overwhelming situations and experiences. There is a significant and persistent risk of future suicide following an episode of self-harm. Figure 19 shows that emergency hospital admissions for intentional self harm remain lower than the national, however has been climbing in recent years.

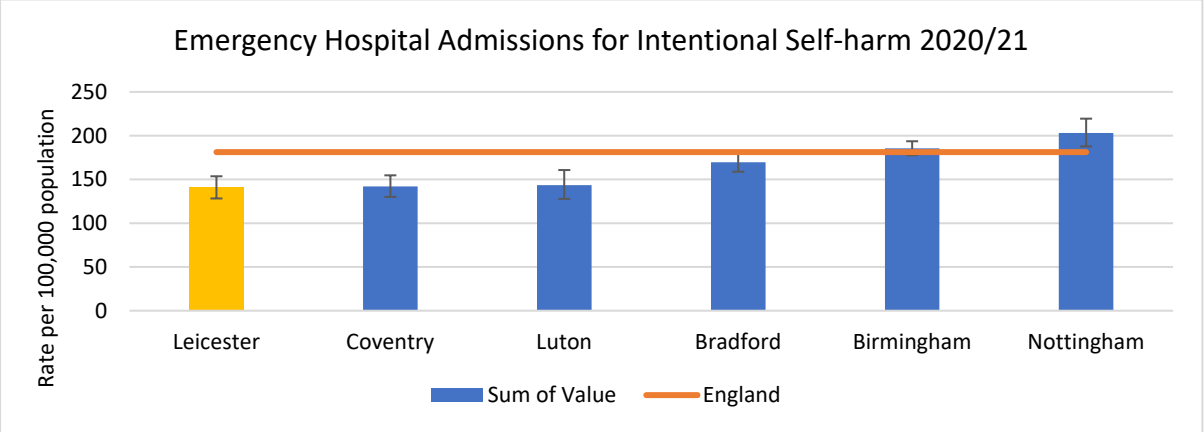
Figure 19. Emergency hospital admissions for intentional self-harm, Leicester and England 2011 to 2021



Source: *OHID 2023*

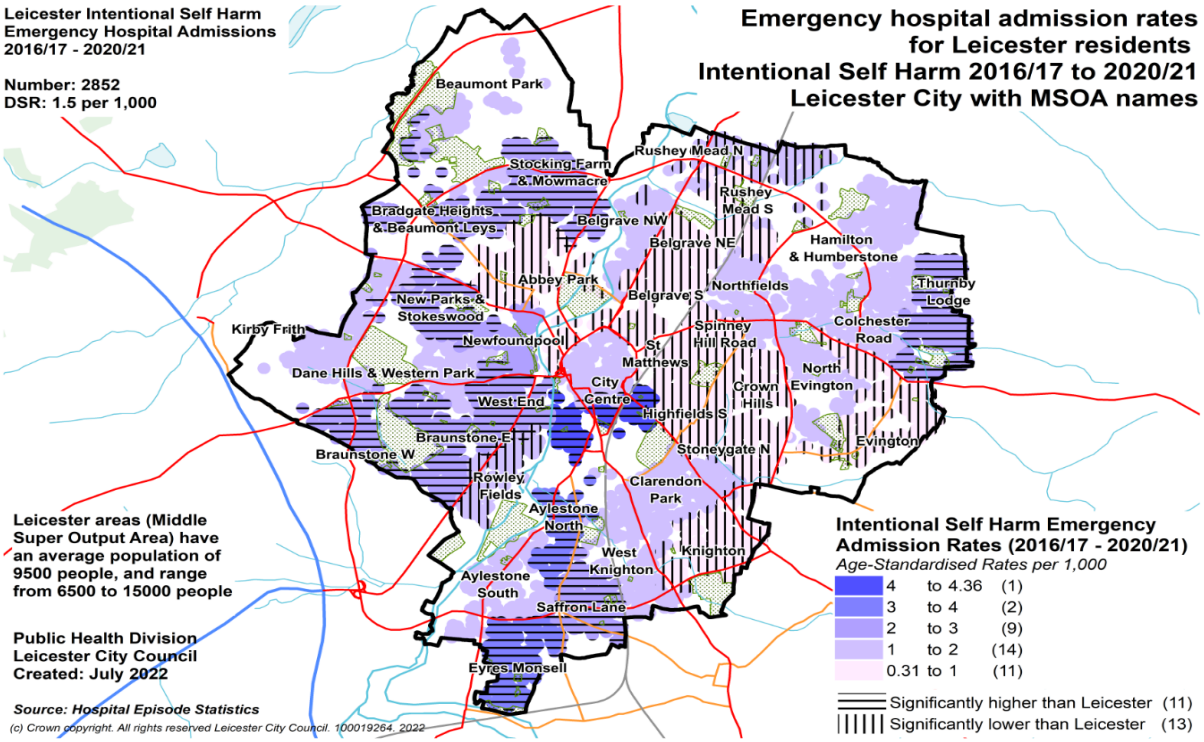
Figure 20 shows that emergency hospital admissions for intentional self harm in the most recent year are significantly lower than the national and some of our comparators. When mapped across the city by MSOA neighbourhood (figure 21), areas to the south, west and north west report significantly higher rates. These include some of our most deprived areas Eyres Monsell, Saffron, Braunstone, West End and City south, New Parks, Beaumont Leys, Mowmacre and Stocking Farm, and Thurnby Lodge.

Figure 20. Emergency hospital admissions for intentional self-harm, Leicester and comparators 2020/21



Source: *OHID 2023*

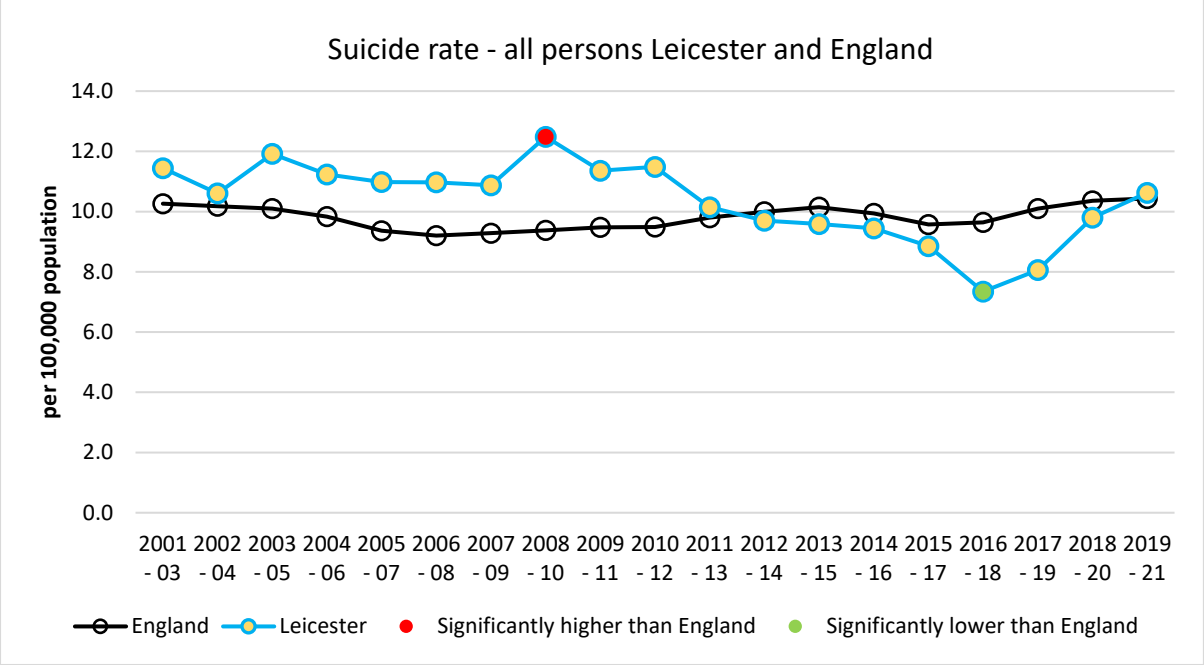
Figure 21. Emergency hospital admissions for intentional self-harm, Leicester MSOA map 2016/17- 2020/21



Suicide is a significant cause of death in young adults and is seen as an indicator of underlying rates of mental ill-health. In 2022, EMAS data registered 186 suicide attempts in Leicester City in the 18–25 year old cohort (reduced from 2021, but increased from 2020). Suicide is a major issue for society and a leading cause of years of life lost. It is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals, and societal resources can help to prevent people dying by suicide.

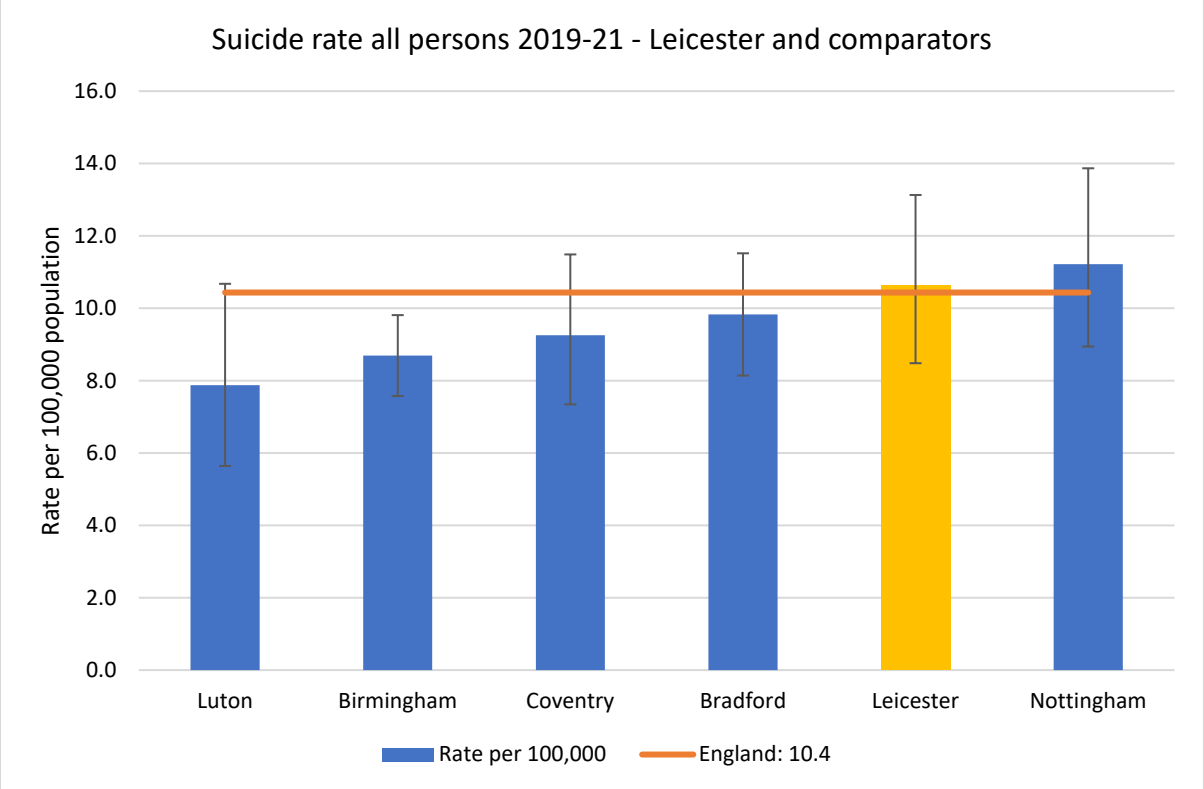
Figure 22 shows that suicide rates in Leicester have tended to be statistically similar to the national rate. Over the most recent reporting periods suicide rates have been increasing in the city. Figure 23 shows how Leicester compares to similar areas, the city reports statistically similar suicide rates to these areas.

Figure 22. Suicide rate all persons trend from 2001 to 2021



Source: *OHID 2023*

Figure 23. Suicide rate all persons trend from 2019 to 2021



Source: *OHID 2023*

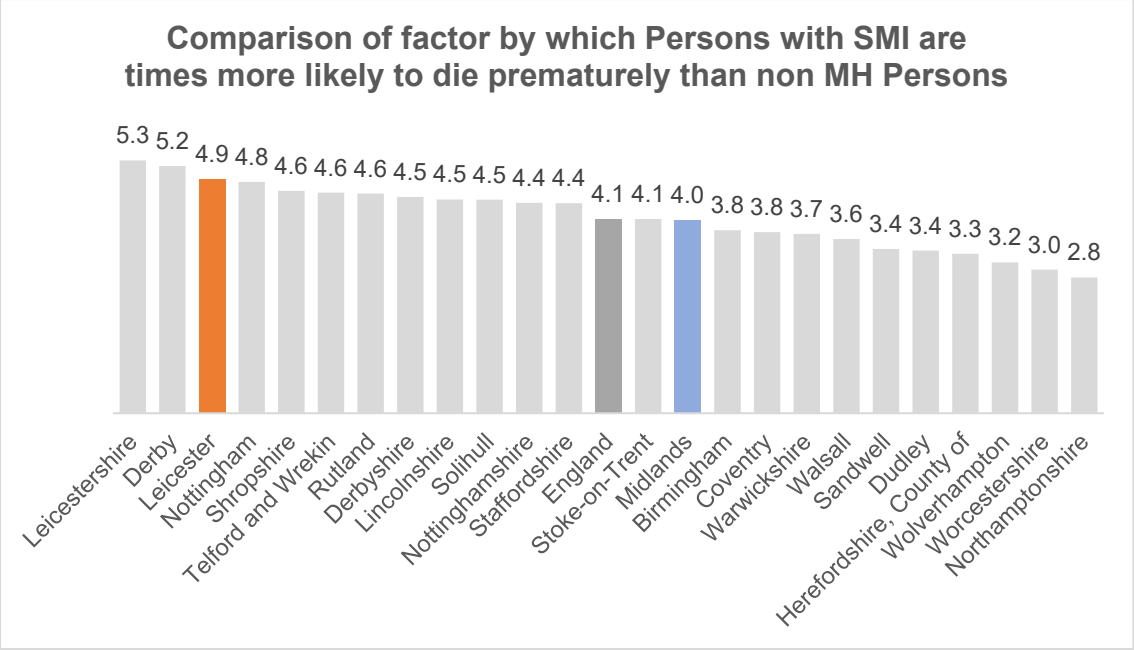
4.7 MENTAL HEALTH AND MORTALITY

People with severe mental illness (SMI) often experience poor physical health as well as poor mental health. They frequently develop chronic physical health conditions at a younger age than people without SMI. These chronic conditions include obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), stroke, heart failure and liver disease. People with SMI are at increased risk of developing more than one of these chronic conditions.

These physical health problems increase the risk of premature death in people with SMI. Although people with SMI die prematurely from physical conditions, their SMI may still have been a significant feature in their lives, influencing their lifestyle, risk of developing chronic health conditions, their access to health services, and their ability to self-manage physical health conditions. It is estimated that for people with SMI, 2 out of 3 deaths are from physical illnesses.[31]

In Leicester those with a SMI are about 5 times more likely to die prematurely compared to those without an SMI, in England this figure is about 4 (figure 24 below). Leicestershire and Rutland also report higher factors for SMI premature death.

Figure 24. SMI mortality and non Mental Health mortality comparison (2018-20)



Source: *OHID 2023*

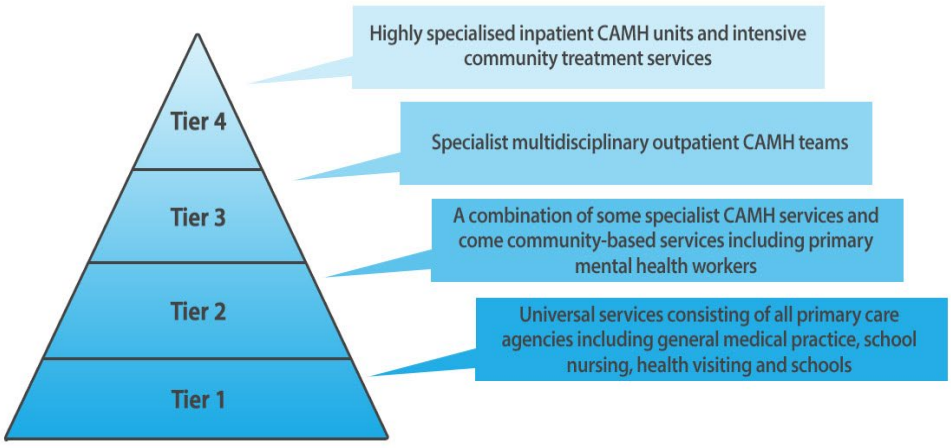
5 CURRENT SERVICES IN RELATION TO NEED

Perinatal Maternal Mental Health: Midwives routinely inquire about women's current mental health during pregnancy and the early post-partum period. Maternity services have access to perinatal mental health teams. Specialist help for women is delivered through a community perinatal mental health team. Inpatient care is given by accredited mother and baby units in Nottingham and Derby. Together these services counsel women with serious disorders about the effects of pregnancy on their condition; provide information and advice about possible effects of their medication on pregnancy; provide additional training to psychiatric teams about perinatal mental health and raise awareness about the risks to mental health linked to pregnancy and childbirth.

Child and Adolescent Mental Health: Mental health is a significant and potentially increasing health concern for young people. Between the ages of 16 – 18 young people are more susceptible to mental illness, undergoing physiological change and making important transitions in their lives. Meeting the mental wellbeing needs of children and adolescents requires partnership working between universal and specialist services. This partnership consists of children's health and social care services, schools and local authorities, voluntary sector organisations, parents, children, young people, and families.

Currently child and adolescent mental health services (CAMHS) are provided through a network of services. These follow a tiered model of care, with different services for different levels of severity (Figure 25).

Figure 25. Child and adolescent mental health services (CAMHS) tiered model



Source: *Royal College of Psychiatrists (2008): Psychological therapies in psychiatry and primary care*

Some Leicester CAMHS services work across tiers or assist in helping children adjust from the care of one tier to another. However, the structure of mental health services can often

create gaps for young people undergoing the transition from children and young people's mental health services to appropriate support including adult mental health services.

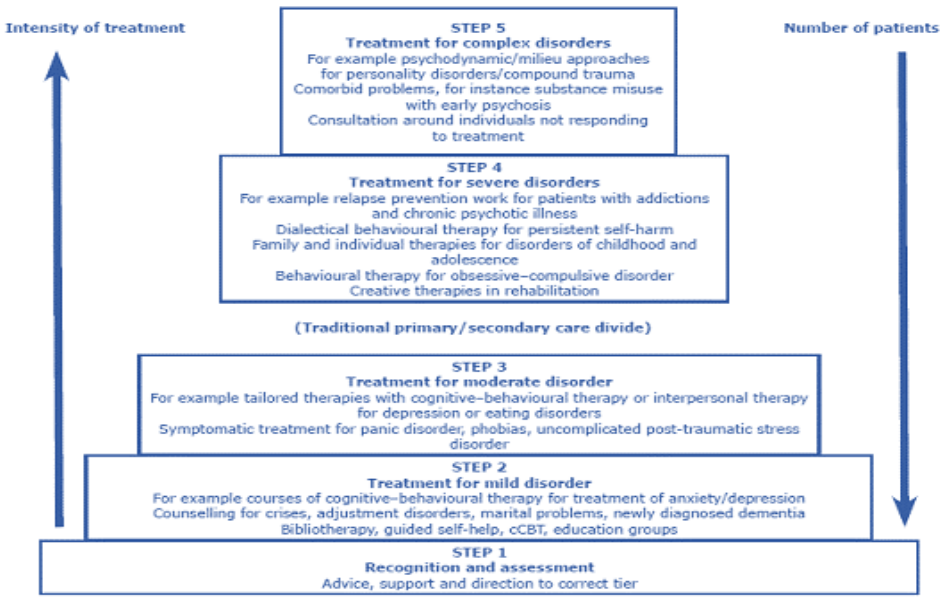
Online counselling and emotional well-being digital platforms are available for young people aged 18–25 in Leicester including the universities. NHS Talking Therapies are available for 16+ year olds.

Student Mental Health: Both De Montfort University and the University of Leicester offer student counselling and support. Local services used by students include GP surgeries (Victoria Park Health Centre and Mill Lane Surgery), the Open Mind talking therapy service, local crisis team and Emergency Department, and the PIER (Psychosis Intervention and Early Recovery) team. Crisis cafes (DeMontfort student union / Leicester University Students union – provided by Mental Health Matter) +_digital online counselling provision.

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. In Leicester, compared to the England average, there is a significantly higher number of total contacts with mental health services but a significantly worse rate for people moving into recovery after using NHS Talking Therapies . [32]

Care is delivered according to the stepped care model of service provision, which is shown in Figure 26 below.

Figure 26. Stepped care model of service provision



Source: *Royal College of Psychiatrists (2008): Psychological therapies in psychiatry and primary care*

This approach works by service users moving up and down the steps of care, according to their needs and the impact of specific interventions or services. For working-age adults, these services include:

NHS Talking Therapies: Psychological treatments which are compliant with National Institute for Clinical Excellence (NICE) guidelines within Primary Care. Talking therapy provides treatments for people with mild to moderate mental health problems in line with Steps 2 and 3 of the Stepped Care model.

Mental Health Wellbeing and Recovery Support Service: Preventative mental health support through advice & navigation and community recovery support. The service is open access and uses 1:1 and group/peer support to help people to build confidence, retain/regain independence and recover from mental ill health by working towards individual outcomes.

Mental Health Facilitators: A primary-care based service for patients with more severe and enduring mental illness, such as schizophrenia or bi-polar disorder.

Inpatient hospital care: A safe setting for patients in the most acute stage of mental illness when admission will help progress to recovery. Some people in acute care services will be detained in hospital under the 1983 Mental Health Act [MHA]. Acute inpatient services in Leicester are based at the Bradgate Unit at Glenfield Hospital, where there are four types of inpatient services, including psychiatric intensive care units.[33]

Crisis House: A residential setting which supports people experiencing mental health crisis who do not need hospital admission but cannot be treated at home. This service also has a crisis helpline for telephone support, guidance, and signposting to other services.

Acute day services: An alternative to admission for people who are acutely unwell and are sometimes used to facilitate early discharge and prevent readmission.

Mental Health Central Access Point [CAP]: People in need of mental health support for themselves or others can contact the CAP. The phoneline is staffed by Turning Point. Caller's needs are discussed and explored. Calls are transferred to an appropriate member of staff for assessment and intervention.

Place of Safety and Triage Car: The place of safety is the Section 136 (S136) suite at the Bradgate Mental Health Unit. This suite is used for emergency psychiatric assessment by an approved mental health practitioner of people detained by police, under S136 of the MHA. This applies when the police believe the person with mental illness requires immediate care.

The individual should be medically fit on examination, and not physically unwell, injured or intoxicated. S136 is used on an exceptional basis, although when it is appropriate to be used, it is preferable for the individual to be detained in a healthcare setting rather than a criminal justice setting. Local Clinical Commissioning Groups and Leicestershire Partnership

Trust (LPT) are working to develop a place of safety which will meet the needs of young people in mental health crisis.

The triage car brings together Leicestershire Police and a mental health nurse from Leicestershire Partnership Trust to respond to people with mental health problems in public places. The triage car has reduced the number of people being admitted to inpatient care or being detained under the MHA.

Community Mental Health Teams (CMHTs): Multi-disciplinary health and social care teams supporting people living with and people caring for individuals with mental health problems. They design, implement and evaluate packages of care to enable people to stay in the community. CMHTs have statutory and mandatory duties to deliver care under the *Mental Health Act* and the *National Health Service and Community Care Act.*

Approved Mental Health Professionals (AMHP) service: This service is made up of social workers who are specifically trained in mental health and the Mental Health Act and associated code of practice and qualified as approved mental health professionals (AMHPs). The service responds to urgent requests to assess people who may require detention under the Mental Health Act due to the nature or degree of their mental illness.

Complex care services: Patients receiving complex care are among the most vulnerable people in contact with mental health care services. Complex care is part of the NHS and local authority joint commissioning strategies. An example of complex care is provision of specialist supported housing or intensive supported living.

Enablement Supported Living Services for Mental Health: supports people in the community including those with enduring mental health needs and people with a dual diagnosis of mental health & learning disability. The service ensures that people are provided with support that enables them to participate in their community and maintain their health and wellbeing.

Recovery Supported Living Services for people with Complex Adult Mental Health: a specialised 'step down' service that prioritises patients coming out of hospital with more complex care, support and accommodation needs, as well as people om the community who, due to a deterioration in their social situation, are at risk of hospital admission. The service provides 24-hour onsite support with an aim that people are supported to move on after 12-15 months.

Older People: In Leicester, there are several specialist mental health services that help to diagnose and support older people with mental illness. In addition, the local authority carries out social care assessments for older people living with mental health problems, along with their carers. Support offered by social care may involve carer support and practical assistance with tasks, such as home help, meals on wheels, day and respite care, and funding for residential care.

Primary care provides early recognition of mental health problems in older people, along with treating a mental health problem with coexisting physical illness. A typical general practice of list size 10,000 will include approximately 1,500 people aged 65 and over. These are likely to include 75 with dementia, 225 with depression (including 30 with severe depression), 30 with psychoses and 30 others with various less common though significant conditions.

Older people with long-term complex health needs, often towards the end of life, are eligible for Continuing Care packages. Within an old age psychiatric service, those needing care are likely to have a diagnosis of dementia, behavioural difficulties or a long-term functional illness. To qualify for Continuing Care, the complexity, intensity or deterioration of the condition is assessed as requiring constant or regular attention and supervision by multidisciplinary specialised nursing support. There are also options for intermediate care, which offers the opportunity to explore a range of options for community assessment, treatment and support of older people with a mental health problem beyond the scope of primary care.

5.1 UNDERSTANDING ETHNIC MINORITY EXPERIENCES OF MENTAL HEALTH SERVICES

The NHS Race and Health Observatory (RHO) Rapid evidence review considered ethnic inequalities in mental health services in six key areas: [34]

- Attitudes to help-seeking and experiences of general mental health services
- Primary and secondary care mental health services
- Psychological and talking therapies, including Improving Access to Psychological Therapy services
- Secondary care mental health services
- Inpatient services
- Youth mental health services

5.1.1 ATTITUDES TO HELP-SEEKING AND EXPERIENCES OF GENERAL MENTAL HEALTH SERVICES

The review identified the following issues:

Lack of trust: A lack of trust in authority figures deters some communities from seeking help from mental health services. This mistrust stems from the belief that health professionals would not understand racism. There is also awareness of incidents involving excessive force in a psychiatric hospital setting.

Some communities felt that psychiatric medications were targeted at neutralising rather than curing them, that there was too much reliance on medications, and that psychiatrists did not take patients' concerns about side effects seriously.

Some ethnic minorities reported fear of social services involvement preventing them from accessing mental health services.

Lack of knowledge: Not knowing how to access services and support of pathways to help can mean some people give up, e.g., some patients have multiple suicide attempts due to lack of engagement from/with services. Some groups reported lack of GP knowledge about available local services.

Attitudes of professionals: Some ethnic minority groups found mental health professionals' attitudes patronising and judgemental which deterred them seeking help. Participants reported police lacked empathy dealing with people in mental health crises, and variation in treatment for mental health crises in A&E.

People from Black and Black British ethnic backgrounds reported greater levels of unfair treatment and discrimination in mental health services compared with their White counterparts, and that they were more likely to be put on medication but not offered counselling. They felt they were more likely to be diagnosed with psychosis, but also that staff fears around stereotyping Black patients due to their ethnicity may lead to under-diagnosis.

Language barriers and interpreters: Language barriers and lack of access to official interpreters were cited by some as barriers to accessing mental health services and causes of distress, for example on admission to psychiatric wards. There was a perception that some interpreters were unreliable or may break confidentiality, or that some interpreters may hold stereotypes about patients. There was a feeling that there should be more professionally trained interpreters. This is relevant to Leicester as compared to the England benchmark, Leicester has a lower proportion of people who speak English as their first language. The 2021 Census reports that English is the first language of 91% of the population of England. However, it is the first language for only 70% of the population of Leicester. [35]

Stakeholders' opinions: There were concerns that ethnic inequalities in healthcare are longstanding and intractable and that there do not seem to be any policies on the horizon that might address them.

One stakeholder commented that there are insufficient community, non-clinical services for Black people which means they tend to present in crisis and then are more likely to be diagnosed with schizophrenia than their White counterparts. They are more likely to re-enter the system after discharge and to be sectioned, so there is a historical context in terms of how mental health services came into being and continue to operate which means the picture is not optimistic for Black communities trying to access mental health services.

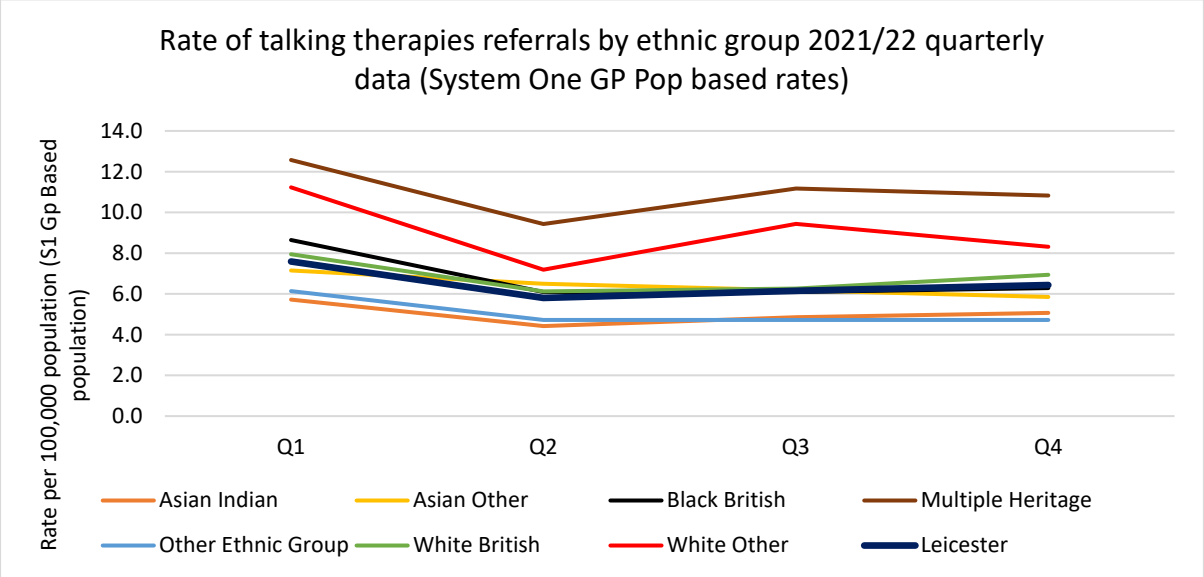
5.1.2 NHS TALKING THERAPY AND MENTAL HEALTH SERVICES

The NHS Race and Health Observatory (RHO) Rapid evidence review found that, compared with White people, many ethnic minority groups were:

1. less likely to self-refer to talking therapies than be referred by a GP
2. more likely to be referred to talking therapies by secondary care than by a GP
3. more likely to be referred to talking therapies through community services e.g. Job Centre, education providers, prison and probation services
4. less likely to be referred for cognitive behavioural therapy for schizophrenia, schizoaffective disorders, bipolar disorder, depression, or psychosis, or while inpatients, and less likely to receive a minimum of 16 sessions.
5. Attend fewer CBT sessions than White people
6. More likely to report experiencing lasting bad effects of receiving psychological treatment

Figure 27 (below) shows that in 2021/22 in Leicester, talking therapy referrals were lowest in Asian Indian and Other ethnic groups, and highest in White Other and Multiple Heritage ethnic groups.

Figure 27. Talking therapies referrals by ethnic group



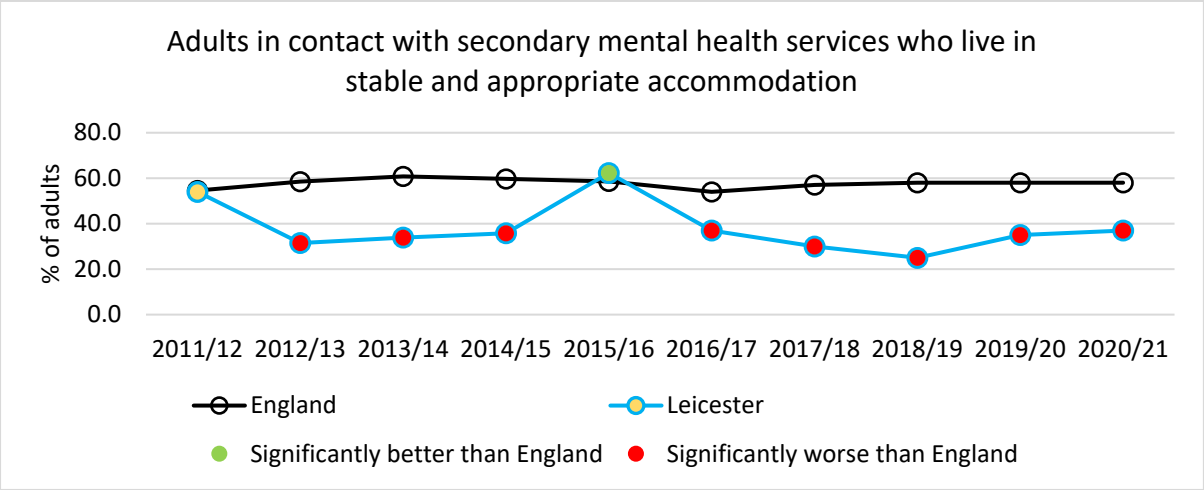
Source: *NHS System One 2022*

5.2 HOUSING AND EMPLOYMENT OF THOSE ENGAGED IN MENTAL HEALTH SERVICES

Maintaining stable and appropriate accommodation and providing social care in this environment helps prevent the need to readmit people into hospital or more costly residential care. Housing service commissioners and providers have a key role in improving mental health outcomes - providing both settled housing and the services people need to

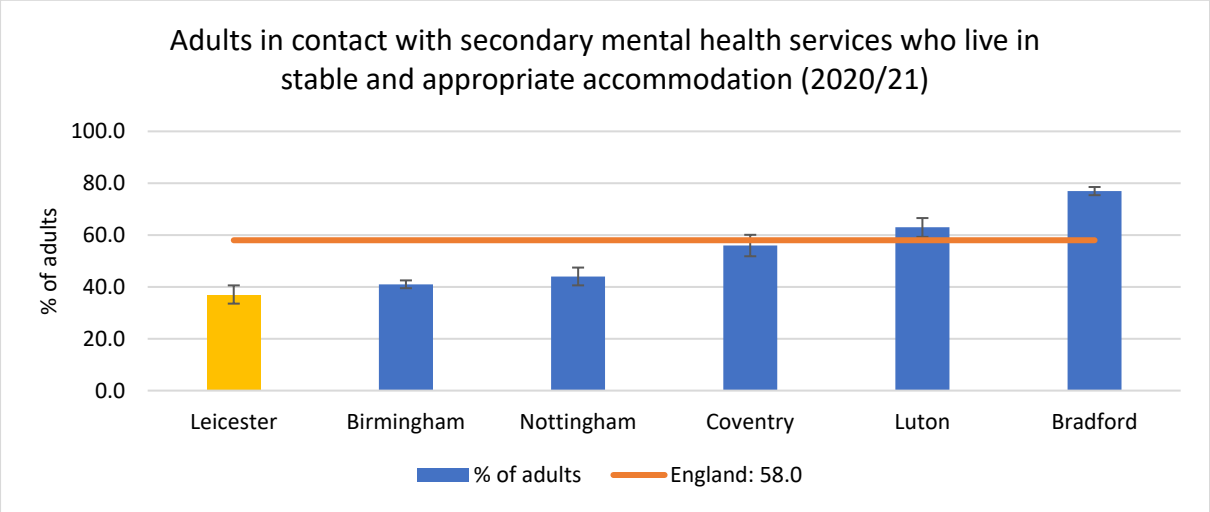
maintain their homes. Figures 28 and 29 show the percentage of adults in contact with mental health services who live in stable accommodation. In Leicester about a third (37%) of adults in contact with mental health services live in stable accommodation, in England it is over half (58%). Leicester has consistently reported significantly worse rates over the last five years compared to England. Leicester also reports lower rates compared to similar areas.

Figure 28. Adults in contact with mental health services who live in stable accommodation Leicester and England trend



Source: *OHID 2023*

Figure 29. Adults in contact with mental health services who live in stable accommodation Leicester and comparators

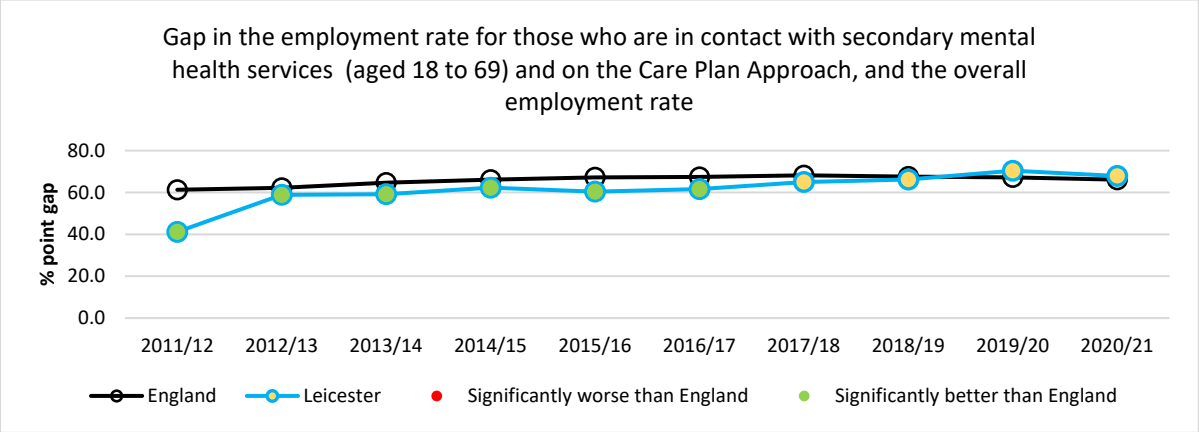


Source: *OHID 2023*

Note: This indicator is now replaced with the proportion of adults in contact with secondary mental health services living independently, with or without support

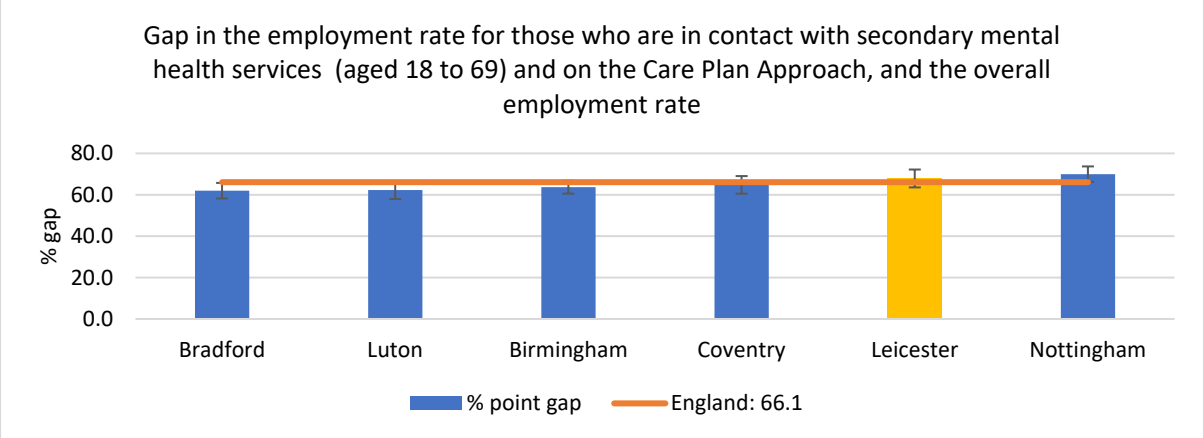
Another major factor in maintaining good mental health is stable employment. The relationship between mental health and unemployment is bidirectional. Good mental health is a key influence on employability, finding a job, and remaining in that job. Unemployment causes stress, which ultimately has long term physiological health effects and can have a negative impact on mental health, including depression, anxiety, and lower self-esteem.[36] Figures 30 and 31 shows the gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate. In Leicester and England the gap between the employment rate of those receiving mental health services and the overall employment rate has remained consistent at about 70 percentage points. The percentage point gap has increased over the last 10 years. Leicester, England and comparator areas have statistically similar percentage point gaps.

Figure 30. Gap in employment between those in contact with mental health services and the overall employment rate.



Source: *OHID 2023*

Figure 31. Gap in employment between those in contact with mental health services and the overall employment rate



Source: *OHID 2023*

6 PROJECTED SERVICE USE AND OUTCOMES

Depression and severe depression in working age adults: Table 3 below shows the projected prevalence of mental ill health problems for people aged 18-64 years.[37] The Projecting Adult Needs and Service Information (PANSI)[37] estimates are based on national modelling and differ slightly to earlier estimates. They report an estimated 43,625 working age adults in Leicester have a common mental health problem and by 2025 the number of people estimated to have a common mental health disorder in Leicester is 44,016, rising to 45,656 by 2035. A 1.2% increase by 2025 and 5.6% increase by 2035. Numbers affected by other mental illnesses such as personality disorder and psychoses are also projected to increase over the next 10 years in line with the population.

Table 3. Projections of population aged 18-64 with mental ill health problems in Leicester

Mental health - all people	2020	2025	2030	2035	2040
People aged 18-64 predicted to have a common mental disorder	43,625	44,016	44,946	45,656	45,749
People aged 18-64 predicted to have a borderline personality disorder	5,541	5,592	5,710	5,801	5,813
People aged 18-64 predicted to have an antisocial personality disorder	7,834	7,958	8,162	8,333	8,382
People aged 18-64 predicted to have psychotic disorder	1,623	1,641	1,678	1,707	1,713
People aged 18-64 predicted to have two or more psychiatric disorders	16,676	16,856	17,233	17,529	17,583

Source: *POPPI 2021; https://www.poppi.org.uk/*

Depression and severe depression in older people: The population aged 65 years and over is projected by POPPI (Projecting Older People Population Information System), to increase from 44,000 in 2020 to 48,500 by 2025. Rates for the prevalence[38] of depression and severe depression are applied to these population figures in Tables 4 & 5. These show that there are currently an estimated 3,772 people aged 65 and over with depression in Leicester and that this is projected to increase to 4,166 by 2025. By 2025 there is a projected 13.6% increase in the number of older people with depression in Leicester, and a 39.1% % rise by 2035. Currently there are an estimated 1,187 older people with severe depression in Leicester, it is estimated that will increase to 1,320 by 2025; an increase of 10% from 2020.

Table 4. Projections of population 65+ with depression in Leicester

Depression – 65+	2020	2025	2030	2035	2040
People aged 65-69 predicted to have depression	1,141	1,241	1,319	1,297	1,258
People aged 70-74 predicted to have depression	917	996	1,081	1,160	1,146
People aged 75-79 predicted to have depression	629	801	867	955	1,033
People aged 80-84 predicted to have depression	546	556	716	773	858
People aged 85 and over predicted to have depression	540	572	605	734	843
Total population aged 65 and over predicted to have depression	**3,772**	**4,166**	**4,588**	**4,919**	**5,138**

Source: *POPPI 2021; https://www.poppi.org.uk/*

Table 5. Projections of population 65+ with severe depression in Leicester

Severe Depression – 65+	2020	2025	2030	2035	2040
People aged 65-69 predicted to have depression	343	370	395	388	378
People aged 70-74 predicted to have depression	178	194	210	226	222
People aged 75-79 predicted to have depression	259	333	361	396	431
People aged 80-84 predicted to have depression	174	174	288	246	273
People aged 85 and over predicted to have depression	234	250	265	328	378
Total population aged 65 and over predicted to have depression	**1,187**	**1,320**	**1,458**	**1,582**	**1,682**

Source: *POPPI 2021; https://www.poppi.org.uk/*

7 UNMET SERVICE NEEDS AND GAPS

Perinatal Maternal Mental Health: There needs to be more capacity for women to have timely access to specialised therapy. There also is scope to work with professionals who regularly see women during and after pregnancy, such as health visitors, to build emotional resilience and awareness of mental health problems into their preventative work.

Child and Adolescent Mental Health: The agenda for developing mental health services for children and young people will be focused on the Future in Mind report, which highlights areas of need such as tackling stigma around mental health problems, improving access to mental health services for children and young people who are particularly vulnerable, and reducing CAMHS waiting times overall.

Certain recommendations from this report have begun to be implemented across Leicester. However, the report suggests that many changes can be achieved by working differently, between the NHS, local authorities, voluntary and community services and schools. The main gaps for commissioners to address for child and adolescent mental health are:

- Targeting commissioned resources at the areas of greatest need.
- Encouraging early prevention of mental health problems, by raising awareness of emotional resilience and mental wellbeing in schools.
- Ensuring 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 adjacent to health care, such as education and community organisations, contribute to protecting childhood mental health.
- Improving CAMHS service access and outcomes.
- Developing specific care pathways for children and adolescents in mental health crisis.

Student Mental Health: De Montfort University and University of Leicester both offer student counselling and support, with links to primary care and talking therapies. However, students who may require secondary care for a mental health problem may face more barriers. Accessing care can impact on academic work, and some students live between university and parental home addresses but may only be able to access care at one of these addresses. University counselling services are designed to support students' studies, however, there is evidence that they are used for generic student mental health support. The main gaps for commissioners to address for student mental health are:

- Continuity of care between part-time addresses.
- Services to be flexible in response to student needs.
- Consideration needs to be given as to how student counselling services fit into an integrated student mental health care framework, including their relationship with main general practices.

Working Age Adults: In Leicester there are fewer cases of diagnosed depression than expected, higher rates of hospital admission for mental illness and worse than average outcomes. Support needs to be developed both for people living with a mental health problem and accessing care, and for people who may not have a diagnosable mental health

problem but may be vulnerable during periods of high stress. The main gaps for commissioners to address to improve the mental health of working age adults are:

- Improve diagnosis of mental health problems, particularly in communities where there may be a stigma attached to living with a mental health problem.
- Improve parity of esteem, both in primary and secondary care.
- Combat stigma amongst the wider population around speaking about mental health and wellbeing.
- Commissioners should focus on prevention and early access to appropriate care, improving the capacity and capability of resources. This could be developed locally by developing an integrated approach with the statutory and voluntary sector.
- An improvement in crisis response, with fewer people being treated out of area.

Older People: In Leicester there is a need to ensure that mental health services for older people are commissioned on the basis of need, rather than age or disease. Although there is an integrated approach between health, social care and voluntary and community sector, this needs to be improved to ensure that the mental health needs of older people are addressed as early and effectively as possible. This includes access to crisis care, psychiatric liaison in the Emergency Department and routes for safe discharge into the community.

While not all older people may need formal support, there is a large gap between need and current service provision. As an example of this, there are more recipients of adult social care than those with recorded carers' assessments.

Minority Groups: Cultural perceptions about mental health can affect both access to and experience of services. Issues and experiences vary widely, both between different communities in Leicester and within BME groups. An individual's experiences of mental health services may additionally be influenced by factors such as 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 confidence in statutory services. Employing practitioners who are able to communicate concepts around mental health and wellbeing in different languages is required, as well as combatting the stigma around mental health within these communities.

Compared to the general population, members of the LGBT community have greater exposure to negative wider determinants of health, such as abuse, unemployment and trauma. They are recorded as having poorer experiences of hospital and residential care, poorer access to health and social care provision and are particularly subject to stigma, insensitivity and discrimination. LGBT people have higher rates of poor mental health compared to the general population. There is a need to develop specialist care for members of the LGBT community, particularly for transgender individuals.

8 RECOMMENDATIONS FOR CONSIDERATION BY COMMISSIONERS

- The Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health has been shown to make a valuable contribution to achieving a fairer and more equitable society. Signing the consensus statement and committing to a plan to address the prevention and promotion of better mental health is a cost-effective, evidence-based approach to reducing health inequalities and preventing future harm.
- Leicester's Joint Integrated Commissioning Strategy for Adult Mental Health (2021 – 2025)[39] sets out key details on how to prevent mental ill health and build resilience in people and communities. There is a continued goal to achieve parity of esteem between mental and physical health across the life course of this strategy. Commissioners are encouraged to take note of this strategy and refer to the action plan.
- Leicester's Care, Health and Wellbeing Strategy 2022-2027 sets out key priorities for the health and wellbeing of the people of Leicester over the next five years. Promoting positive mental health within Leicester across the life course is a key priority. To achieve there is a focus on improved access for children and young people to mental health and emotional wellbeing services, improved access to primary and neighbourhood level mental health services for adults, reduce levels of social isolation in older people and adults, work towards having no deaths from suicide in the city.
- Data in the JSNA shows the strong links between high deprivation neighbourhoods and communities with significantly higher prevalence of poor mental health related issues. Our most deprived communities must be considered when planning and delivering mental health services.
- The increases in the cost of living have placed additional pressures on all communities across Leicester. The Cost of Living Vulnerability Index[40] reports that Leicester is amongst the most vulnerable local authorities in the country to cost of living increases. It highlights the high proportion of low pay jobs in the city and suggests that the crisis threatens worsening living standards and could exacerbate place based inequalities. Commissioners should consider the implications of the cost of living crisis on communities in Leicester.
- The brain does not finish developing until the age of 25, and there is an argument for building young adult services that meet the developmental needs of young people while they have so many changes in their lives. This is to ensure that there is a continuity in support during this transitional period and there is joint planning with all relevant receiving services (e.g. education, employment, housing).

- Consider ethnic inequalities in mental health services. Local data suggests that some ethnic minority communities are less likely to engage in talking therapies.
- Combat stigma amongst the wider population around speaking about mental health and wellbeing.

9 KEY CONTACTS

Gurjeet Rajania, Principal Public Health Analyst, Division of Public Health, Leicester City Council
gurjeet.rajania@leicester.gov.uk

Hannah Stammers, Public Health Analyst, Division of Public Health, Leicester City Council
hannah.stammers@leicester.gov.uk

Mark Wheatley, Public Health Principal, Division of Public Health, Leicester City Council
mark.wheatley@leicester.gov.uk

10 REFERENCES

[1] World Health Organisation (WHO), 2013, Investing in Mental Health: A case for action.
[2] Meltzer, H et al., 2009, Adult Psychiatric Morbidity in England 2007. Results of a Household Survey. Health and Social Information Centre. Social Care Statistics.
[3] Friedli, L. and Parsonage, M., 2007, Mental Health Promotion: Building the Economic Case. Northern Ireland Association for Mental Health
[4] WHO ibid

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

[6] Barry, M, and Friedli, L., 2008, The influence of social, demographic and physical factors on positive mental health in children, adults and older people. Foresight Mental Capital and Wellbeing Project. State-of-Science Review: Government Office of Science and Innovation, London, UK.

[7] Royal College of Physicians and the Royal College of Psychiatrists (2013), Smoking and Mental Health.

[8] PHE, 2018, Health Matters: Reducing health inequalities in mental illness

https://publichealthmatters.blog.gov.uk/2018/12/18/health-matters-reducing-health-inequalities-in-mental-illness/

[9] PHE, 2018, Wellbeing and Mental Health: Applying All Our Health, https://www.gov.uk/government/publications/wellbeing-in-mental-health-applying-all-our-health/wellbeing-in-mental-health-applying-all-our-health (accessed 27/07/18)

[10] Pocklington, C., 2017, Depression in older adults, BJMP 2017;10(1):a1007 http://www.bjmp.org/content/depression-older-adults (Accessed 01/08/18)

[11] PHE,2019-21, Suicide Prevention Profile.

[12]Hewlett, E. & Horner, K. (2015). Mental Health Analysis Profiles: OECD Working Paper No. 81. Available at: http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2015)4&docLanguage=En [Accessed on 27/07/18].

[13] UKHSA, Alcohol dependence and mental health, 2020. Alcohol dependence and mental health - UK Health Security Agency (blog.gov.uk)

[14] National Drug Treatment Monitoring System (NDTMS), 2022, Proportion of dependent drinkers not in treatment (%).

[15] PHE, 2020, Health Matters Smoking and Mental Health. Health Matters: Smoking and mental health - UK Health Security Agency (blog.gov.uk)

[16] Centre for Mental Health,2015, The costs of perinatal mental health problems – report summary, LSE Personal Social Services Research Unit.

[17] Hughes K. et al., 2017, The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health;2;e356-66.

[18] Royal College of Psychiatrists. (2016). Parental Mental Illness: The impact on children and adolescents. Information for parents, carers and anyone who works with young people. Retrieved from www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/parentalmentalillness.aspx [Accessed 25/07/18].

[19] Leicester Children and Young People Health and Wellbeing Survey 2021/22, https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-information/leicester-health-and-wellbeing-surveys/ (accessed 27/07/18)

[20] Higher Education (HE) student enrolments by HE provider, 2019/20, HESA.

[21] Office for National Statistics (ONS), 2015, Prediction of Loneliness using Census 2011 data.

[22] Chakraborty, A., McManus, S., Brugha, T., Bebbington, P., & King, M. (2011). Mental health of the non-heterosexual population of England. Journal of Psychiatry, 198, 143–148.

[23] ONS, 2016, Sexual Identity, UK.

[24] Her Majesty's Prison and Probation Service, 2021, Prison Population Figures HMP Leicester Prison population figures: 2021 - GOV.UK (www.gov.uk).

[25] NHS Digital, Number of Patients Registered at a GP Practice: Jan 2022. Patients Registered at a GP Practice, January 2022 - NHS Digital

[26] Health Matters: rough sleeping, PHE, 2020. Health matters: rough sleeping - GOV.UK (www.gov.uk)

[27] Leicester City Council, Leicester Health & Wellbeing Survey 2018, Ipsos Mori.

[28] Ibid 18

[29] Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services. Volume two: practical mental health commissioning. London: Joint Commissioning Panel for Mental Health; 2012. Available from: www.jcpmh.info/resource/guidance-perinatal-mental-health-services

[30] Beaumont, J., & Loft, H. (2013). Measuring National Wellbeing: Health, 2013. London: ONS.

[31] Office for Health Improvement and Disparities(OHID), 2023, Premature Mortality in adults with severe mental illness (SMI). Available from: Premature mortality in adults with severe mental illness (SMI) - GOV.UK (www.gov.uk)

[32] PHE, 2018, Mental Health and Wellbeing JSNA, https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna (Accessed 31/07/2018).

[33] Leicester Crisis Care Concordat, https://www.crisiscareconcordat.org.uk/areas/leicester/ (Accessed 31/07/2018).

[34] NHS Race & Health Observatory, Ethnic Inequalities in Healthcare: A Rapid Evidence Review (2022) Ethnic Inequalities in Healthcare: A Rapid Evidence Review - NHS - Race and Health ObservatoryNHS – Race and Health Observatory (nhsrho.org)

[35]Office for National Statistics, Main Language Spoken, Census 2021.

[36] The Health Foundation, Unemployment and Mental Health: Why both require action for our COVID-19 recovery, 2021. Unemployment and mental health - The Health Foundation

[37] Projected by PANSI at http://www.pansi.org.uk/index.php?pageNo=402&areaID=8640&loc=8640 This table is based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009

[38] McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787–1795.

[39] Leicester City Council, Joint Integrated Commissioning Strategy for Adult Mental Health 2021-25, Mental Health BOOKLET8a (leicester.gov.uk)

[40] Mudie, R., Fogden, R. & Franklin, B. (2022), The levelling up outlook #5, Centre for Progressive Policy.