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Summary

- Mental health is central to the public’s health and “there is no health without mental health”.
- In general mental health appears to be better in Hampshire than England as a whole, but there are areas and groups that experience poorer mental health, often associated with deprivation and the wider determinants of health.
- Mental wellbeing leads to:
  - Improved quality of life and individual flourishing.
  - Increased educational attainment.
  - Safer communities with less crime.
  - Reduced health inequalities – both physical and mental health.
  - Lower health and social care utilisation.
  - Improved productivity and employment retention.
  - Reduced sickness absence from work.
  - Reduced levels of mental illness and distress.
- People with mental illness have significantly higher rates of illness and premature death from diseases such as heart disease, stroke, diabetes, respiratory disease and infections. Those with schizophrenia and bipolar disorder die an average of 25 years earlier than the general population, largely due to such physical health problems.
- Many physical illnesses increase the chances of poor mental health. It is estimated that 12 to 18 per cent of all NHS expenditure on long term conditions is linked to poor mental health – at least £1 in every £8 spent.
- Mental health problems are common.
- Hampshire has both a higher prevalence of depression and a higher admission rate for unipolar depressive disorder compared to England.
- Since 2006-08, there has been an increase in the rate of deaths from suicide and injury of undetermined intent in Hampshire.

Recommendations

**Children and young people**

1. Ensure that the health visitors continue to identify mothers at risk or in early stages of postnatal depression and offer appropriate support and treatment.
2. Continue to support the mental wellbeing work in schools.
3. Commission evidence based parenting programmes, particularly amongst those at highest risk.
4. Commission effective services to diagnose and treat conduct disorders in childhood, especially amongst first time entrants to the youth justice system.
5. Ensure there is adequate support for young people leaving care, particularly on transition to adult services.
6. Ensure that CAMHS services are easily accessible to young people and are non-stigmatising.
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**Adults**
1. Support the development of initiatives to improve and maintain mental health in the workplace, including public sector employers.
2. Continue to support the programme of work being undertaken with BME communities by the Community Development workers to improve access to mental health promotion and mental health care services.
3. Continue to work with local Armed Forces to improve access to acceptable mental health promotion, treatment and care for service and ex-service personnel.
4. Improve support for people with mental illness to obtain and retain stable accommodation.

**Older people**
1. Improve the prevention, early diagnosis and treatment of depression in older people wherever they live.
2. Commission integrated physical and mental health services across primary and secondary care.
3. Ensure training for all health service staff in mental health awareness and on treatment options across all age groups to increase identification of mental health problems and early intervention.
1. Introduction

Mental health is central to the public’s health and “there is no health without mental health”. It is now well understood that positive mental health or mental wellbeing is more than simply the absence of mental illness.

1.1 Mental wellbeing

Mental well-being is a state “in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make contribution to his or her community” WHO, 2004.

Positive mental wellbeing reduces population mortality and populations with good mental wellbeing also have improved overall health, recover more rapidly, are admitted to hospital less frequently and have high levels of employment and productivity. Underlying social, economic and environmental dimensions can affect a person’s mental wellbeing – such as employment status, education, health and community or neighbourhood characteristics.

Promoting mental wellbeing aims to:
- Improve mental wellbeing in the general population, with concomitant improvements in mental and physical health, reductions in health service usage and wider social gains.
- Improve the wellbeing of those at risk of developing mental health problems and prevent such problems occurring through targeted interventions.
- Improve wellbeing in those who have mental health problems and through recovery assist them to achieve more fulfilled lives.
1.2 Mental illness
Mental illness generally refers to more serious mental health problems that often require treatment, sometimes from specialist services.

Someone can have a mental illness, but still enjoy good mental well-being; just as people with physical illness can live a productive life and enjoy good wellbeing. Equally, someone can have poor mental well-being, but have no clinically identifiable mental health problem.

It is important to consider the whole spectrum of mental health and what we can do to improve mental well-being and prevent mental health problems; as well as helping people with mental illness to recover.

1.3 Why is mental health important?
Mental health and wellbeing can positively affect almost every area of a person’s life: education, employment, family and relationships. It can help people achieve their potential, realise their ambitions, cope with adversity, work productively and contribute to their community and society.

Mental wellbeing matters to individuals, families, communities and local economies because it leads to:
- Improved quality of life and individual flourishing.
- Increased educational attainment.
- Safer communities with less crime.
- Reduced health inequalities – both physical and mental health.
- Lower health and social care utilisation.
- Improved productivity and employment retention.
- Reduced sickness absence from work.
- Reduced levels of mental illness and distress.

Thus, promoting good mental health has both individual and community benefits, not least of which is the impact that mental health has on physical health, and vice-versa.

People with mental illness have significantly higher rates of illness and premature death from diseases such as heart disease, stroke, diabetes, respiratory disease and infections. Those with schizophrenia and bipolar disorder die an average of 25 years earlier than the general population, largely due to physical health problems. Despite this they frequently do not receive the interventions they need, including screening. Depression is associated with a 50% increase in mortality, which is comparable to the effect of smoking.

Some behaviours that increase the risk of physical illness, such as smoking, drug and alcohol abuse are higher among those with mental illness; however they often miss out on access to interventions to support their health improvement.
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Many physical conditions increase the chances of poor mental health, for example depression is two to three times more common in people with a chronic physical health problem than in people who are in good physical health. However, it is often untreated, despite being associated with increased mortality and increased healthcare costs. It is estimated that 12 to 18 per cent of all NHS expenditure on long term conditions is linked to poor mental health – at least £1 in every £8 spent.

2. Level of need in the population

2.1 Overview of mental health in the community
Figure 1 is a part of a summary from the Community Mental Health Profiles (CMHP) 2013 (http://www.nepho.org.uk/cmhp), that presents a range of mental health information for local authorities in England. The CMHP are designed to give an overview on mental health risks, prevalence and services at a local, regional and national level, and the indicators included have been specifically selected to reflect the government’s mental health strategy “No Health without Mental Health”.

Figure 1: Local values for Hampshire
In general people’s mental health appears to be better in Hampshire than for England as a whole. The indicators of issues shown in figure 1 in which people in Hampshire fare significantly worse than the national average are:

- percentage of adults 18+ with dementia (0.65 compared to 0.53)
- percentage of adults 18+ with depression (12.47 compared to 11.68)
- hospital admissions for unipolar depressive disorders (47.9 compared to 32.1)
- hospital admissions for Alzheimer’s and other dementia (105 compared to 80)
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- percentage of people with mental illness having settles accommodation (25.9 compared to 66.8)
- emergency hospital admissions for self harm (DSR 220 compared to 207)

2.2 Mental health and wellbeing in the general population

In 2012 a national survey was undertaken to assess levels of wellbeing in the population. The initial results showed that people in Hampshire were generally more satisfied; happier; felt things in their life were more worthwhile and less anxious than in England in general. However this countywide picture across the population of 1.32 million, hides very local variation.

Table 1: Measures of mental health and wellbeing

<table>
<thead>
<tr>
<th></th>
<th>Proportion % (95%CIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hampshire</td>
</tr>
<tr>
<td>People with low satisfaction score</td>
<td>20.3 (18.1-22.5)</td>
</tr>
<tr>
<td>People with low happiness score</td>
<td>25.2 (22.8-27.5)</td>
</tr>
<tr>
<td>People with high anxiety score</td>
<td>36.0 (33.4-38.6)</td>
</tr>
<tr>
<td>People with low worthwhile score</td>
<td>16.4 (14.3-18.5)</td>
</tr>
</tbody>
</table>

Source: The first full year data from these questions was published by ONS in July 2012 and are being treated as experimental statistics.

ONS is currently measuring individual/subjective well-being based on four questions included on the Integrated Household Survey:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, how happy did you feel yesterday?
3. Overall, how anxious did you feel yesterday?
4. Overall, to what extent do you feel the things you do in your life are worthwhile?

Responses are given on a scale of 0-10 (where 0 is “not at all satisfied/happy/anxious/worthwhile” and 10 is “completely satisfied/happy/anxious/worthwhile”)

2.3 Mental health inequalities

Poor mental health both contributes to and is a consequence of wider health inequalities. It is associated with increased health-risk behaviour and increased morbidity and mortality from physical ill health. Mental health problems occur more frequently in unequal societies that leave behind more vulnerable people. More equal societies are psychologically healthier than unequal ones.

Consistent associations have been found between mental ill health and various markers of social and economic adversity – low education, low income; low social status; unemployment and poorer material circumstances. People with a history of mental illness experience both more social isolation and less involvement with their communities. They are more likely to live in socially deprived urban areas, characterised by poor housing, high levels of crime and low levels of social capital.

Figure 2 shows the mental health indicator from the Index of Multiple Deprivation. It shows the variation in mood or anxiety disorders in adults under 60, by ward and
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lower layer super output area (LLSOA). This indicator combines and weights prescribing, secondary care, health benefit and suicide data to produce a more precise measure of the underlying rate of mental health problems than a single indicator alone.

Havant and Gosport have the highest number of LLSOAs in the most deprived decile nationally, suggesting greater mental health need; while Winchester, East Hampshire and Hart have the least.

Figure 2: Index of multiple deprivation: Mental health indicator

These socio-economic inequalities are particularly pronounced for severe mental illness. The prevalence of psychotic disorders amongst the lowest quintile of household income is nine times higher than in the highest. The social gradient is also evident for common mental health problems, with a two-fold variation between the highest and lowest quintiles.
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People with long term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities. By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent. Further detail on the impact of multiple and complex problems can be found in the Adult services social care chapter.

The social gradient in mental health problems is particularly pronounced in childhood with a three-fold variation in prevalence between the highest and lowest socio-economic groups. Rates of illness are particularly high amongst children in care and other vulnerable groups such as young offenders. Table 2 illustrates some of these differences.

Table 2: Associations between childhood mental health problems and a range of measures of social disadvantage (Green et al, 2005)

<table>
<thead>
<tr>
<th>Family type</th>
<th>% of children with any disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couples</td>
<td>7.7</td>
</tr>
<tr>
<td>Lone parents</td>
<td>15.6</td>
</tr>
<tr>
<td><strong>Educational qualifications of parents</strong></td>
<td></td>
</tr>
<tr>
<td>Degree</td>
<td>4.4</td>
</tr>
<tr>
<td>A-level</td>
<td>8.9</td>
</tr>
<tr>
<td>None</td>
<td>17.0</td>
</tr>
<tr>
<td><strong>Family employment</strong></td>
<td></td>
</tr>
<tr>
<td>Both parents working</td>
<td>7.5</td>
</tr>
<tr>
<td>One parent working</td>
<td>9.3</td>
</tr>
<tr>
<td>No parents working</td>
<td>19.5</td>
</tr>
<tr>
<td><strong>Household income per week</strong></td>
<td></td>
</tr>
<tr>
<td>Over £770</td>
<td>5.3</td>
</tr>
<tr>
<td>Under £200</td>
<td>13.9</td>
</tr>
<tr>
<td><strong>Socio-economic classification</strong></td>
<td></td>
</tr>
<tr>
<td>Managerial/professional</td>
<td>5.2</td>
</tr>
<tr>
<td>Routine occupations</td>
<td>14.9</td>
</tr>
<tr>
<td>Long-term unemployed</td>
<td>16.1</td>
</tr>
</tbody>
</table>

2.3.1 Poverty

Levels of poverty are high in those with mental illness, and this is compounded by high levels of debt and low take up of available welfare benefits. When employed, there is a greater likelihood that those with a history of mental illness will be in low skilled, low paid and insecure jobs. An important barrier encountered by those with mental illness is widespread stigma.

Often people with a mental health problem do not receive appropriate services for physical health problems, for example research showed that people with mental illness received poorer quality care for diabetes and heart attack, even though they are more at risk of a range of physical health problems.

There is also evidence that people with mental illness are more likely to be refused insurance and access to financial services.
2.3.2 Older people

Older people may experience discrimination at all levels of mental health care: from primary prevention, identification and treatment through to standards of care and access to treatments for those with acute mental illness.

One of the key issues is the high rate of depression and associated low rate of identification in older people, both those living at home and amongst those in residential care. Although 20% to 40% of older people in the community show symptoms of depression, only about 4% to 8% will consult their GP about it. This is particularly true for older men. Even when depression is identified studies show lower levels of treatment and referral to secondary services than for younger adults.

2.3.3 Ethnicity

Ethnicity has important impacts on mental health. People from BME groups often have different presentations of problems and different relationships with health services. Rates of psychosis are up to nine times higher for people from African Caribbean communities living in the UK than for the White British population. Rates of common mental disorders are comparable between White, Black and South Asian men; but are higher in South Asian women. Immigrants are more vulnerable to mental health problems than the indigenous population, with two to eight times the risk of psychosis.

2.3.4 Lesbian, Gay, Bisexual and Transgender mental health

Anxiety, depression, self-harm and suicidal feelings are more common among lesbian, gay and bisexual people than heterosexual people. A quarter of gay men and a third of lesbians have harmed themselves deliberately (compared to one in seven heterosexual people) and rates of drug and alcohol misuse are also higher.

There is a strong association between homophobic bullying and mental health problems.

2.4 Mental health problems and mental illness

A wide range of factors interact to influence our mental health over the course of our lives: from our genes, as some mental health problems have a genetic component; through our family circumstances; education; our social and support networks; occupation and financial security; physical environment and having purposeful and fulfilling activities.

Mental health problems are common:
- 1 in 6 of the adult population experiences mental ill health at any one time (around 22,000 people in Hampshire).
- 10% of children have a mental health problem (around 31,000 in Hampshire), and 50% of lifetime mental illness is present by the age of 14.
- 10% of new mothers suffer from postnatal depression (around 1,500 women each year in Hampshire).
- 20% of working-age women and 17% of working-age men are affected by depression or anxiety at any one time.
Half of all women and a quarter of all men will be affected by depression at some time in their life and 15% experience a disabling depression.

- 4% of the population has a personality disorder.
- 1% of the population has a serious mental health problem.
- Dementia currently affects 5% of people aged over 65 and 20% of those aged over 80 (see Dementia chapter).

Half of those with common mental health problems are limited by their condition and a fifth are disabled by it. Mental illness accounts for more disability adjusted life years (DALYs) lost per year than any other health condition in the UK, accounting for 20%, compared to around 16% for cardiovascular disease and 16% for cancer, with no other condition exceeding 10%.

Recent estimates put the annual wider economic costs of mental health problems at around £105 billion. There are substantial cost savings to be made by promoting mental health and wellbeing. Potentially, 25 to 50% of mental health problems are preventable through interventions in the early years and by ensuring a positive start in life.

2.5 Risk factors for mental health problems
Some key risk factors are shown within the Community Mental Health Profiles (CMHP 2013). Experience of mental health problems in early years and childhood has a lasting impact on future mental health. Between a quarter and half of adult mental illness may be preventable with appropriate interventions in childhood and adolescence.

Poor mental health in childhood is associated with risk behaviours such as smoking and substance abuse, teenage pregnancy, bullying and violent behaviour. It is also associated with lower educational achievement; reduced employment opportunities; subsequent criminal behaviour, misuse of drugs and higher suicide rates.

For more background details please see Maternity and Children and Young People chapters.

2.5.1 Pregnancy and perinatal period
Maternal smoking, use of alcohol and poor diet are associated with lower birth weight and poor mental health in children.

Anxiety, depression and maternal stress during pregnancy have been linked to impaired emotional, cognitive and language development in infants. One in seven women will experience mental health problems during pregnancy or in the postnatal period and one in ten new mothers are likely to experience postnatal depression. It is important to continue to commission an effective health visiting service which can identify and help mothers with postnatal depression as early as possible.

2.5.2 Early years and childhood
In the pre-school years children develop social-emotional skills, such as self-awareness, self-regulation and empathy as they learn to express their emotions and
interact with others. These skills continue to develop throughout primary school, and a positive relationship with at least one parent is important in the development of resilience and well-being.

Early neglect and trauma are associated with problems in later life including anxiety, impulsivity and hyperactivity, as well as poor problem solving and empathy. Good parenting helps children to develop good social and emotional skill and has been shown to have the single greatest influence on children’s health outcomes including accident rates, teenage pregnancy, substance misuse, truancy, school exclusion and underachievement, child abuse, employability, juvenile crime, as well as mental illness.

2.5.3 Children experiencing violence and abuse
Rates of mental health problems are significantly higher in adults who have been abused as children. Children growing up in households where there is domestic violence are at increased risk of behaviour problems, emotional trauma and mental health problems in adulthood.

2.5.4 Young offenders
Young offenders have higher rates of mental health problems than their contemporaries. They are 18 times more likely to attempt suicide, and many have earlier undiagnosed and untreated conduct disorders. Interventions to address conduct disorders have been shown to reduce offending behaviour.

2.5.5 Looked after children
Looked after children are at five to six times increased risk of developing mental health problems. They have a four to five times higher risk of self-harm, and a six to eight times increased risk of conduct disorders.

2.5.6 Young carers
Many young people find themselves caring for family members, often taking on adult roles and responsibilities and leaving little time for their own social, emotional and educational needs. This in turn can have short and long term impacts on their mental health.

2.5.7 Disabled children
Physical and learning disabilities can have an impact on mental health, and children with learning disability have a 6.5 fold risk of mental health problems.

2.5.8 Employment and work
Long term unemployment is associated with poorer physical and mental health. Those who are unemployed are three times more likely to suffer from a common mental health problem.

Some work and working environments can lead to prolonged stress which is linked to psychological conditions such as anxiety and depression as well as physical conditions such as heart disease, back pain and headache. Working environments that pose risks for mental health impose high demands on employees without giving
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them sufficient control and support to manage these demands. Poor physical conditions such as a dirty, noisy environment can also lead to stress. People in lower paid jobs are more likely to experience poor working conditions such as lack of control of their workload, lack of job security, limited support and exposure to physical hazards.

The costs associated with employees’ mental health problems are significant and are linked to loss of productivity due to sickness absence, early retirement and increased staff turnover. Productivity can also be reduced through the lower levels of performance of employees who are at work but experiencing stress or mental health problems which has become known as “presenteeism”. This is estimated to cost nearly twice as much as absenteeism.

Employees in public administration, defence, education and health and social work have some of the highest rates of self-reported stress, anxiety and depression. As a large number of people in Hampshire work in these sectors, this provides opportunities to develop policies and programmes to improve mental health in the workplace.

2.5.9 Substance misuse
Alcohol and substance misuse may disrupt the neural changes occurring during adolescence and this can affect attention, learning and memory.

Co-morbidity of alcohol or substance misuse and mental illness is very common. For many people with severe mental health problems harmful alcohol or drug use contributes to a pattern of relapse and risk. About 80% of people with alcohol problems have anxiety and depression, and over 30% have severe depression.

Alcohol and substance misuse is strongly associated with both attempted and successful suicide.

2.5.10 Physical activity
Regular physical activity is associated with improved mental health as well as a reduced risk of coronary heart disease, diabetes, obesity, osteoporosis and colon cancer. In older adults physical activity is associated with increased functional capacity which supports mental wellbeing.

2.5.11 Offenders
Mental health problems of this group are complex and are often linked with suicide and self-harm, substance misuse, learning disability, HIV risk and poor physical health.

It is estimated that around 90 per cent of all prisoners have a diagnosable mental health problem, including personality disorders and/or a substance misuse problem. More than 70 per cent of the prison population has two or more mental health disorders.
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The types of crime committed by people with mental illness are no different from the crimes committed by people who do not have mental illness.

The suicide rate of men on probation is nearly nine times higher than the general population and the suicide rate in prisons is almost 15 times higher than in the general population.

2.5.12 Armed forces/veterans
A significant number of service personnel and their families are based in Hampshire, as well as veterans who choose to remain here. Prevalence of mental disorders in serving and ex-service personnel is broadly similar to that of the general population; however more recent conflicts and military operations may have an impact on the future prevalence rates.

A minority of service and ex-service personnel with mental health problems access mental health services. The stigma of mental illness is thought to contribute to this. The most common disorders amongst veterans are depression, anxiety disorders, post traumatic stress disorder (PTSD) and substance misuse, often in combination. The suicide rate is broadly similar to the rest of the population, although there may be an increased risk amongst those who leave the service early, especially if they delay seeking help.

Ex-service personnel are vulnerable to social exclusion, and a significant minority may experience homelessness, unemployment and alcohol abuse. Around 6% of the prison population is reported to be ex-service.

2.5.13 Homelessness
Homelessness can be both a cause and effect of mental health problems. For some people with mental health problems, securing and retaining suitable housing can be difficult, but it a vital component of important part of their care.

The CMHP 2013 suggests that the percentage of adults in Hampshire receiving secondary mental health services known to be in settled accommodation was significantly lower (26%) than the average for England (67%). Please see Homelessness chapter for more information on local issues.

2.5.14 Older people
As Hampshire has an increasing proportion of older people, the impact of mental health problems is important for local communities and services. The majority of mental health problems experienced by older people, other than dementia, are no different to those experienced by working age adults. Co-existing problems such as dementia, physical illness and disability can create complex needs that require specific skills and understanding, and services that can respond in a flexible and integrated way.

Older people with a mental health need account for a significant proportion of those who use health and social care services. A conservative estimate is that

- 40% of people attending their GP,
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- 50% of all general hospital inpatients and
- 60% of care home residents have a mental health problem

2.5.15 Carers
Families, friends and a range of carers provide vital support and care to older people with mental health problems. The demanding and stressful nature of this role means that they may often be at risk of developing mental health problems themselves. This is particularly so when they are elderly and frail. One third of people who care for an older person with dementia have depression, so providing effective advice, support and treatment where relevant can improve the health and wellbeing of both the carers and those they care for.

For further details see Adult Services Social Care chapter.

3. Projected service use and outcome

Table 3: Predicted numbers of people aged 18-64 with specific mental health problems and disorders 2015-2025 in Hampshire

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-64 predicted to have depression</td>
<td>20049</td>
<td>20265</td>
<td>20414</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have common mental health problems</td>
<td>129510</td>
<td>130936</td>
<td>131944</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a personality disorder</td>
<td>34412</td>
<td>34747</td>
<td>34954</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a psychotic disorder</td>
<td>4311</td>
<td>4355</td>
<td>4383</td>
</tr>
</tbody>
</table>

Source: Projecting Adult Needs and Service Information System (PANSI) ©

Table 3 estimates the number of adults between 18 and 64 with a range of mental health problems over the next ten years. These estimates are based on the prevalence for each condition recorded in the National Prevalence Survey and applied to Hampshire population estimates for future years.

The number of people with psychotic illness, most of whom will need treatment by secondary mental health services at some point is much lower than the number of people with neurotic illness (also known as common mental health problems and including mild to moderate depression, anxiety disorders, phobias and obsessional compulsive disorders). Many of the latter will never seek help from any statutory service; many will be treated by primary care services and some with more complex problems will be treated in secondary services. This demonstrates that there is the need for a wide range and quantity of services to help people with varying complexities of need.
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As can be seen from Table 3, if the only change is in the numbers within the 18-64 year population, then there will only be a relatively small increase in the number of people with each condition.

However, if other things change which predispose to mental illness, such as an increase in unemployment then there could be a greater increase in the numbers of people with mental health problems, particularly common mental health problems and depression. Conversely, if we act to implement interventions which we know can prevent children and young people from developing mental health problems and disorders, then we should be able to reduce the impact of mental illness amongst the adult population of the future.

The following figures show the number of people aged 16-64 estimated to have common mental disorders between 2012 and 2020. There is a projected increase in the numbers in Hampshire overall (Figure 3). As can be seen from the subsequent figures 4 to 14, there is considerable variation between different areas with Basingstoke, Eastleigh, Fareham, Gosport and the New Forest seeing a projected increase in numbers; and East Hampshire, Havant, Rushmoor, Test Valley and Winchester.

Figure 3: Number of people aged 16-64 projected to have a common mental disorder in Hampshire

![Trend data for Hampshire](image)

Sources: Projecting Adult Needs and Service Information - 16-64 years data & Projecting Older People Population Information System - 65+ years data
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Note: Different scales

Figure 4: Number of people aged 16-64 projected to have a common mental disorder in Basingstoke and Deane

Figure 5: Number of people aged 16-64 projected to have a common mental disorder in Fareham

Figure 6: Number of people aged 16-64 projected to have a common mental disorder in East Hampshire

Figure 7: Number of people aged 16-64 projected to have a common mental disorder in Gosport

Figure 8: Number of people aged 16-64 projected to have a common mental disorder in Eastleigh

Figure 9: Number of people aged 16-64 projected to have a common mental disorder in Hart
Figure 10: Number of people aged 16-64 projected to have a common mental disorder in Havant

Figure 11: Number of people aged 16-64 projected to have a common mental disorder in Test Valley

Figure 12: Number of people aged 16-64 projected to have a common mental disorder in the New Forest

Figure 13: Number of people aged 16-64 projected to have a common mental disorder in Winchester

Figure 14: Number of people aged 16-64 projected to have a common mental disorder in Rushmoor

Sources: Projecting Adult Needs and Service Information - 16-64 years data & Projecting Older People Population Information System - 65+ years data.
3.1 Depression
The CMHP 2013 indicates that Hampshire has both a higher prevalence of depression and a higher admission rate for unipolar depressive disorder compared to England.

Depression is common and disabling. The estimated prevalence of major depression among 16-65 year olds in the UK is 21/1000 (males 17, females 25). Mixed anxiety and depression is prevalent in a further 10 per cent of adult patients attending general practices. It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after cardiovascular disease in terms of the world's disabling diseases.

Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs.

Depression is the most common mental health disorder in later life but it is not a natural or normal part of ageing, and effective interventions are available. Hampshire has a higher proportion of older people which may contribute to higher rates. Those with physical health problems have higher rates of depression, and up to 50% of older people in residential care have clinically severe depression, yet only between 10% and 15% receive any active treatment. Table 4 and Figure 15 show the number of people aged over 65 predicted to have severe depression from 2012 to 2020.

Depression is often a predictable response to a range of factors such as social isolation, increasing disability and physical ill health, lack of opportunities for meaningful activity and reduced independence.

Greater awareness of these risk factors and the availability of a range of informal care and support, and alternative treatment options in addition to medication can help to improve detection and intervention. Treating depression improves the quality of life for older people.

Table 4: Number of people over 65 predicted to have severe depression. Trend data for Hampshire.

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>7098</td>
<td>7569</td>
<td>7907</td>
<td>8205</td>
<td>8617</td>
</tr>
</tbody>
</table>
3.2 Suicide
Between 2009 and 2011, 332 people died due to suicide or injury of undetermined intent in Hampshire, an average of over 100 deaths per year. Rates of suicide and injury of undetermined intent are shown as three year averages due to large fluctuations in numbers of cases across time. The latest suicide and injury of undetermined intent rate for Hampshire is 8.1 per 100,000 population (based on 2009-2011 data). This rate is not significantly different from that of England.

Since 2006-08, there has been an increase in the rate of deaths from suicide and injury of undetermined intent in Hampshire. This increase can be attributed to an increase in male suicides. National data shows that the majority of suicides are adult males (three fold higher rate than in females). The highest rate being for males aged 30 to 49 years.

At district level, rates fluctuate between 5.7 per 100,000 in Eastleigh to 12.2 per 100,000 in Farnham (2009-2011). These rate differences are not statistically significant and there are large fluctuations in rates between districts over time.

Further information on those people who have died from suicide or injury (taken from a local analysis of 2007 to 2011 Hampshire data of 336 deaths) showed that the majority of deaths (76%) were as a result of hanging, of these 4% also recorded the use of either prescription, over the counter or illegal drugs. Multiple injuries were the next main method; this included jumping from a height and collision with a train. Nationally data suggests that hanging, strangulation and suffocation continue to be
the most common methods of suicide for men, accounting for more than half of all male suicide deaths.

**Figure 16: Suicides and injuries of undetermined intent in all ages in Hampshire**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Directly standardised rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire</td>
<td>9.5</td>
</tr>
<tr>
<td>Basingstoke and Downton</td>
<td>8.8</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>8.6</td>
</tr>
<tr>
<td>Fareham</td>
<td>8.5</td>
</tr>
<tr>
<td>Gosport</td>
<td>10.9</td>
</tr>
<tr>
<td>Hart</td>
<td>8.4</td>
</tr>
<tr>
<td>Havant</td>
<td>7.9</td>
</tr>
<tr>
<td>New Forest</td>
<td>9.2</td>
</tr>
<tr>
<td>Northmoor</td>
<td>9.0</td>
</tr>
<tr>
<td>Test Valley</td>
<td>9.5</td>
</tr>
<tr>
<td>Waverley (Fareham only)</td>
<td>8.1</td>
</tr>
<tr>
<td>Weymouth</td>
<td>9.4</td>
</tr>
</tbody>
</table>

Sources: ONS Public Health Mortality Annual Extract & ONS LSOA mid year population estimates.

*Comparative data are not available for all indicators

**3.3 Deliberate self harm**

People who self-harm are at increased risk of suicide. At least half of people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year. Around one in 100 people who self-harm take their own life within the following year. Risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods of self-harm.

The Community Mental Health Profiles shows that the directly standardised rate for emergency hospital admissions for self harm (2011/12) in Hampshire is significantly higher than rate for England.

Figure 18 shows that overall admission rates for deliberate self harm are higher amongst women than men (the reverse of the position for suicide rates). The admission rate is significantly higher than the Hampshire average amongst women in South East Hampshire, and amongst men in South East Hampshire and Fareham and Gosport. This may reflect higher prevalence rates, but local clinical practice and thresholds for admission will also have an impact on admission rates.
Figure 17: Rolling average of suicides and injuries of undetermined intent in all ages across Hampshire

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th>Females</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006 to 2008</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007 to 2009</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008 to 2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009 to 2011</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: CDS received from Provider Trusts via SUS & ONS 2010 LSOA mid year population estimates
*Comparator data are not available for all indicators

Figure 18: Admission rates for intentional self harm

Intentional Self Harm Emergency Admissions by Clinical Commissioning Group, 2009/10 to 2011/12 pooled. Directly Age Standardised Rates per 100,000 population.
Sources: CDS received from Provider Trusts via SUS & 2010 ONS LSOA mid year population estimates
4. **Current services in relation to need**

Please refer to the *Children and young people* chapter for more detail about child and adolescent mental health services (CAMHS) with regard to need.

The Joint Hampshire Adult Mental Health Commissioning Strategy 2012-2017 set out priorities for Hampshire’s adult mental health services and recommend priorities for generic social, health and voluntary agencies, acknowledging the need to prevent mental illness and promote emotional wellbeing.

Services to promote mental health and wellbeing are provided by a range of organisations and are often not targeted at mental wellbeing specifically—such as housing, education or leisure activities. However addressing the wider determinants of health supports mental wellbeing.

There are many self-help, voluntary and community services which provide a range of advice, support and services to people with mental health problems and their families.

In 2012 Mental Health Wellbeing Centres were commissioned across Hampshire (Fareham, Basingstoke, Frimley, Havant, Lyndhurst, New Milton, Hythe, Andover, Romsey, Winchester, and Eastleigh) to deliver support to individuals with mental health problems to aid their recovery. The commissioning of these services arose from the extensive consultation on the Joint Commissioning Strategy which provided strong support for Wellbeing Centres from service users and carers and all of the other interested parties in mental health. The development over the five year period will include a focus on the following key areas:

- Service user and carer involvement.
- Peer support workers.
- Personalisation.
- Encouraging positive mental health and wellbeing.
- Accessible base and satellite resources.
- Use of information technology, including social media.
- Robust links and effective care pathways with the GP practices and the NHS Foundation Trusts providing the secondary mental health care.
- Partnership working throughout the mental health system.
- Links with the local armed forces families and support for armed forces veterans.
- Progressing support for young people who are care leavers or in transition from receiving CAMHS (Child and Adolescent Mental Health Services).
- Reaching individuals and communities that have not previously used mental health services.
- Use of WRAP (Wellness Recovery Action Planning) and the Recovery Star.

4.1 **General Practice**

General practitioners diagnose and treat common mental health problems and together with a range of support services and secondary mental health services, they help to keep people with more severe mental illness well. They also provide the full
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range of general health services to people with mental illness including things like screening and Health Checks.

As part of their contract, GPs keep a Mental Health Register (people with schizophrenia, bipolar disorder and other psychoses) and a Depression Register which helps us to understand the local prevalence of these conditions. There are criteria for adding people to the registers, but figures depend on how individual practices identify patients and record information.

Figures 19 and 20 show the recorded prevalence for mental health by CCG and local authority respectively. Apart from Gosport, all are below the national prevalence rate of just over 0.8%. Rushmoor, Havant and East Hampshire are at or above the rate for the South Central area.

**Figure 19: Mental Health Register: Prevalence rates by CCG**

![Mental Health Register](image-url)
Figures 21 and 22 show the prevalence rates of depression as recorded on the GP registers. Apart from East Hampshire and Winchester all are above the national and South Central rate, with Rushmoor having the highest prevalence of depression at just under 15%, and Basingstoke and Deane and Hart having the next highest rates at between 13 and 14%.

**Figure 21: Depression Register: Prevalence rates by CCG**
4.2 Increased access to psychological therapies (IAPT)

IAPT is a national programme to increase access to evidence based, cost effective psychological therapies for anxiety and depression. IAPT services aim to improve the health and wellbeing of people, as well as improving their employment or benefit status.

The local programme was initially developed in areas identified as having greatest need, but now local commissioners are extending coverage to ensure services across Hampshire. The scope of IAPT has broadened since its initial piloting to be accessible to previously underrepresented group such as veterans, BME groups, older people, people with peri-natal mental health issues, and young people; as well as to people with medically unexplained symptoms and people with long term conditions.

The CMHP (Figure 1) shows that Hampshire IAPT services had a significantly better recovery rate (51.9) compared to the England average (43.8).

4.3 Specialist mental health services (secondary care)

Specialist mental health services provide a range of services to people with more severe mental illness. The focus is very much on recovery and is increasingly community based, with specialist teams for early intervention in psychosis, home treatment and crisis response; as well as inpatient services. The main provider for Hampshire is Southern Health NHS Foundation Trust, but North East Hampshire and Farnham CCG commissions mental health services from Surrey and Borders Partnership NHS Foundation Trust.
Figure 1 showed that admission rates for depression in Hampshire were higher than the average for England. Figures 23-26 show more detail about local admission rates for unipolar depressive disorder. Admission rates are significantly higher for women in all areas except North East Hampshire and Farnham (Figure 23). They are higher in areas of greater deprivation (Figure 24), and are significantly higher in Gosport and Havant (figure 25). Figure 26 shows that admission rates have decreased over the last three years, which could be due to improvements in community services, and earlier diagnosis and interventions such as IAPT.

Figure 23: Admission rates for unipolar depressive disorder by gender.

![Admission rates for unipolar depressive disorder by gender](image)

Figure 24: Admission rates for unipolar depressive disorder by deprivation.

![Admission rates for unipolar depressive disorder by deprivation](image)

Figure 25: Admission rates for unipolar depressive disorder by district.

![Admission rates for unipolar depressive disorder by district](image)

Figure 26: Trend in admission rates for unipolar depressive disorder.

![Trend in admission rates for unipolar depressive disorder](image)

Figures 27 to 30 show patterns of admission for more severe mental illness (schizophrenia, schizotypal and delusional disorders). Admission rates for males are nearly twice that of females (figure 27); and there is a similar gradient with deprivation with more people being admitted from more deprived areas of Hampshire (Figure 28). There are significantly higher admission rates amongst people from Gosport, Havant, New Forest and Winchester (Figure 29). Admission rates have been falling over the last three years (figure 30).
4.4 Links with physical health

Mental and physical health are closely interconnected. The same risk factors affect both; mental disorders can present with both mental and physical symptoms; physical ill health can have an impact on mental health and vice versa.

The evidence indicates that poor mental health is a larger contributor to poor physical health and health risk behaviours than the other way round. However, good mental health and wellbeing are associated with reduced mortality rates, both in healthy people and those with illness.

People with long term physical health conditions are at twice the risk of developing mental health problems. Very few of them are diagnosed or receive treatment for their mental health problem whether they are in hospital or the community. This can lead to significantly poorer health outcomes and reduced quality of life.

An increasing number of frail elderly people are admitted to acute hospitals with a complex mix of social, physical and mental health problems. Whilst this cohort of patients is estimated to be around 10% of emergency medical admissions, the
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longest occupants remain in hospital for well over 28 days and occupy 50% of acute medical beds. Around 60% of older people occupying general hospital beds will have or will develop a mental disorder during their admission. The presence of mental health needs is an independent predictor of poor outcomes for the individual.

It is estimated that one in seven of these patients will die in hospital, often due to complications of an extended stay; and levels of independence decline during the hospital stay, particularly for those with underlying conditions such as dementia.

Mental health problems frequently remain undiagnosed and untreated, and care is often insufficiently integrated to address an individual's complex range of need.

Innovative forms of liaison psychiatry demonstrate that providing better support for co-morbid mental health needs can reduce physical health care costs in hospitals. Liaison psychiatry services are not yet commissioned across all of Hampshire and this should be a priority for local CCGs.

Conversely the physical health needs of those with mental health problems can often be overlooked as has been described earlier. One of the indicators in shows the excess under 75 mortality rate in adults with serious mental illness. Hampshire (911) is not significantly different from the rest of England (921). Given the relative health of people in Hampshire overall compared to England, it could be expected that this rate would be better.

Ensuring that people with serious mental illness have access to the full range of health promotion and treatment services in would help to improve this outcome.

5. User and provider views

When developing the Joint Hampshire Mental Health Commissioning Strategy the ten most important things that stakeholders, including many service users and carers wanted were:

- Accessible services – both in time and place.
- Community support/social groups.
- Complementary and alternative therapies.
- Early intervention/preventive support.
- Employment services/benefits advice.
- Family and carer support, including respite.
- Psychological/talking therapies.
- Services out of hours – specialist and third sector.
- Service user involvement.
- Wellbeing centres/one-stop shops.
6. Evidence of what works

6.1 Positive mental health for all

Good mental wellbeing can:

- Increase life expectancy, provide protection from heart disease, improve health outcomes from a range of long term conditions.
- Reduce risks to health through positive behaviours such as reductions in alcohol and substance misuse.
- Reduce health inequalities – both in physical and mental health, and impact positively on the social determinants of health.
- Reduce the consequences of mental illness or distress and is associated with
  - Improved educational attainment and subsequent occupation and wellbeing outcomes.
  - Safer communities with less crime.
  - Improved productivity and employment retention.
  - Reduced sickness absence from work.

There are many things we can all do to improve and maintain our mental health and wellbeing, and help us be more resilient to adverse events. The “Five ways to wellbeing” in Figure 31 from the Foresight mental capacity and wellbeing project are an evidence based set of simple interventions we can all use.

**Figure 31: Five ways to wellbeing**

<table>
<thead>
<tr>
<th>Connect</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Be active</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Take notice</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Keep learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Give</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do something nice for a friend, or a stranger. Thanks someone. 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 create connections with the people around you.</td>
</tr>
</tbody>
</table>

*Source: Foresight mental capacity and wellbeing project*
6.2 Prevention of mental health problems for those at risk

The table from “Mental health promotion and mental illness prevention: the economic case” shown in Figure 32 models a range of cost effective interventions that target interventions towards people at higher risk of mental health problems. It also shows the benefits accrued to the NHS, public sector and more widely if these interventions were to be implemented.

6.3 Improve wellbeing for those living in recovery

NICE has produced several guidelines for the treatment of people with mental health and behavioural problems (http://www.nice.org.uk/guidance) as well as pathways (http://pathways.nice.org.uk/guidance). There are also two quality standards relevant to mental health “Depression in adults” and “Service users experience in adult mental health”.

Figure 32: Total return on investment (all years): economic pay-offs per £ expenditure

<table>
<thead>
<tr>
<th>Intervention</th>
<th>NHS</th>
<th>Other public sector</th>
<th>Non-public sector</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early identification and intervention as soon as mental disorder arises</td>
<td>1.08</td>
<td>1.78</td>
<td>5.03</td>
<td>7.89</td>
</tr>
<tr>
<td>Early intervention for conduct disorder</td>
<td>0.40</td>
<td>–</td>
<td>0.40</td>
<td>0.80</td>
</tr>
<tr>
<td>Health visitor interventions to reduce postnatal depression</td>
<td>0.19</td>
<td>0</td>
<td>0.14</td>
<td>0.33</td>
</tr>
<tr>
<td>Early Intervention for depression in diabetes</td>
<td>1.01</td>
<td>0</td>
<td>0.74</td>
<td>1.75</td>
</tr>
<tr>
<td>Early intervention for medically unexplained symptoms</td>
<td>0.51</td>
<td>–</td>
<td>4.52</td>
<td>5.03</td>
</tr>
<tr>
<td>Early detection of psychosis</td>
<td>2.62</td>
<td>0.79</td>
<td>6.85</td>
<td>10.27</td>
</tr>
<tr>
<td>Early intervention in psychosis</td>
<td>9.68</td>
<td>0.27</td>
<td>8.02</td>
<td>17.97</td>
</tr>
<tr>
<td>Screening for alcohol misuse</td>
<td>2.24</td>
<td>0.93</td>
<td>8.57</td>
<td>11.75</td>
</tr>
<tr>
<td>Suicide training courses provided to all GPs</td>
<td>0.08</td>
<td>0.05</td>
<td>43.86</td>
<td>43.99</td>
</tr>
<tr>
<td>Suicide prevention through bridge safety barriers</td>
<td>1.75</td>
<td>1.31</td>
<td>51.39</td>
<td>54.45</td>
</tr>
<tr>
<td>Promotion of mental health and prevention of mental disorder</td>
<td>9.42</td>
<td>17.02</td>
<td>57.29</td>
<td>83.73</td>
</tr>
<tr>
<td>Prevention of conduct disorder through social and emotional learning programmes</td>
<td>0</td>
<td>0</td>
<td>14.35</td>
<td>14.35</td>
</tr>
<tr>
<td>School-based interventions to reduce bullying</td>
<td>–</td>
<td>–</td>
<td>9.69</td>
<td>9.69</td>
</tr>
<tr>
<td>Workplace health promotion programmes</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Addressing social determinants and consequences of mental disorder</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Debt advice services</td>
<td>0.34</td>
<td>0.58</td>
<td>2.63</td>
<td>3.55</td>
</tr>
<tr>
<td>Befriending for older adults</td>
<td>0.44</td>
<td>–</td>
<td>–</td>
<td>0.44</td>
</tr>
</tbody>
</table>
Mental health promotion and mental illness prevention: the economic case
Martin Knapp, David McDaid and Michael Parsonage (editors)
Personal Social Services Research Unit, London School of Economics and Political Science, January 2011, Published by Department of Health

7. Recommendations

7.1 Children and young people
- Ensure that the health visiting service can continue to identify mothers at risk or in early stages of postnatal depression, and that they can offer appropriate support and treatment.
- Continue to support the Healthy Schools programme.
- Commission evidence based parenting programmes, particularly amongst those at highest risk.
- Commission effective services to diagnose and treat conduct disorders in childhood, especially amongst first time entrants too the youth justice system.
- Ensure there is adequate support for young people leaving care, particularly transition to adult services.
- Ensure that CAMHS services are easily accessible to young people and are non-stigmatising.

7.2 Adults
- Support the development of initiatives to improve and maintain mental health in the workplace, including NHS and local government.
- Continue to support the programme of work being undertaken with BME communities by the Community Development workers to improve access to mental health promotion and mental health care services.
- Continue to work with local Armed Forces to improve access to acceptable mental health promotion, treatment and care for service and ex-service personnel.
- Improve support for people with mental illness to obtain and retain stable accommodation.

7.3 Older people
- Improve the prevention, early diagnosis and treatment of depression in older people, particularly those in care homes.
- Commission better integrated physical and mental health services in primary and secondary care; including psychiatric liaison services in every acute hospital.
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- Ensure training for all health service staff in mental health awareness and treatment options across all age groups to increase identification of mental health problems and early intervention.