

Joint Strategic Needs Assessment

Mental Health 2010

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1. EXECUTIVE SUMMARY

KEY

In this section the following applies to bullet points:

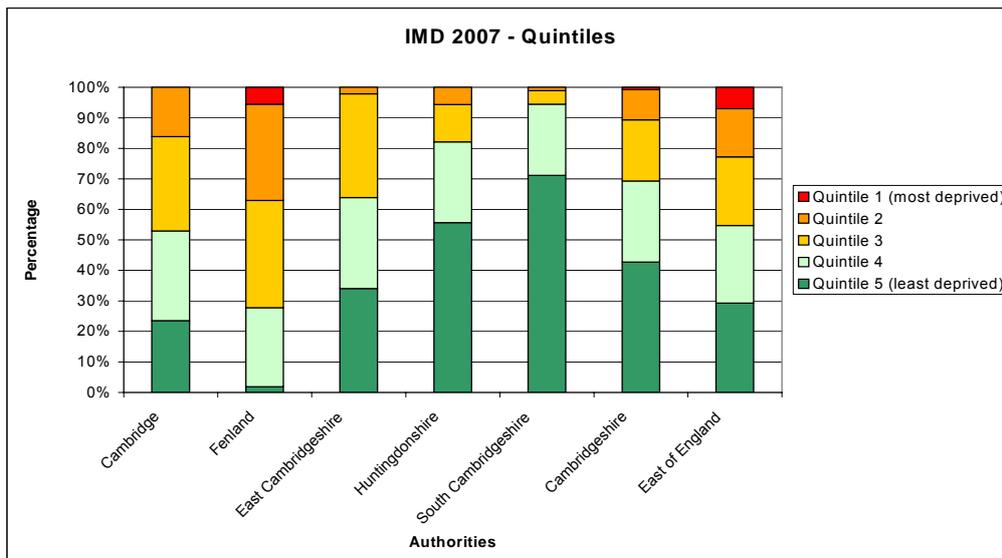
- ❖ Local evidence
- National evidence

What do we know?

1.1 FACTS, FIGURES AND TRENDS

- There are few sources of good quality local data on mental health prevalence so the estimated prevalence of mental health in the local population is derived from applying national data to population statistics for the county.
- ❖ The working age group (16-64 years) in Cambridgeshire in 2009 was over 394,000, which constitutes 66% of the total population. The proportion is noticeably higher in Cambridge City (73%).
- ❖ Population forecasts for the working age population (16-64 years) show that the greatest increases are likely to be in Cambridge City and South Cambridgeshire related to new population growth from new communities.
- It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Many of the risk factors for mental health and illness are linked to deprivation.

Figure 1: Percentage of Lower Super Output Areas (LSOAs) in each local district, by quintile of deprivation

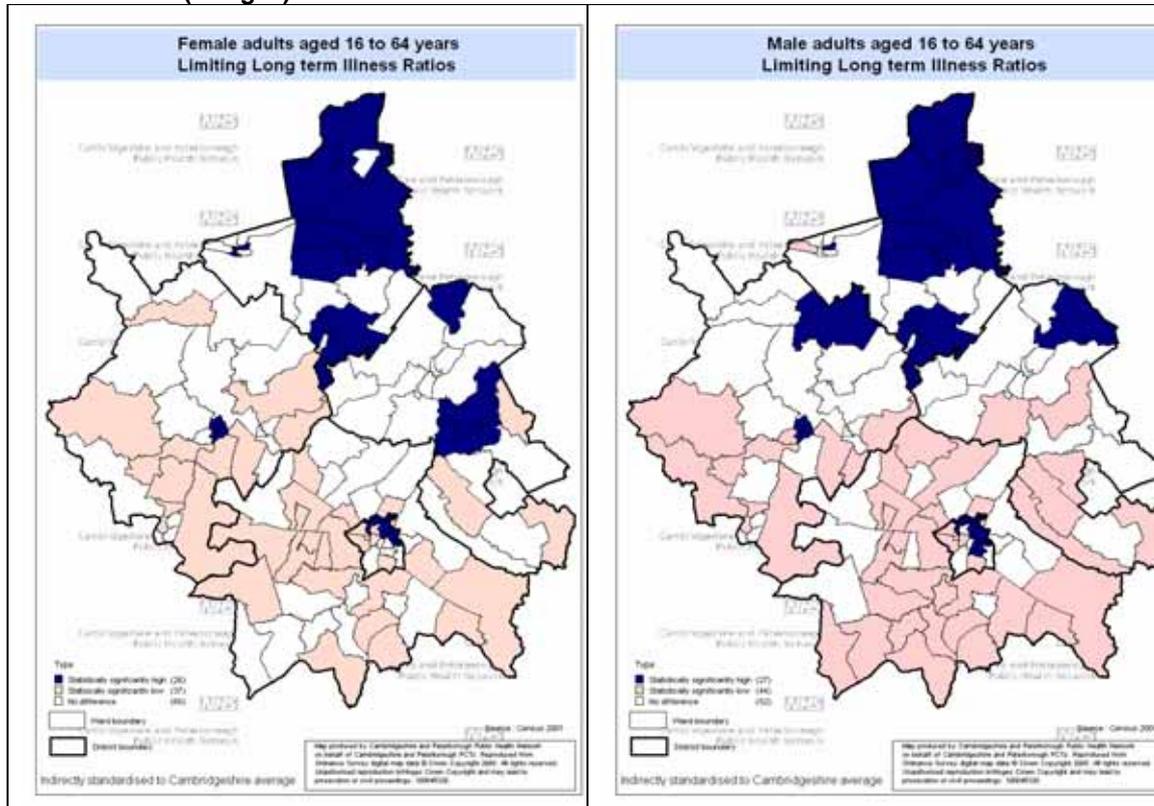


Source: IMD 2007

- Fenland is the only district in Cambridgeshire with LSOAs in the first quintile representing the most deprived areas of England. More than 70% of the LSOAs in South Cambridgeshire are in the fifth quintile representing the least deprived areas of England.
- People with mental health problems are up to twice as likely to report experiencing a long-term illness or disability; over two thirds of people with a persistent mental health problem also have a long-term physical complaint.

- ❖ There is a fairly consistent pattern across the county, with residents being more likely to have a limiting long-term illness or to perceive their health to be poor in wards to the north of the county particularly in and around Wisbech, Huntingdon North, and in parts of Cambridge City.

Figure 2: Limiting long-term illness by ward, indirectly age-standardised (all ages)



- Crime, particularly violent crime, is linked to mental health. They may have similar determinants such as drugs, alcohol and deprivation and victims of crime are more likely to suffer mental health problems such as depression. Those who suffer from mental illness are more likely to be victims of crime than commit crime, although violent crimes committed by people with mental illnesses are more frequently reported.
- ❖ The 2010 national health profiles indicate that Cambridge City's rate of violent crime is statistically significantly higher than in England. However, the trend in violent crime in Cambridge City shows that recorded offences are decreasing, with the rate of offences per 1,000 population at their lowest level in 2009/10 since 2002/03.
- ❖ For the population served by NHS Cambridgeshire, 8.3% of alcohol related hospital admissions are caused by alcohol specific mental and behavioural disorders in men (529 actual admissions) and 2.5% in women (159 admissions). Most of these alcohol specific mental and behavioural admissions occur in the 30-39 year old age group (over 40%).
- Smoking exacerbates stress, anxiety and sleep disorders; all of which will be detrimental to most mental health conditions. Smoking rates are much higher among people with mental health problems than among the general population, in some cases twice that of the general population. The smoking rates are higher in people with phobias and depressive illnesses, and relatively lower in neurotic illnesses. Over 70% of mental health inpatients with psychotic illness smoke.

- ❖ In 2004-06, 13% of the England population had a possible psychiatric disorder. The percentage was higher in Cambridgeshire (15%) but not significantly so.
- ❖ The prevalence of depression is significantly higher in the most deprived area of the PCT compared with the remaining less deprived area.

Table 1: Quality Outcomes Framework (QOF) 2008/09: Recorded prevalence of depression in Cambridgeshire for the most and least deprived areas based on MSOA level proxy IMD 2007 scores for GP practices

Area	Prevalence of depression		
	Prevalence %	Lower 95% CI %	Upper 95% CI %
Most deprived 20%	11.1%	11.0%	11.3%
Least deprived 80%	8.6%	8.5%	8.7%

Source: QOF 2008/09, Health and Social Care Information Centre. Cambridge Access Surgery is excluded from this analysis. MSOA – middle-layer super output area. IMD – Index of Multiple Deprivation

- If Cambridgeshire residents experienced roughly the national average rate of mental health problems, there would be an estimated 41,000 people in Cambridgeshire that have mixed anxiety and depressive disorders, 15,000 people with generalised anxiety disorder and 11,500 with depressive disorders. Estimates for people with schizophrenia range from 580 to 2,890 and for people with affective psychosis from 1,160 to 2,890.
- ❖ The estimate for the number of people with early onset dementia (aged 30-64 years) in Cambridgeshire is 205 based on research done in 2003 by the Early-Onset Dementia Development Group.
- ❖ Figures for mortality from suicide and injury undetermined in 2006-2008 indicate that the Cambridge City and Fenland rates are statistically significantly higher than the rate for England and the rates for Huntingdonshire and South Cambridgeshire are statistically significantly lower than the national rate.
- ❖ The Cambridge Access Surgery serves homeless people. According to QOF data for 2008/09, the recorded prevalence of mental illness at the surgery was 13.7% compared to the NHS Cambridgeshire average of 0.7%. The ratio of reported prevalence of depression to expected prevalence of depression in those aged 18 years and over was 3.24 for the Cambridge Access Surgery compared to a ratio of 1.38 for NHS Cambridgeshire.
- Travellers, migrant workers, prisoners, people with substance misuse problems, people with learning disabilities and residents in new communities are at increased risk of mental ill health and may have difficulty accessing services and health promotion.

1.2 LOCAL VIEWS

- ❖ Local views were solicited from service users, gateway workers and from third sector providers including throughout the summer 2010, Service User Event, Lifecraft, Hunts MIND, Rethink, Richmond Fellowship, Making Space and Arts on Prescription.
- ❖ Areas of unmet or under-met need identified included:
 - ❖ Support at early stages for people experiencing anxiety/stress.
 - ❖ Support for people with post-natal depression.
 - ❖ On going support to help people with long term severe and enduring illness post-crisis.
 - ❖ More alternative to hospital admission both in a crisis and for respite.

- ❖ Easy/quick access to secondary services when the service user is discharged from mental health services.
- ❖ Services for adults 17-22 years old for whom current local service models were unattractive.
- ❖ Provision of services at convenient times for clients with mild to moderate depression, stress and anxiety who are still able to work and therefore cannot access services delivered during working hours.
- ❖ Increase access to services for people who are housebound.
- ❖ Increase counselling services especially for those whose needs fell between the criteria for Improving Access to Psychological Therapies (IAPT) and secondary care.
- ❖ Individual and family debt advice specific to mental health situations.
- ❖ Increase range of services and access for clients who are referred for anger management and stress management; clients with mild eating disorders and those with dual diagnosis.
- ❖ Community services for people with a diagnosis of personality disorder.
- ❖ Employers engaging in mental health and employment law and offering work for individuals with mental health problems including short term placement as a pathway to future employment.
- ❖ Open access and preventative mental health support for people in East Cambridgeshire.

1.3 EVIDENCE AND BEST PRACTICE

- Childhood and early adulthood are key periods in the development of personal resilience and educational and social skills that will provide the foundations for good mental health across the whole life course.
- Key interventions to promote a positive start in early life are:
 - promoting parental mental and physical health;
 - supporting good parenting skills;
 - developing social and emotional skills;
 - preventing violence and abuse;
 - intervening early with mental disorders;
 - enhancing play.
- Interventions that particularly help to maintain mental health in later years include reducing poverty, keeping active, keeping warm, lifelong learning, social connections and community engagement, such as volunteering.
- Interventions to increase individual, family and community resilience include those which reduce inequalities, prevent violence, reduce homelessness, improve housing conditions and debt management, and promote employment.
- Actions to develop sustainable, connected communities include reducing social exclusion by addressing stigma and discrimination, and promoting engagement with social and environmental issues to develop inclusive communities.
- Early intervention and treatment of mental health problems, including referral for psychological therapies, can improve health outcomes for people with physical illnesses. Early physical health promotion in those with mental illness increases wellbeing and also prevents development of physical health problems.

- Participation in the arts and creativity can enhance engagement in both individuals and communities, increase positive emotions and a sense of purpose.
- 'Good Work' can provide meaningful activity and enhance wellbeing. Examples of healthy workplace practices include flexible working and initiatives to reduce workplace stress.
- Education and lifelong learning promote wellbeing and resilience and reduce the risk of mental illness.
- Ensure good overall health by integrating approaches to promoting physical and mental health to reduce health-risk behaviours and health inequalities, and improve health outcomes.
- Ensure the great opportunity for good health through personalised approaches to delivering collaborative mental health support.

1.4 CURRENT ACTIVITY AND SERVICES

- ❖ NHS Cambridgeshire currently commissions approximately 25 care pathways covering a range of mental health services from primary care (including Improving Access to Psychological Therapies - IAPT) services for people with mild to moderate mental health problems through to secondary care and a range of specialist services for people with severe and enduring mental illness and more complex problems from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).
- ❖ In comparison to similar PCTs a slightly larger percentage of people using NHS Mental Health services in Cambridgeshire are admitted to inpatient facilities.
- ❖ In comparison to neighbouring PCTs and peer group counties, more services are delivered by Community Psychiatric Nurses (CPNs) in Cambridgeshire than any other area.
- ❖ In addition to the core CPFT services, a range of voluntary and community (third sector) organisations provide services locally. Examples of provision in 2009/10 include:
 - ❖ Throughout Cambridgeshire, at least 2,000 people have accessed the services of **Lifecraft** where main interventions offered are a telephone helpline and counselling.
 - ❖ 596 people have accessed the services of **Hunts MIND**. They offer counselling services, mental health promotion through the Well Life Project, a Day Service and Home and Community Support.
 - ❖ 470 people have accessed the services of **Rethink** which offers as its main services a newsletter, telephone helpline and monthly meeting for carers in Cambridge.
 - ❖ 301 people have accessed the services of the **Richmond Fellowship** where employment advice is given, and interventions are used to enable people with wide ranging severe and enduring mental health problems to retain and regain work.
 - ❖ 197 people have accessed the services of **Making Space**. The main interventions continue to be one to one support and information for carers.
 - ❖ 42 people have accessed the services of **Choices Counselling** which offer specialist counselling for up to two years for individuals who have been victims of sexual abuse both in childhood and adulthood.
 - ❖ 31 people accessed the services of **Arts on Prescription** from the **Arts and Minds Project** where arts and crafts activities are offered mainly to those with mild to moderate levels of depression, stress and anxiety.
- ❖ A wide of range of additional services and interventions to those mentioned above are provided through local authorities, the voluntary and other sectors that support wellbeing such as leisure and arts services.

What is this telling us?

1.5 WHAT ARE THE KEY INEQUALITIES?

- ❖ The prevalence of mental ill health among the working age population is high in Cambridge City because of the demography, new growth, higher levels of crime, alcohol related harm and suicide.
- ❖ Fenland also has a high prevalence of mental ill health due to the association between mental ill health and its determinants with deprivation. Suicide rates are high in Fenland.
- Homeless, Travellers and prison populations have high levels of mental ill health. Migrant workers and black and minority ethnic communities are also vulnerable and may have barriers to accessing mental health services.

1.6 WHAT ARE THE KEY GAPS IN KNOWLEDGE/SERVICES?

- There is a perceived need for more counselling services especially for those whose needs fell between the criteria for IAPT and secondary care.
- People making the transitioning into or out of adult mental health services need to be catered for. Young adults (17-22 years old) may find current local service models unattractive and people with young onset dementia often have very different needs to older people with dementia.
- There is robust evidence for interventions that have the largest impact on improving mental health and wellbeing for the general population. Current service provision is more focused on mental illness and further opportunities exist to invest in 'preventive' interventions in a range of settings eg workplace health and through different providers.

1.7 IS WHAT WE ARE DOING WORKING?

Some of the important issues for planning and commissioning services identified in the 2008 JSNA were:

- Population growth in Cambridge City and South Cambridgeshire, including New Communities, and the increases in the older population over the next 10-15 years.

All mental health services are flexible to respond to need across the county. The identified concern regarding population growth in Cambridge City and South Cambridgeshire is being met by deployment of staff according to need. NHS Cambridgeshire is in the process of redesigning older peoples' mental health services to take account for the increase in population and will consult on providing more services within the community.

Cambridge City and South Cambridgeshire Improving Health Partnership has led work on the measures needed to build social capital and connected communities which influence mental health and wellbeing in new communities. The need to ensure that there are resources for community development and monitoring of community wellbeing outcomes has been identified and is described in the New Communities JSNA.

- The provision of mental healthcare for people from black and minority ethnic communities, Travellers and the prison population.

NHS Cambridgeshire does not commission specific mental health services for different client groups but has worked to improve access for marginalised groups by providing services in community settings which are accessible to all and providing culturally sensitive information in a range of languages. Consultations engage all potential client groups in Cambridgeshire to ensure appropriate services are commissioned.

A Travellers Health Team (THT) has been set up to address wider health issues and the need for further understanding of mental health needs in this community has been identified (see Travellers JSNA).

- Evidence base for mental health promotion – what works?

At national level, a comprehensive review of the evidence base for promoting health and wellbeing¹ has been undertaken. Key areas have been summarised in this JSNA.

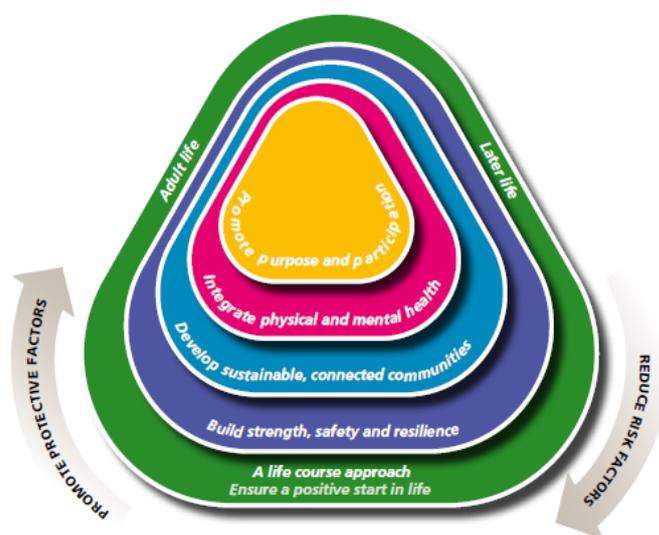
- Mapping the areas of deprivation and ensuring that mental health service provision is targeted appropriately.

The findings of the 2008 JSNA were used to target provision of services according to identified areas of deprivation. However, more work can be done in this area and GP Commissioning is expected to play a key role in continuing this work.

- Partnership working to promote education, employment and healthy lifestyles.

Mental wellbeing is 'everybody's business'. The *Confident Communities* report¹ provides a 'public mental health framework' that illustrates how different agencies and sectors can contribute to the mental health promotion and wellbeing agenda.

Figure 3: A framework for developing wellbeing



Source: New Horizons, Confident Communities Brighter Futures

Local district health partnerships, the countywide Community Health and Wellbeing Partnership and other partnerships working within Local Strategic Partnership structures provide opportunities to bring the different determinants of health together. An example of this is the jointly produced *Strategy to Tackle Health Inequalities in Cambridgeshire*².

1.8 RECOMMENDATIONS

1. The comprehensive evidence base of what works to promote mental health and wellbeing in communities should be used by the range of partnerships that operate within the Local Strategic Partnerships and Cambridgeshire Together structures when developing and commissioning strategies and plans. Effective interventions for promoting mental health

¹ HM Government Confident Communities, Brighter Futures March 2010.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114774

² Strategy to Tackle Health Inequalities in Cambridgeshire: A framework for action.
<http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/OtherPublicHealthReports/Cambridgeshire%20Health%20Inequalities%20Strategy%202009-2011.pdf>

apply throughout the life-course and can be most effective in childhood because of the impact on a range of outcomes throughout life. The *Mental Wellbeing Impact Assessment Tool*³ can be used to ensure that a programme maximises its positive impact.

2. Strengthen and extend partnership working to promote mental health and wellbeing, and provide responsive services by:
 - Obtaining views of local stakeholders on all changes to mental health services to ensure they are patient-centred and socially inclusive.
 - Working with GP Commissioning Clusters to ensure equitable provision and targeting of mental health services based on needs assessments that identify the areas and populations at greatest need.
3. NHS organisations and the Local Authority should take a lead role and work in partnership to promote a healthy workplace for their own and partner organisations.
4. Ensure equitable access to services and mental health promotion for vulnerable groups by:
 - Reviewing and implementing where appropriate the recommendations of the Bradley Report⁴ to reduce inequalities experienced by prisoners.
 - Evaluating the effectiveness of alcohol pilots within A&E, homeless shelters and police stations in improving equitable access for vulnerable groups.
 - Explore best methods to engage with the Travelling communities.
5. Review the availability of counselling services for groups where evidence shows greatest benefit to include:
 - Applying learning and experience from the 14-19s IAPT pilot to implement a 'transition' service for primary care mental health
 - Ensure seamless service for those who do not meet criteria for the IAPT or secondary care services but can benefit from provision of 'talking therapies'.

³ National Mental Health Development Unit, Improving Mental Wellbeing through Impact Assessment Sept 2009. <http://www.nmhdu.org.uk/news/new-edition-of-the-mental-wellbeing-impact-assessment-toolkit/>

⁴ Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

2. INTRODUCTION

2.1 WHAT IS MENTAL HEALTH?

Mental health is fundamental to good health, wellbeing and quality of life. It impacts on how we think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential. We all have mental health needs irrespective of any diagnosis associated with mental health.

2.2 JOINT STRATEGIC NEEDS ASSESSMENT

The concept of Joint Strategic Needs Assessment (JSNA) was introduced in the Government's *Commissioning Framework for Health and Wellbeing*, which was published in March 2007. JSNAs 'describe the future health, care and wellbeing needs of local populations and the strategic direction of service delivery to help meet those needs.' The key elements of the JSNA process are involving all important stakeholders from health and social care, identifying those needs and service requirements that are most relevant and important to its population and making use of existing information, identifying information gaps and including the views of service users, patients and the population.

The aim of a JSNA is to

- Provide analyses of data to show the health and wellbeing status of local communities.
- Define where inequalities exist.
- Provide information on local community views and evidence of effectiveness of interventions which will help to shape future plans for services.
- Make specific recommendations based on the information and evidence collected.

The following outcomes should be delivered by the JSNA:

- Define achievable improvements in health and wellbeing outcomes for the local community.
- Send signals to existing and potential providers of services about potential service changes.
- Support the delivery of better health and wellbeing outcomes for the local community.
- Inform the next stages of the commissioning cycle.
- Aid better decision-making.

2.3 ADULT MENTAL HEALTH JSNA

The first *JSNA on Adult Mental Health in Cambridgeshire* was published in June 2008 and concentrated on working age adult mental health, but where relevant, covered other age groups. The data were analysed for the local authority districts in Cambridgeshire, and compared with the East of England and England where possible. This JSNA refreshes and updates the data covered in the 2008 report and reflects new national mental health policy⁵ published in 2009.

New Horizons: a shared vision for mental health supersedes the 10 year National Service Framework for Mental Health (1999-2009). The cross government programme of action to improve mental health and wellbeing has twin aims:

- Improving the mental health and wellbeing of the population
- Improving the quality and accessibility of services for people with poor mental health

⁵ HM Government. *New Horizons: A shared vision for Mental Health* Dec 2009

The JSNA aims to support these twin aims, understanding both the wellbeing needs for the general population as well as the more specific needs and service responses required for people with poor mental health. It has also drawn on the most recent evidence base outlined in *Confident Communities, Brighter Futures: A framework for developing wellbeing* to help identify effective preventative approaches to promote wellbeing for all (as in the first aim of *New Horizons*). *New Horizons* policy builds on a wider national and international policy context as summarised in the section on the policy context below.

This report focuses on the adult 'working age' population defined broadly as 16 to 64 years. This reflects the organisation of commissioning arrangements for mental health services in Cambridgeshire. There is an acknowledgement that gaps may exist at transitions between services at both ends of the working age spectrum. Of particular interest are the needs of people with early onset dementia and functional mental health disorders where the typical age range of 55 to 70 years overlaps working age and old age.

New Horizons follows a whole population/life course approach. In line with this, this JSNA cross-references to the *Children and Young People's JSNA* and *Older People's JSNA* which are also being updated as part of the JSNA Phase 4 process.

The previous JSNA made reference to marginalised groups such as prisoners, Travellers, migrant workers, the homeless and people with learning disabilities. Specific and detailed health needs assessments or JSNAs have been conducted for these groups and these have been cross-referenced in this refreshed version.

Although separate needs assessments for drug and alcohol services are conducted regularly, we have included information on these areas in light of the fact that mental health disorders are often associated with substance abuse.

2.4 POLICY CONTEXT

The benefits that improving mental health and wellbeing bring to individuals, communities and society are increasingly recognised. We already know a great deal about what works, and interest and knowledge in this area are growing, nationally and internationally.

- The *Mental Health Declaration for Europe*⁶ (2005) highlighted that promotion of mental health and the prevention, treatment, care and rehabilitation of mental health problems are a priority and that mental wellbeing is fundamental to the quality of life and productivity of individuals, families, communities and nations.
- In 2008 the World Health Organization published the findings of its *Commission on the Social Determinants of Health*⁷, which highlighted the importance of social circumstances in influencing health and wellbeing, the need to take steps to tackle these – and the structural factors at wider policy and economic levels that lead to health inequities.
- In England 2010, the *Marmot Review*⁸ of health inequalities.
- In France, the 2009 *Sarkozy Commission on the Measurement of Economic Development and Social Progress* proposed a switch in focus from measuring economic productivity to people's wellbeing as an indicator of national wealth.

Mental health is intrinsic to wellbeing. This was highlighted in:

⁶ WHO (2005). Mental Health Declaration for Europe. Facing the Challenges, Building Solutions <http://www.euro.who.int/document/mnh/edoc06.pdf>

⁷ WHO (2008) Closing the gap in a generation. Health equity through action on the social determinants of health. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

⁸ Marmot Review (2010) Fair society, healthy lives. Strategic review of health inequalities in England post 2010. www.ucl.ac.uk/gheg/marmotreview

- the 2009 *WHO report*⁹ on mental health, resilience and inequalities
- *the Foresight Mental Capital and Wellbeing project*¹⁰ (2008) brought together an impressive amount of evidence to support the economic and social arguments for policy development and government action in this area.

The current economic climate, concerns about the environment and sustainable development, and our increasing life expectancy have generated further interest in wellbeing, with a focus on resilience and the value for money of different interventions and approaches.

There is a clear association between wellbeing, good mental health and improved outcomes for people of all ages and social classes, across a number of domains. These include longevity, physical health, social connectedness, educational achievement, criminality, maintaining a home, employment status and productivity.

These aspects are brought together in the most current national policy published in 2009 - *New Horizons: a shared vision for mental health* followed by the *Confident Communities, Brighter Futures* report in 2010 that provided the evidence base and offered a framework for developing wellbeing based on a life course approach.

In October 2010, the Royal College of Psychiatrists report *No Health without Public Mental Health*¹¹ set out a position statement for the case for public mental health. The report advocates that prevention and promotion approaches should complement the treatment of mental illness with a strategic sustainable approach.

The policy context within which the National Mental Health Commissioning Programme¹² is operating continues to develop. Alongside the significant changes to commissioning policy set out in the NHS White Paper¹³ there are a number of other important policy drivers. The Public Health White Paper¹⁴ published in November 2010 sets out a life-course approach to health and wellbeing that contributes to mental health and wellbeing.

The report *Commissioning Mental Wellbeing for All: A toolkit for Commissioners*¹⁵ specifically identifies 10 commissioning areas where evidence based interventions have been shown to make a significant contribution to improving mental wellbeing (see 3.6).

A new Mental Health Strategy will follow in 2011 that builds on the existing policy set out in *New Horizons*.

In addition, a Suicide Prevention Strategy is currently being developed and is scheduled for publication early 2011.

⁹ Friedli L, Mental health, resilience and inequalities WHO 2009. <http://www.mentalhealth.org.uk/publications/?entryid5=68603>

¹⁰ HM Government Foresight Mental Capital and Wellbeing project 2008
http://www.foresight.gov.uk/Mental%20Capital/Mental_capital_&_wellbeing_Exec_Sum.pdf

¹¹ Royal College of Psychiatrists, No health without public mental health: the case for action. Position Statement PS4/2010. October 2010
<http://www.nmhdu.org.uk/nmhdu/our-work/mental-health-commissioning-programme/>

¹² Equity and Excellence liberating the NHS July 2010 DH
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

¹³ Healthy Lives , Healthy People: Our Strategy for Public Health in England 30 November 2010 DH

¹⁴ Newbigging K and Heginbotham C., Commissioning Mental Wellbeing for All: A toolkit for Commissioners. Nov 2010 University of Central Lancashire (uclan). Commissioned by the National Mental Health Development Unit <http://www.nmhdu.org.uk/news/commissioning-wellbeing-for-all-a-toolkit-for-commissioners/>

3. GENERAL WORKING AGE

3.1 BASIC DEMOGRAPHY OF CAMBRIDGESHIRE

There is a lack of good quality local data on mental health prevalence and national data is used to calculate the estimated prevalence of mental ill health in the local population using the population statistics. Thus, the estimated number of people with mental health conditions is going to be greater in districts such as Huntingdonshire and South Cambridgeshire, based solely to their larger population compared to other districts.

However, other demographic factors such as age sex, ethnicity and deprivation can influence the risk of mental illness and wellbeing and will have implications for local planning of services. These risk factors are discussed more fully below. This is also the case for population forecasts which will influence future service planning.

Table 2: CCCR total population estimates, mid 2009, all ages by age group, Local Authority

Local Authority	Age band										Total
	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	
Cambridge City	6,400	10,500	27,700	22,900	14,400	12,200	10,800	7,200	4,800	2,100	119,100
Cambridge City (%)	5.4%	8.8%	23.3%	19.2%	12.1%	10.2%	9.1%	6.0%	4.0%	1.8%	
East Cambridgeshire	5,200	9,500	8,800	8,600	12,600	11,500	10,500	7,200	4,900	1,700	80,300
East Cambridgeshire (%)	6.5%	11.8%	11.0%	10.7%	15.7%	14.3%	13.1%	9.0%	6.1%	2.1%	
Fenland	5,100	11,200	10,500	10,400	12,700	12,700	12,500	9,400	6,800	2,100	93,300
Fenland (%)	5.5%	12.0%	11.3%	11.1%	13.6%	13.6%	13.4%	10.1%	7.3%	2.3%	
Huntingdonshire	9,500	20,200	19,300	18,300	26,200	24,500	21,400	14,400	7,800	2,800	164,600
Huntingdonshire (%)	5.8%	12.3%	11.7%	11.1%	15.9%	14.9%	13.0%	8.7%	4.7%	1.7%	
South Cambridgeshire	8,800	17,900	15,100	15,300	22,400	20,700	19,200	13,300	8,100	2,900	143,600
South Cambridgeshire (%)	6.1%	12.5%	10.5%	10.7%	15.6%	14.4%	13.4%	9.3%	5.6%	2.0%	
Cambridgeshire	35,000	69,100	81,500	75,400	88,300	81,600	74,400	51,500	32,400	11,500	600,800
Cambridgeshire (%)	5.8%	11.5%	13.6%	12.6%	14.7%	13.6%	12.4%	8.6%	5.4%	1.9%	

Source: Cambridgeshire County Council Research Group Mid 2009 based single year population estimates (Note: Figures are rounded to the nearest 10). Note: Totals may not sum due to rounding.

The table shows population estimates for 2009 by Local Authority. The mid-2009 population for Cambridgeshire is estimated to be 600,800.

Table 3: Population forecasts 2008 – 2021, all ages, Local Authority

Local Authority	Year				% change 2008 to 2021
	2008	2011	2016	2021	
Cambridge City	117,700	125,000	141,400	153,600	30.5%
East Cambridgeshire	79,400	79,300	80,200	81,100	2.1%
Fenland	92,900	93,100	96,300	100,300	8.0%
Huntingdonshire	163,100	165,500	165,800	166,800	2.3%
South Cambridgeshire	142,500	142,200	158,600	171,900	20.6%
Cambridgeshire	595,500	605,000	642,300	673,700	13.1%

Source: Cambridgeshire County Council Research Group mid 2009 based district forecasts

The population forecasts for the county show an overall increase from 2008 to 2021 of about 13%, with significantly higher increases in Cambridge City and South Cambridgeshire (about 31% and 21% respectively). This is related to the New Growth in the west of the county ('The London-Stansted-M11 corridor'). The growth in East Cambridgeshire and Huntingdonshire is estimated to be lowest at 2.1% and 2.3%, respectively.

While planning for future services, it will be necessary to consider the growth in different age groups in the different local authorities. Estimates are provided for the working age

population defined as age 16 to 64 years which approximates the age group for commissioning arrangements for adult mental health services. Tables for population estimates for the younger and older populations are included as this information is important for planning for transition between services at either end of the working age population. More detailed information on the demography of these age groups can be found in the relevant chapters of the JSNA.

The Working Age Population

Table 4: CCCRg population estimates, mid 2009, People of working age (16 to 64 years), Local Authority

Local Authority	Age bands (years)				% of total population
	16-24	25-39	40-64	Total 16-64	
Cambridge City	26,800	30,200	30,100	87,100	73.1%
East Cambridgeshire	7,800	14,500	28,600	50,900	63.4%
Fenland	9,200	16,200	31,900	57,300	61.4%
Huntingdonshire	17,200	30,600	60,000	107,800	65.5%
South Cambridgeshire	13,300	25,900	51,600	90,800	63.2%
Cambridgeshire	74,300	117,400	202,200	393,900	65.6%

Source: Cambridgeshire County Council Research Group - Mid-2009 population estimates by age group and district in Cambridgeshire

The working age group (16-64 years) in Cambridgeshire in 2009 constitutes 66% of the total population. The proportion is noticeably higher in Cambridge City (73%).

Table 5: Population forecasts 2008 to 2021, working age (16 – 64 years), Local Authority

Local Authority	Year				% change 2008 to 2021
	2008	2011	2016	2021	
Cambridge City	86,320	92,170	102,570	108,230	25.4%
East Cambridgeshire	50,660	50,520	49,170	48,650	-4.0%
Fenland	57,050	58,280	58,600	59,640	4.5%
Huntingdonshire	107,150	109,630	106,030	103,480	-3.4%
South Cambridgeshire	91,170	89,520	95,740	100,360	10.1%
Cambridgeshire	392,210	400,000	412,010	420,250	7.1%

Source: Cambridgeshire County Council Research Group - Mid-2008 population forecasts by working age population (2001-2021)

Population forecasts for an approximation of the 'working age' population – shown here for the age groups 16 to 64 years, show that the greatest increases in the population are likely to be in Cambridge City and South Cambridgeshire. A relatively small increase is forecast in Fenland with a decline in the working age population in Huntingdonshire and East Cambridgeshire.

The Younger Population

Table 6: CCCRg population estimates, mid 2009, the younger population (0 to 19 years), Local Authority

Local Authority (number by age and % of total population)	Age band				Total aged 0-19 & % of population
	0-4	5-10	11-15	16-19	
Cambridge City (num)	6,400	6,400	5,000	7,700	25,500
Cambridge City (%)	5%	5%	4%	7%	21%
East Cambridgeshire (num)	5,200	5,900	4,600	3,500	19,200
East Cambridgeshire (%)	6%	7%	6%	4%	24%
Fenland (num)	5,100	6,300	6,200	4,600	22,200
Fenland (%)	5%	7%	7%	5%	24%
Huntingdonshire (num)	9,500	11,600	10,800	7,900	39,800
Huntingdonshire (%)	6%	7%	7%	5%	24%
South Cambridgeshire (num)	8,800	10,500	9,100	6,200	34,600
South Cambridgeshire (%)	6%	7%	6%	4%	24%
Cambridgeshire (num)	35,000	40,700	35,700	29,900	141,300
Cambridgeshire (%)	6%	7%	6%	5%	24%

Source: Cambridgeshire County Council Research Group, mid 2009 population estimates

There are around 141,000 children living in Cambridgeshire. Cambridge City has the lowest proportion of children in their overall population.

Mental health and wellbeing in childhood influences mental health across the life course – up to half of lifetime mental health problems start by the age of 14^{16,17} and estimates suggest that between a quarter to a half of adult mental illness may be preventable with appropriate interventions in childhood and adolescence¹⁷

Poor mental health and wellbeing in childhood and adolescence is also associated with a broad range of poor adult health outcomes. These include poorer adult mental health and an increased risk of suicide as well as higher levels of antisocial behaviour, involvement in crime, smoking, alcohol and drug misuse and poorer socio-economic status and lower levels of employment¹⁸.

¹⁶ Kessler RC, Berglund P, Demler O et al (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archive*

¹⁷ Kim-Cohen J, Caspi A, Moffitt TE et al (2003) Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort. *Archives of General Psychiatry*, 60, 709-717

¹⁸ Fergusson DM, Horwood LJ, Ridder EM. (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. *J Child Psychol*, 46, 837-49.

The Older Population

Table 7: CCCR population estimates, mid 2009, the older population (55 years and over), Local Authority

Local Authority (number by age & % of total population)	Age group					
	55-64	65-74	75-84	65+	75+	85+
Cambridge City (num)	10,800	7,200	4,800	14,100	6,900	2,100
Cambridge City (%)	9%	6%	4%	12%	6%	2%
East Cambridgeshire (num)	10,500	7,200	4,900	13,800	6,600	1,700
East Cambridgeshire (%)	13%	9%	6%	17%	8%	2%
Fenland (num)	12,500	9,400	6,800	18,300	8,900	2,100
Fenland (%)	13%	10%	7%	20%	10%	2%
Huntingdonshire (num)	21,400	14,400	7,800	25,000	10,600	2,800
Huntingdonshire (%)	13%	9%	5%	15%	6%	2%
South Cambridgeshire (num)	19,200	13,300	8,100	24,300	11,000	2,900
South Cambridgeshire (%)	13%	9%	6%	17%	8%	2%
Cambridgeshire (num)	74,400	51,500	32,400	95,400	43,900	11,500
Cambridgeshire (%)	12%	9%	5%	16%	7%	2%

Source: Cambridgeshire County Council Research Group, mid 2009 population estimates

There are just over 95,000 people aged 65 years or over (16% of the total population), nearly 44,000 people aged 75 years or over (7% of the total population) and 11,500 people aged 85 years and over (2% of the total population) in Cambridgeshire. However, there is local variation within the county with Fenland having 20% of its population aged over 65 and 10% over 75 compared to Cambridge City having 12% of its population aged over 65 and 6% aged over 75.

While planned new housing will lead to considerable population growth, population ageing will also be an important demographic trend over the coming years. In general people are living longer and there will therefore be increasing numbers and proportions of people aged over 75 years and over 85 years.

Population ageing is likely to have the greatest impact in the rural districts. Increases in the number of children and adults of working age will be concentrated in areas of new housing growth.

Concepts of mental health in older people do not differ substantially from those held by younger people; most differences in behaviour are caused by physical and mental illness or social disadvantage, rather than the ageing process. However, age-related decline in mental wellbeing should not be viewed as an inevitable part of ageing and both the expectations of older people themselves and of society in general should be higher (*Mental Health and Older People Forum, 2008; NICE, 2008*).^{19 20}

Common misconceptions include the assumption that depression is natural and cognitive decline is a normal feature of ageing. Improved physical health, supportive social conditions and opportunities for personal growth improve mental health regardless of age. Wider benefits of mental health promotion in older age also impact on wider society and can reduce costs of care.²¹

Promoting good health and healthy behaviours throughout life has the potential to ensure that benefits are continued into later years. Substantial gains can occur through the

¹⁹ Mental Health and Older People Forum (2008) *A collective responsibility to act now on ageing and mental health: a consensus statement*.

²⁰ Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care. NICE public health guidance 16 (2008)

²¹ UK Inquiry into Mental Health and Wellbeing in Later Life, 2006

adoption of a long-term approach that prevents problems developing. For example, interventions that help to look after the heart (not smoking, moderate alcohol consumption, physical exercise, low blood pressure, healthy diet) also help to protect against cognitive decline and dementia in old age.

Further facts related to mental health in older life with an evidence base for interventions to promote mental health and wellbeing are outlined in the *JSNA for Older People*. Further information can be found in *New Horizons Confident Communities* ^{Error! Bookmark not defined.} 2010 Report (Section 2 – A life course perspective).

Ethnicity

Table 8: Ethnicity, mid 2007 estimate for the whole population, Local Authority

Area	Total population (000's)	White	Mixed	Asian or Asian British				Black or Black British			Chinese	Other
				Indian	Pakistani	Bangla deshi	Other Asian	Caribbean	African	Other		
Cambridge	120.0	83.9%	2.3%	3.1%	0.9%	1.0%	0.9%	0.8%	1.5%	0.2%	3.3%	2.2%
East Cambridgeshire	81.0	94.9%	1.4%	0.6%	0.2%	0.1%	0.2%	0.4%	0.4%	0.2%	0.9%	0.6%
Fenland	91.4	96.0%	1.0%	0.7%	0.3%	0.1%	0.2%	0.3%	0.4%	0.1%	0.3%	0.3%
Huntingdonshire	167.7	94.0%	1.5%	1.0%	0.6%	0.2%	0.2%	0.4%	0.6%	0.4%	0.4%	0.7%
South Cambridgeshire	137.3	93.6%	1.5%	1.0%	0.4%	0.2%	0.4%	0.5%	0.7%	0.1%	0.8%	0.9%
Cambridgeshire	597.4	92.3%	1.5%	1.3%	0.5%	0.4%	0.4%	0.5%	0.8%	0.2%	1.1%	1.0%
England	51,092.0	88.2%	1.7%	2.6%	1.8%	0.7%	0.7%	1.2%	1.4%	0.2%	0.8%	0.7%

Source: ONS experimental estimates mid 2007

The table above provides estimates on the ethnic composition in different districts of Cambridgeshire. Cambridge City has the highest proportion of people from a non-white ethnic group. The other districts have a lower proportion of non-white ethnic group as compared with England and Wales.

Table 9: Ethnic population estimates mid 2007 by district. People of pensionable working age (men aged 16 – 64 and women aged 16 – 59 years)

Ethnic group	Cambridge City	East Cambs	Fenland	Hunts	South Cambs	Cambs
White	71,700	46,300	51,100	98,500	78,100	345,700
White: British	60,600	42,200	49,200	91,700	73,200	316,900
White: Irish	1,100	400	300	800	800	3,400
White: Other White	10,000	3,600	1,500	6,100	4,100	25,300
Mixed	1,900	600	400	1,300	1,000	5,200
Mixed: White and Black Caribbean	400	100	100	300	200	1,100
Mixed: White and Black African	200	100	100	200	100	700
Mixed: White and Asian	700	200	200	400	300	1,800
Mixed: Other Mixed	600	200	100	400	300	1,600
Asian or Asian British	5,800	700	900	2,300	2,000	11,700
Asian or Asian British: Indian	3,200	400	400	1,200	1,000	6,200
Asian or Asian British: Pakistani	900	200	200	600	400	2,300
Asian or Asian British: Bangladeshi	800	100	100	200	200	1,400
Asian or Asian British: Other Asian	900	100	200	300	400	1,900
Black or Black British	2,500	600	600	1,800	1,300	6,800
Black or Black British: Caribbean	800	200	200	500	500	2,200
Black or Black British: African	1,500	300	300	700	700	3,500
Black or Black British: Other Black	200	100	0	500	100	900
Chinese or Other Ethnic Group	5,600	1,000	500	1,400	1,800	10,300
Chinese or Other Ethnic Group: Chinese	3,400	600	200	500	800	5,500
Chinese or Other Ethnic Group: Other Ethnic Group	2,200	400	300	900	1,000	4,800
Total working age population (All Ethnic Groups)	87,400	49,200	53,500	105,300	84,100	379,500

Source: ONS Experimental Statistics (mid 2007 based)

This table shows the experimental estimates for 2007 by Local Authority for people of working age. Cambridge City also has the highest proportion of working age people from a non-white ethnic group.

The provision of mental health care for people from black and minority ethnic communities raises important and complex issues including linguistic and cultural competence. Variations

between ethnic groups in rates of various types of treatment and in particular of the use of compulsion of the Mental Health Act have been the subject of considerable debate over the last two decades.

The NIMHE report on mental health services for black and minority ethnic communities *Inside Outside*²² stated 'It is fundamental ... to the setting and monitoring of relevant standards and outcomes that services undertake ethnic monitoring and that data can be analysed by ethnicity in local information systems.'

A 2008 report²³ looking at risk factors for suicide by ethnic group identified that higher rates of suicide exist among black African (2.5 times) and black Caribbean (2.9 times) men aged 13-24 as well as black African (3.2), black Caribbean (2.7) 162 and South Asian (2.8) women aged 25-39 than among their white British counterparts.

3.2 GENERAL RISK FACTORS FOR MENTAL HEALTH PROBLEMS

The following section sets out local data on factors that may be risk factors associated with poor mental health and wellbeing.

Deprivation

It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Mental health problems are common, and the personal, social and financial costs are immense. Our most deprived communities have the poorest health and wellbeing.

A social gradient in health exists in that better social and economic position results in better health⁸. Social and economic inequalities are fundamental drivers of health and wellbeing. In England each year, between 1.3 million and 2.5 million years of life are lost as a result of health inequality, which results in an annual cost of £56–68 billion.

Relative deprivation is associated with increased risk of mental illness²⁴ with 15% of children at the lowest income levels experiencing mental health problems compared with 5% of children at the highest income levels²⁵. Higher income inequality is linked to higher rates of mental illness, decreased rates of trust and social capital, and increased hostility, violence and racism²⁶ as well as lower wellbeing scores²⁷.

Poor mental health is associated with unemployment, lower income and other adversity. It is also associated with increased risk-taking behaviour, so that increased smoking is responsible for a large proportion of the excess mortality of people with mental health problems²⁸. One explanation for the strong social gradient in health is that relative deprivation is a catalyst for a range of negative emotional and cognitive responses to inequity²⁹. Such stress may underlie the causes of some unhealthy behaviours.

²² Inside Outside: Improving mental health services for BME communities. NIMHE 2003

²³ Bhui K, McKenzie K (2008). Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales. *Psychiatr Serv.*, 59, 414-420.

²⁴ Melzer D, Fryers T, Jenkins R. (2004) Social Inequalities and the Distribution of Common Mental Disorders. Maudsley Monographs Hove, Psychology Press.

²⁵ Green H, McGinnity A, Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

²⁶ Wilkinson RG, Pickett KE (2007) The problems of relative deprivation: why some societies do better than others. *Social Science and Medicine*, 65(9), 1965-1978

²⁷ Alesina A, Di Tella R, MacCulloch R (2004) Inequality and happiness: are Europeans and Americans different? *Journal of Public Economics*, 88, 2009–2042

²⁸ Brown S, Barraclough B, Inskip H (2000) Causes of the excess mortality of schizophrenia. *British Journal of Psychiatry*, 177, 212–217.

²⁹ Marmot M, Wilkinson R (2006) Social Determinants of Health, 2nd Edition. Oxford: Oxford University Press, ISBN: 9780198565895.

Mental illness further exacerbates inequality³⁰, those with serious mental illness dying on average 25 years earlier than those without. Stigma and discrimination compounds this inequality.

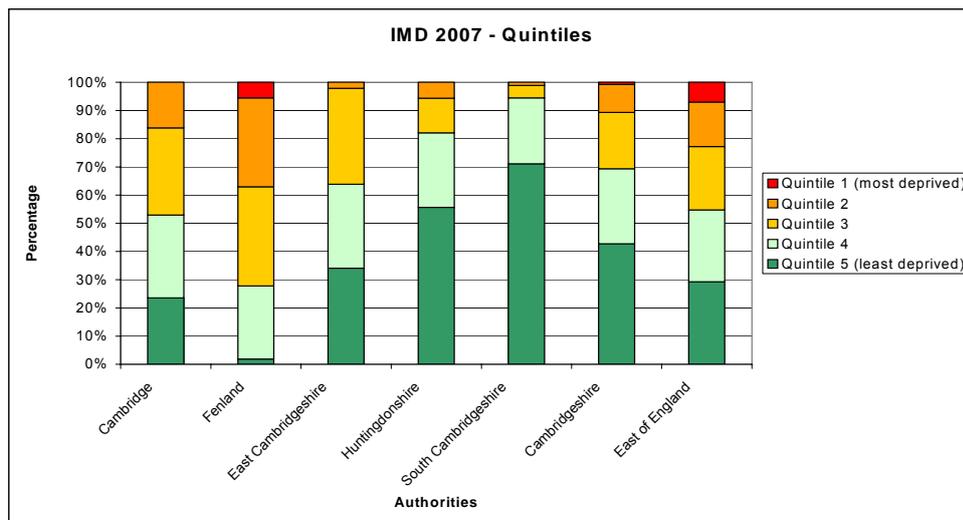
Mental health, individual resilience and social exclusion are influenced by a range and interaction of different factors across the life course such as social position, education, housing, employment and exposure to violence. Addressing these wider determinants will improve health and reduce inequalities.

Given the evidence that those from disadvantaged backgrounds are more likely to suffer mental health disorders, measures of deprivation can help to identify areas where the need for mental health services and prevention activity is likely to be greatest, thus ensuring that mental health services and interventions are targeted appropriately.

The *Index of Multiple Deprivation 2007* (IMD 2007) commissioned by the Office of the Deputy Prime Minister and constructed by the Social Disadvantage Research Centre at the University of Oxford is a measure of multiple deprivation for small geographical areas. This is assessed across seven domains: income; employment; health and disability; education, skills and training; housing and distances to services; living environment and crime; and a composite score is calculated.

IMD 2007 scores have been calculated for small geographical areas known as Lower Super Output Areas (LSOAs) covering the whole of England. These individual small area IMD 2007 scores have been grouped into quintiles representing the most through to the least deprived areas of England. The proportion of each local district's LSOAs that belong to each of the five deprivation quintiles produce a useful summary measure of deprivation compared with the East of England.

Figure 4: Percentage of Lower Super Output Areas (LSOAs) in each local district, by quintile of deprivation

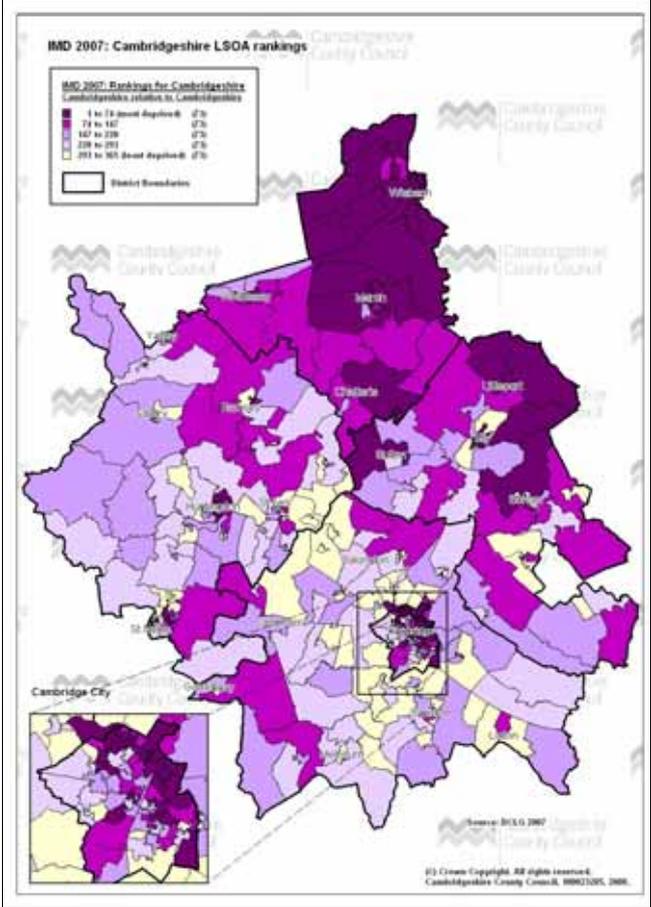


Source: IMD 2007, Communities and Local Government, 2007

³⁰ ParksJ, SvendsenD, SingerP. FortIME (2006). Morbidity and mortality in people with serious mental illness. National Association of State Mental Health Programme Directors, 13th technical report.

There is considerable variation within local districts in Cambridgeshire in the proportion of LSOAs belonging to the most and least deprived fifths of all areas in England. Fenland is the only district in Cambridgeshire with LSOAs in the first quintile representing the most deprived areas of England. More than 70% of the LSOAs in South Cambridgeshire are in the fifth quintile representing the least deprived areas of England.

Figure 5: Cambridgeshire IMD 2007 scores (showing Cambridgeshire deprivation quintiles). The LSOAs shaded darkest represent the most deprived 20% of Cambridgeshire’s LSOAs



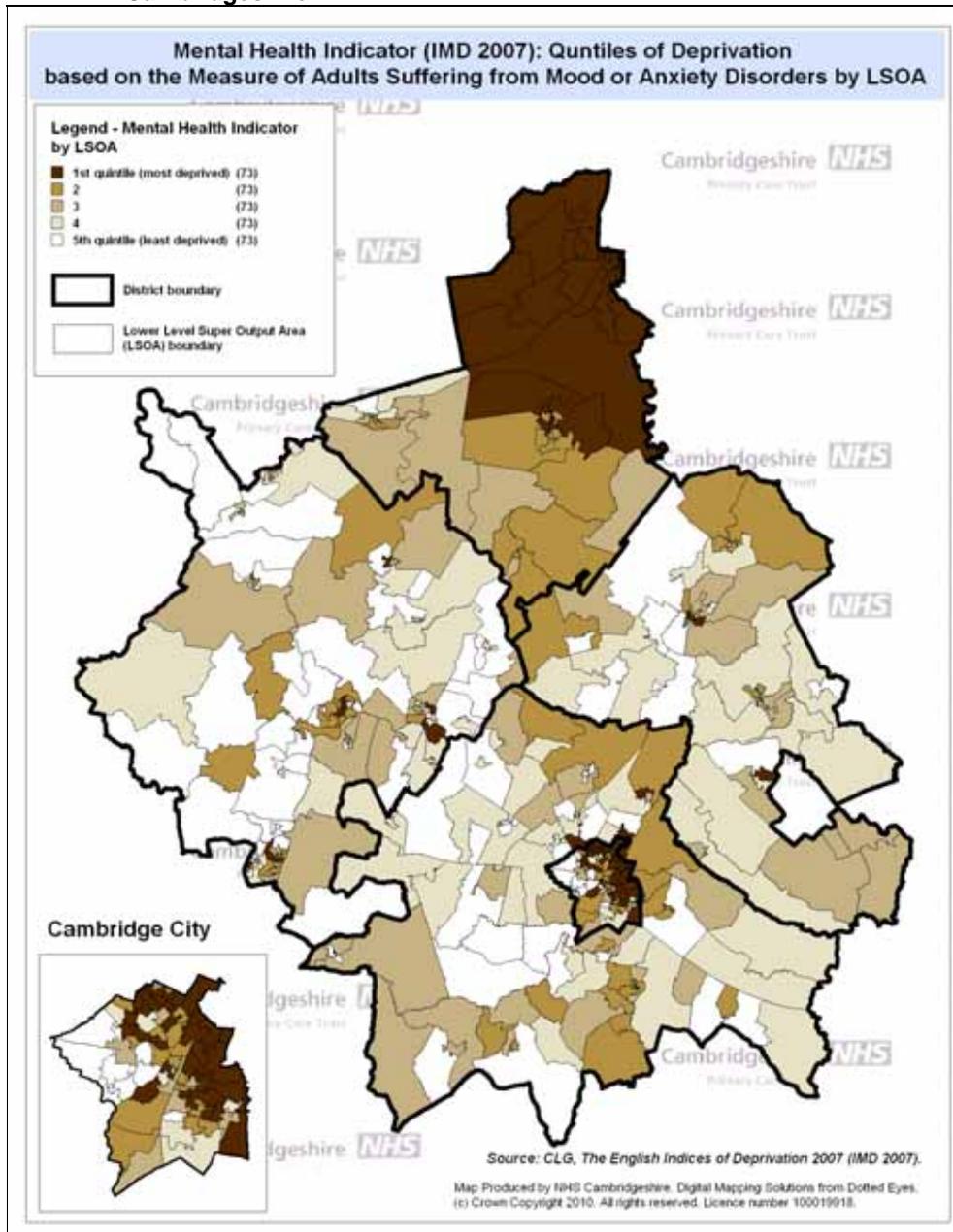
Source: IMD 2007, Communities and Local Government, 2007

The Mental Health Indicator in IMD 2007 is an Underlying Indicator in the Health Deprivation and Disability domain of IMD 2007. It was published in 2007, with the underpinning data relating to 2005. It uses a combination of data sources to provide a composite score reflecting the relative extent of adults suffering from mood or anxiety disorders. Adults are defined as those aged under 60 years.

A lower super output area (LSOA) in North Wisbech (E01018107) is the most deprived locality in Cambridgeshire based on this mental health indicator. In terms of districts, 11 (55%) of the twenty most deprived LSOAs are in Fenland and 9 (45%) are in Cambridge City. Overall, 40% of the twenty most deprived LSOAs according to the IMD 2007 Mental Health Indicator are in North or South Wisbech in Fenland, 15% are in King’s Hedges and 10% are in East or West Chesterton in Cambridge City.

The map below illustrates the IMD 2007 Mental Health Indicator: Measure of Adults Suffering from Mood or Anxiety Disorders by LSOA and by quintile according to quintile based on the score. The darker the shading the higher the score and the greater the relative deprivation based on this mental health measure.

Figure 6: Indices of Multiple Deprivation 2007: Mental Health Indicator (Measure of Adults Suffering from Mood or Anxiety Disorders) by lower super output area (LSOA) and quintile based on the Mental Health Indicator score for Cambridgeshire



Source: IMD 2007 Mental Health Indicator, Communities and Local Government, 2007

Employment

There is a positive link between employment and mental health. Research shows that people generally enjoy better mental health when they are at work³¹. Employment can protect a person's mental health by boosting confidence and self-esteem; unemployment can be both a consequence and cause of mental health problems³². People with mental health problems can be particularly sensitive to the negative effects of unemployment.

- Unemployed and economically inactive people are one of the highest population groups at risk of developing a mental health disorder.
- Every year 200,000 people move to incapacity benefits due to mental health problems.
- Economically inactive people are five times more likely, and unemployed people are four times more likely, to develop a mental health disorder.
- Unemployment increases rates of depression, particularly in the young—who are usually most badly hit when jobs are few.
- Para-suicide rates in young men who are unemployed are 9.5-25 times higher than in employed young men.
- Unemployment affects the mental health of men more than that of women.

Mental ill health has an impact on the workforce of all organisations. Promoting the mental wellbeing of employees can yield economic benefits for the business or organisation in terms of increased commitment and job satisfaction, staff retention, improved productivity and performance and reduced staff absenteeism.

At any one time one worker in six will be experiencing depression, anxiety or problems relating to stress. The average employee takes seven days sick leave each year adding up to 70 million lost working days and costing £8.4 billion a year in sickness absence³³. This includes those absent from work and 'presenteeism' – the loss of productivity that occurs when employees come to work but function at less than full capacity because of ill health.

*NICE Public Health Guidance*³⁴ provides guidance and recommendations aimed at all employers to promote employees mental wellbeing and supports key national reports including *Dame Carol Black's Review*³⁵. *The NHS Health and Wellbeing Boorman review*³⁶ recommended:

- all NHS organisations provide staff health and wellbeing services that are centred on prevention (of both work-related and lifestyle-influenced ill-health), are fully aligned with wider public health policies and initiatives, and are seen as a real and tangible benefit of working in the NHS.
- all NHS leaders and managers are developed and equipped to recognise the link between staff health and wellbeing and organisational performance and that their actions are judged in terms of whether they contribute to or undermine staff health and wellbeing.

³¹ Waddell and Burton. *Is Work Good for your health and wellbeing?* The Stationery Office 2006

³² Burchardt T. *Employment Retention and the Onset of Sickness or Disability: Evidence from the Labour Force Survey (LFS) Longitudinal Data Sets*. Department for Work and Pensions. 2003.

³³ The Sainsbury Centre for Mental Health. *Mental Health at Work: Developing the business case*. 2007.

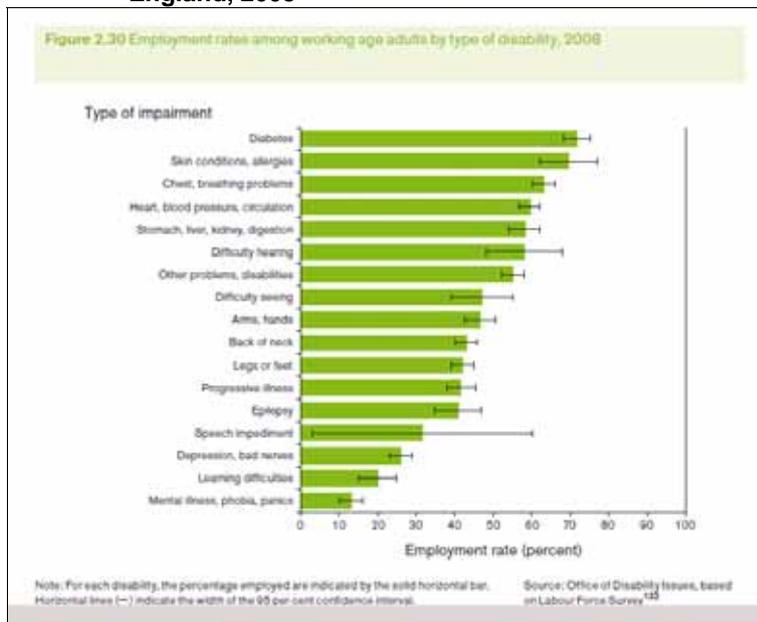
³⁴ NICE Public Health Guidance 22 - *Promoting mental wellbeing through productive and healthy working conditions: Guidance for employers*, November 2009

³⁵ Dame Carol Black's Review of the health of Britain's working age population: *working for a healthier tomorrow*. London TSO 2008

³⁶ Boorman S, *NHS health and Wellbeing Final report* DH November 2009

People with mental health disorders are also more likely to have lower rates of employment compared to other disease conditions and disabilities as illustrated by findings from the *Marmot report*⁸.

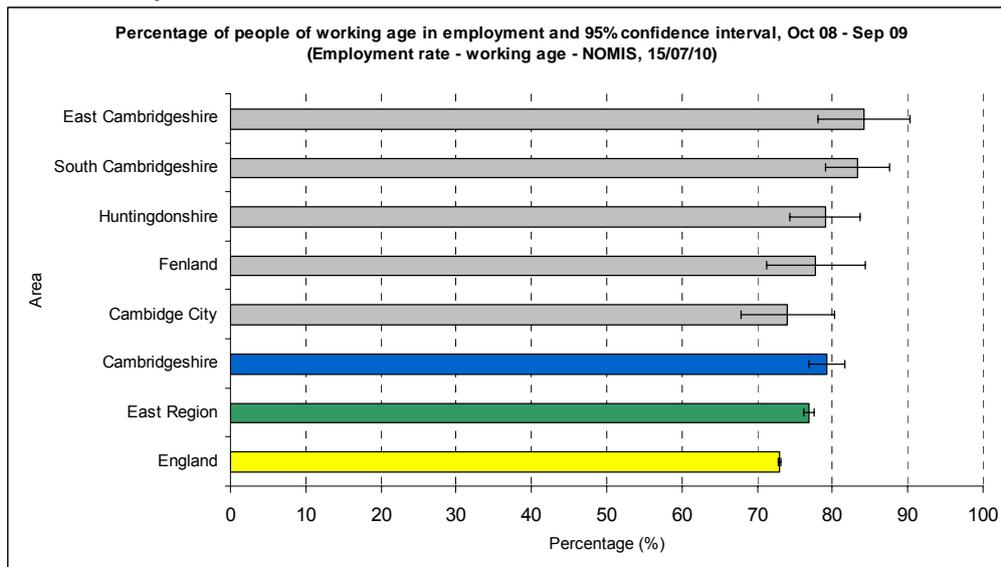
Figure 7: Employment rates among working age adults by type of disability in England, 2008



Source: Fair Society Healthy Lives (Marmot Review).
<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>, Page 70.

Over three-quarters of people of working age are in employment (either employees, self-employed or on government employment/training programmes) in England. Working age is defined as males aged between 16 and 64 and females aged between 16 and 59. In 2008/09 Cambridge City and Fenland had a lower proportion of people in employment compared to the other districts but this difference was not statistically significant. The trend in people in employment declined slightly in Cambridgeshire between 2004/05 and 2008/09 but Cambridge City, East Cambridgeshire and Fenland had increasing trends over the same period.

Figure 8: Percentage of people of working age in employment, October 2008 to September 2009



Source: NOMIS Annual Population Survey at <https://www.nomisweb.co.uk/> (downloaded 15/07/10)

Table 10: Trend in percentage of people of working age in employment, October 2004 to September 2005 to October 2008 to September 2009

Area	Annual population survey period					Trend
	2004/05	2005/06	2006/07	2007/08	2008/09	
Cambridge City	71.4	74.5	70.5	70.0	74.0	↑
East Cambridgeshire	82.8	79.4	76.8	86.1	84.2	↑
Fenland	75.6	69.8	77.0	76.7	77.8	↑
Huntingdonshire	82.4	84.2	80.6	82.2	79.0	↓
South Cambridgeshire	84.5	80.6	83.1	81.2	83.3	↓
Cambridgeshire	79.7	78.6	78.0	79.0	79.3	↓
East Region	78.3	77.4	76.9	77.6	76.9	↓
England	74.7	74.2	74.4	74.5	73.0	↓

Source: NOMIS Annual Population Survey at <https://www.nomisweb.co.uk/> (downloaded 15/07/10). ↑ denotes an increasing trend and ↓ denotes a decreasing trend.

Housing need

Housing need and tenure is known to be a key determinant of mental health. According to the *Cambridgeshire Horizons Strategic Housing Market Assessment (SHMA)*³⁷, between 1997 and 2004, the number of households accepted as being in priority need by local authorities due to 'physical disabilities' increased by 24% and due to mental health problems by 65%”

The Cambridge housing sub-region (Cambridgeshire, Forest Heath and St Edmundsbury) shares a common housing needs register and operates a choice based lettings scheme. Under choice based lettings, people bid for available properties advertised in the *Homelink* magazine. The property is then allocated to the bidder who is the best fit for the type of

³⁷ SHMA http://www.cambridgeshirehorizons.co.uk/documents/shma/ch_35_disability_and_housing_issues.pdf.

property, with the most urgent level of need who has been waiting the longest amount of time. Band A represents the highest, most urgent level of need and band D is for people with low housing need. As of mid-August 2010 there were 18,449 households on the needs register in the Cambridgeshire districts. Band C is the largest priority band.

Table 11: Number of households on the housing needs register by district and priority band, August 2010

Area	Band A	Band B	Band C	Band D	Pending	Total
Cambridge City	154	486	2,871	3,052	205	6,768
East Cambridgeshire	26	157	683	372	36	1,274
Fenland	69	256	1,144	1,052	18	2,539
Huntingdonshire	162	402	1,452	1,210	1	3,227
South Cambridgeshire	170	342	2,117	1,985	27	4,641
Cambridgeshire	581	1,643	8,267	7,671	287	18,449

Source: Locata data supplied by CCCR, 19/08/10

Table 12: Number of vulnerable households on the housing needs register by district and vulnerability type, August 2010

Area	Cambridge City	East Cambs	Fenland	Hunts	South Cambs	Cambridgeshire
Age Related Mental Infirmary	3	1	0	2	0	6
Age Related Physical Infirmary	36	5	18	46	5	110
Hearing Impairment	2	0	5	13	0	20
Learning Disability	17	1	14	67	7	106
Mental Health Issues	54	5	34	80	11	184
Permanent physical disability	56	9	50	156	32	303
Visual Impairment	1	0	0	12	0	13
Total	169	21	121	376	55	742
% due to mental health issues as a % of all vulnerable households on register	32%	23%	28%	21%	20%	25%

Source: Locata data supplied by CCCR, 19/08/10

NB: There are no statistically significant differences between the proportions of vulnerable households with a vulnerability type related to mental health in Cambridgeshire.

One in four vulnerable households on housing needs registers in Cambridgeshire is related to mental health issues. The proportions are not statistically different across the districts and range from 32% in Cambridge City to 20% in South Cambridgeshire.

Homelessness is complex and there is rarely a simple explanation for someone becoming homeless. Homelessness is more than a housing issue and can occur as a result of poor health, unemployment, imprisonment or poverty. Homeless people generally experience difficulties with accessing health services; this poor access also impacts on their health status. The JSNA Chapter on Homelessness explores the topic in greater detail.

Education

Education has a significant bearing upon employment and social inclusion, both of which impact upon mental health. Certain groups of people are at higher risk of common mental health problems; these groups include those with no, or low level, qualifications and the unemployed. Psychiatric disorders and suicidal attempts are most likely to occur in people facing socio-economic disadvantage, such as those in unskilled occupations or unemployed, and who lack formal qualifications. Individuals with a psychotic disorder are most likely to have left school before reaching sixteen years of age, and hold no qualifications.

Poor outcomes and/or attainment for education and training are associated with mental health problems and other adverse health outcomes. The attainment of five or more A*-C GCSEs including Maths and English is higher in South Cambridgeshire (nearly 70% of pupils) and lower in Fenland (41% of pupils), compared to the County average (56%) and that for England (51%). All districts show an improving trend over the three years 2007 to 2009. Variation among the 20 most deprived wards in the county is striking (14% of pupils in Wisbech Waterlees compared to 74% in Cottenham. Two year trends in attainment are very variable among these wards.

Table 13: Comparative trends in Secondary pupils achieving 5+ A*-C at GCSE including English and Maths

District of school	2007	2008	2009	3 year trend
Cambridge City	50.4	52.8	54.9	↑
East Cambridgeshire	48.3	50.3	56.0	↑
Fenland	34.9	41.3	41.2	↑
Huntingdonshire	48.1	51.5	54.0	↑
South Cambridgeshire	61.1	66.8	68.7	↑
Cambridgeshire	49.6	53.6	56.2	↑
Statistical Neighbours	51.3	53.6	55.3	↑
England	45.9	48.4	50.9	↑

Source: DCSF in SFR 01/2010, SFR 34/2009 and SFR 27/2009. ↑ denotes an increasing trend and ↓ denotes a decreasing trend.

Table 14: % achieving 5+ A*-C including English & Maths in the 20% most deprived wards in Cambridgeshire

Ward	IDACI Score (Ward ave)	2008		2009		2 year trend
		KS4 cohort	%	KS4 cohort	%	
Wisbech Waterlees	0.39	45	15.6	58	13.8	↓
Wisbech Medworth	0.38	19	21.1	26	23.1	↑
Huntingdon North	0.37	89	31.5	79	27.8	↓
Abbey	0.34	89	36.0	66	30.3	↓
King's Hedges	0.32	100	44.0	88	38.6	↓
East Chesterton	0.32	74	41.9	79	35.4	↓
Wisbech Clarkson	0.29	24	12.5	23	21.7	↑
Wisbech Staithe	0.28	30	33.3	28	21.4	↓
Parson Drove and Wisbech St Mary	0.26	37	27.0	28	32.1	↑
Whittlesey Kingsmoor	0.25	21	47.6	22	36.4	↓
Elm and Christchurch	0.25	42	23.8	36	36.1	↓
Wisbech Hill	0.25	43	32.6	38	42.1	↑
March East	0.22	70	38.6	75	40.0	↑
Wisbech Peckover	0.21	18	27.8	11	63.6	↑
Roman Bank	0.21	37	18.9	34	35.3	↑
Whittlesey Lattersey	0.20	25	56.0	26	61.5	↑
Wisbech Kirkgate	0.19	29	37.9	17	17.6	↓
Arbury	0.19	62	54.8	66	53.0	↓
Littleport West	0.18	21	47.6	32	37.5	↓
Wenneye	0.16	28	46.4	42	54.8	↑
Milton	0.16	35	80.0	47	59.6	↓
Cottenham	0.16	92	78.3	88	73.9	↓
Cherry Hinton	0.16	95	56.8	88	46.6	↓
Romsey	0.16	42	42.9	42	50.0	↑
Birch	0.16	25	36.0	31	58.1	↑
Cambridgeshire			53.6		56.2	↑

NB: Deprivation is measured using the Income Deprivation affecting Children Index (IDACI) 2007. Calculations are based on pupils' ward of residence and include only those attending a Cambridgeshire maintained secondary school.

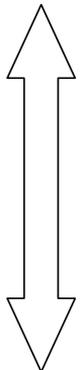
Source: NHSC Children's JSNA, 2010 ↑ denotes an increasing trend and ↓ denotes a decreasing trend.

Non-participation in education, employment or training between the ages of 16 and 18 is a major predictor of later unemployment, low income, depression, involvement in crime and poor mental health.

Cambridgeshire has a decreasing trend of 16 to 18 year olds who are not in education, training or employment between 2005 and 2009 (source: <http://www.fti.communities.gov.uk/DataDownload.aspx>, 27/08/10). Cambridgeshire rates are lower than the England and East OF England comparators throughout this period.

In terms of its CIPFA group of comparator top tier local authorities Cambridgeshire approximately midway between the best performing and worst performing authorities.

Table 15: Percentage of 16 to 18 year olds who are not in education, training or employment (NEET) for Cambridgeshire and its CIPFA comparator group of upper tier local authorities

Area	Year					Interpreting the score: 2009
	2005 (%)	2006 (%)	2007 (%)	2008 (%)	2009 (%)	
Essex	8.6	6.9	5.6	6.7	6.9	Greater % NEET (poorer)  Lesser % NEET (better)
Oxfordshire	4.9	4.8	4.2	6.3	6.5	
West Sussex	4.7	4.5	4.4	5.4	5.9	
Hampshire	4.8	5.2	5.2	6.3	5.7	
Warwickshire	6.2	6.7	5.8	5.8	5.6	
Worcestershire	6.5	5.5	4.6	5.3	5.5	
Cambridgeshire	5.8	5.4	5.0	5.2	5.4	
Northamptonshire	8.3	6.4	5.6	5.4	5.2	
Staffordshire	7.4	7.6	5.8	5.3	5.1	
Buckinghamshire	3.9	3.2	2.7	3.7	4.6	
Cumbria	6.7	5.8	5.2	5.0	4.5	
Somerset	5.3	4.8	4.3	3.8	4.4	
North Yorkshire	4.9	4.8	3.8	4.8	4.4	
Gloucestershire	6.0	4.6	4.0	3.8	4.0	
Leicestershire	6.4	5.5	4.6	4.4	3.9	
Hertfordshire	5.1	4.6	4.0	5.0	3.6	
<i>East of England</i>	7	6.8	5.8	6.2	5.9	
<i>England</i>	10.9	7.7	6.7	6.7	N/K	n/a - national comparator

Source: CLG - <http://www.fti.communities.gov.uk/DataDownload.aspx>, 27/08/10.

Additional data on training and education related areas according to various population groups such as Travellers, looked after children and teenage mothers, and by locality can be found in the respective JSNAs on Children and Young People, and Travellers.

Learning and Development

There is an extensive literature on the mental health benefits of learning, which may include both personal growth and development and the value of participation in learning opportunities. Improved health outcomes may relate to increases in human capital, (knowledge and skills), social capital (trust and dependency) and identity capital (positive self-image, assertiveness and confidence).

People who flourish at school enjoy better health and wellbeing than those who do not, though the effect may not be causal. Adults who participate in adult education in their 30s tend to enjoy positive transformations in their health and wellbeing more than their peers who do not. Adult learning is also associated with positive outcomes in health and wellbeing of adults who did not flourish at school.

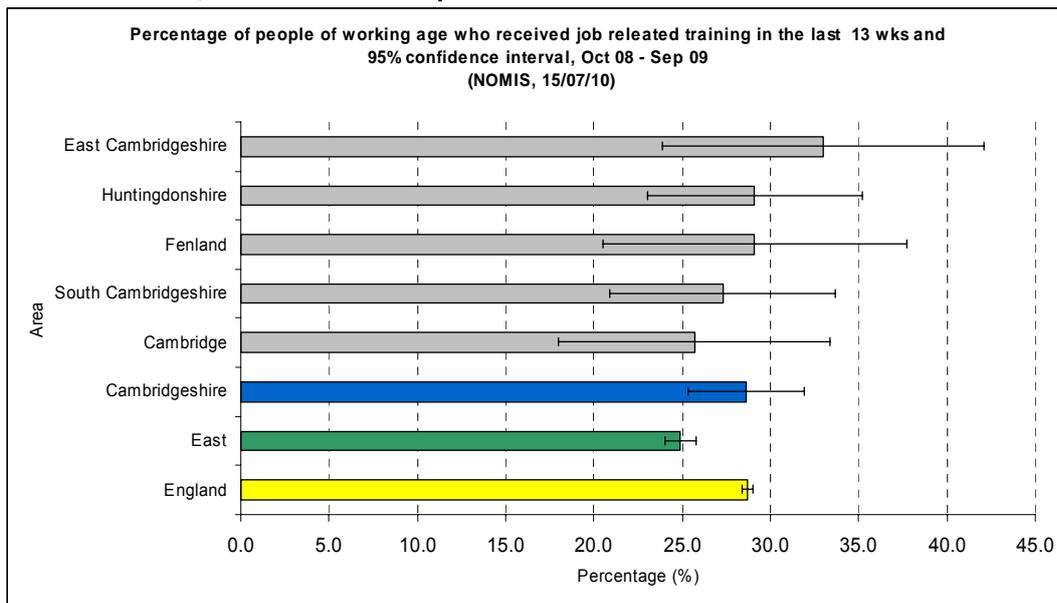
Participation in adult learning therefore does not narrow the gap between those who did and did not flourish at school, but if appropriate provision is available at the right time, it may play an important role in promoting healthy lifestyles, wellbeing and mental health³⁸.

More than one in four of all working age adults, employed and unemployed, received some form of job-related training in the previous thirteen weeks in Cambridgeshire. This was similar to the percentage for England. There is no significant difference between the districts with

³⁸ Hammond C and Feinstein L. Are Those Who Flourished at School Healthier Adults? What Role for Adult Education? Wider Benefits of Learning Research Report No.17. Centre for Research on the Wider Benefits of Learning, 2006.

regard to the amount of job-related training received when compared to the Cambridgeshire figure.

Figure 9: Percentage of working age adults in job-related training in the past 13 weeks, October 2008 to September 2009



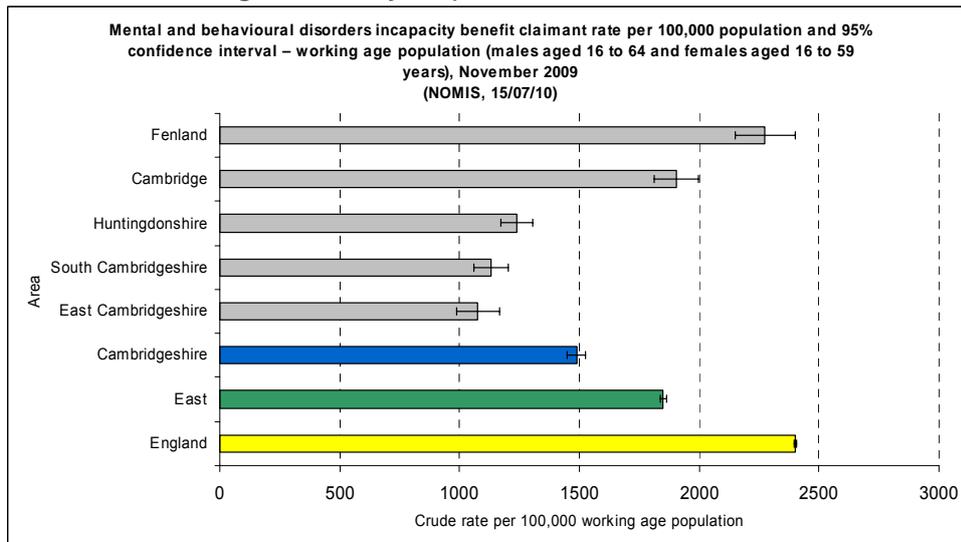
Source: NOMIS Annual Population Survey at <https://www.nomisweb.co.uk/> (downloaded 15/07/10)

Incapacity Benefit

Incapacity benefit is a social security benefit, which can be claimed by working age adults unable to work because of illness. Payment of the benefit depends on an adequate history of national insurance contributions, but disabled people not eligible for payments on the grounds of national insurance contributions may still claim, thereby gaining national insurance credits. This indicator shows rates per hundred thousand working age population claiming incapacity benefit or severe disablement allowance, irrespective of whether their contribution history is sufficient for them to receive payments.

Numbers claiming Incapacity Benefits or severe disablement allowance with a diagnosis in the mental and behavioural disorders category (irrespective of whether they receive payments) are significantly lower in Cambridgeshire (just under 1500 per 100,000) as compared to England (about 2400 per 100,000). However, within Cambridgeshire these are substantially higher in Fenland and Cambridge City (2300 and 1900 per 100,000 respectively). Trends have increased across all districts between November 2000 and 2009.

Figure 10: Mental and behavioural disorders incapacity benefit claimant rate per 100,000 population – working age population (males aged 16 to 64 and females aged 16 to 59 years), November 2009



Source: NOMIS IB-SDA at <https://www.nomisweb.co.uk/> and ONS mid-year population estimates (downloaded 15/07/10)

Table 16: Trends in mental and behavioural disorders incapacity benefit claimant rate per 100,000 population – working age population (males aged 16 to 64 and females aged 16 to 59 years), November 2000 to November 2009

Timepoint	Area							
	Cambridgeshire	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	England	Eastern Region
November 2000	1272.2	1831.2	1031.4	1690.7	987.9	968.9	2329.7	1652.3
November 2001	1347.9	1945.9	1091.3	1860.9	1059.5	990.2	2446.3	1733.4
November 2002	1407.7	1966.8	1142.9	2016.1	1072.1	1062.3	2569.8	1825.6
November 2003	1459.0	2087.5	1187.9	2015.8	1090.4	1113.8	2676.3	1912.2
November 2004	1548.4	2164.8	1260.7	2151.2	1169.6	1197.1	2750.2	1988.1
November 2005	1561.2	2189.3	1281.5	2183.9	1166.8	1185.6	2737.1	1986.9
November 2006	1578.0	2132.9	1239.7	2377.4	1160.8	1208.1	2765.1	2028.0
November 2007	1594.2	2093.8	1219.5	2429.9	1234.6	1212.8	2794.5	2089.3
November 2008	1628.4	2080.1	1189.5	2532.8	1268.9	1285.4	2730.5	2086.6
November 2009	1488.6	1902.6	1075.7	2272.7	1236.5	1128.8	2403.2	1850.2
Trend	↑	↑	↑	↑	↑	↑	↑	↑

Source: NOMIS IB-SDA at <https://www.nomisweb.co.uk/> and ONS mid-year population estimates (downloaded 15/07/10). ↑ denotes an increasing trend and ↓ denotes a decreasing trend.

The following data are presented for lower super output areas (LSOA). The rate is calculated on the mid-2008 working age population derived from the ONS Experimental Population estimates for LSOAs.

50% of the highest twenty rates of people receiving incapacity benefit and severe disablement allowance claimants with a mental health diagnoses in November 2009 are in Cambridge City, while 30% are in Fenland and 10% each are in South Cambridgeshire and Huntingdonshire. The rate of these benefits in the most deprived areas in Cambridgeshire is statistically significantly higher than the rates in the least deprived areas and in Cambridgeshire as a whole.

Table 17: Incapacity benefit and severe disablement allowance claimants with a mental health diagnoses: highest 20 LSOA level rates in Cambridgeshire (crude rate per 100,000 working age population, November 2009)

District	LSOA Code	LSOA Name	MSOA Code	MSOA Local Name	Number of mental health IB-SDA claimants	Rate per 100,000 working age popn
Cambridge	E01018009	Cambridge 004D	E02003722	West Chesterton	85	5,994.4
Fenland	E01018087	Fenland 009C	E02003750	March West	60	5,763.7
Fenland	E01018108	Fenland 002D	E02003743	North Wisbech	60	5,618.0
Cambridge	E01017971	Cambridge 003B	E02003721	East Chesterton	60	5,371.5
South Cambridgeshire	E01018261	South Cambridgeshire 006E	E02003780	Histon and Impington	55	5,203.4
Cambridge	E01017975	Cambridge 001A	E02003719	King's Hedges	50	5,160.0
Cambridge	E01017991	Cambridge 008E	E02003726	Petersfield	70	5,098.3
Cambridge	E01017948	Cambridge 006F	E02003724	Abbey	65	5,094.0
Fenland	E01018078	Fenland 007B	E02003748	March East	40	5,069.7
Cambridge	E01017967	Cambridge 010C	E02003728	Coleridge	45	4,966.9
Huntingdonshire	E01018185	Huntingdonshire 021E	E02003773	St Neots Eynesbury	45	4,843.9
Huntingdonshire	E01018143	Huntingdonshire 008A	E02003760	Huntingdon North	45	4,797.4
Fenland	E01018089	Fenland 003D	E02003744	South Wisbech	65	4,659.5
Cambridge	E01017977	Cambridge 001C	E02003719	King's Hedges	45	4,563.9
South Cambridgeshire	E01018226	South Cambridgeshire 019A	E02003793	Bassingbourn and The Mordens	70	4,492.9
Cambridge	E01017979	Cambridge 001E	E02003719	King's Hedges	45	4,233.3
Cambridge	E01017946	Cambridge 006D	E02003724	Abbey	45	4,065.0
Fenland	E01018103	Fenland 003F	E02003744	South Wisbech	30	4,026.8
Cambridge	E01017952	Cambridge 002D	E02003720	Arbury	40	3,996.0
Fenland	E01018077	Fenland 007A	E02003748	March East	40	3,872.2

Source: NOMIS (<https://www.nomisweb.co.uk/Default.asp>), 13/08/10. ONS Mid 2008 Population Estimates for LSOAs. Rates calculated by NHSC PHI.

NB: The rate is calculated based on the working age population, whereas the number of claimants is related to people aged 16 years and over. Only 100 claimants from nearly 6,000 are of pensionable age and hence the working age population is taken to be a more relevant denominator.

Table 18: Incapacity benefit and severe disablement allowance claimants with a mental health diagnoses: rates by deprivation quintile in Cambridgeshire (crude rate per 100,000 working age population, November 2009)

Deprivation quintile area (IMD 2007 LSOA based)	Number of mental health IB-SDA claimants	Rate per 100,000 working age popn	Lower 95% CI	Upper 95% CI
Most deprived 20%	2,405	3168.7	3046.5	3295.7
Least deprived 80%	3,380	1100.1	1063.8	1137.6
Cambridgeshire	5,785	1509.8	1471.7	1548.9

Source: NOMIS (<https://www.nomisweb.co.uk/Default.asp>), 13/08/10. ONS Mid 2008 Population Estimates for LSOAs. IMD2007 from CLG. Rates and CIs calculated by NHSC PHI.

NB: The rate is calculated based on the working age population, whereas the number of claimants is related to people aged 16 years and over. Only 100 claimants from nearly 6,000 are of pensionable age and hence the working age population is taken to be a more relevant denominator.

Limiting Long Term Illness

Poor quality of life through physical illness is closely related to mental health problems. People with mental health problems are up to twice as likely to report experiencing a long-term illness or disability³⁹; over two-thirds of people with a persistent mental health problem also have a long-term physical complaint⁴⁰.

³⁹ Meltzer H, Singleton N, Lee A, Bebbington P, Brugha T and Jenkins R. The Social and Economic Circumstances of Adults with Mental Disorders. The Stationery Office. 2002.

⁴⁰ Singleton N and Lewis G (Eds.) Better or Worse: a Longitudinal Study of the Mental Health of Adults Living in Private Households in Great Britain. The Stationery Office. 2003.

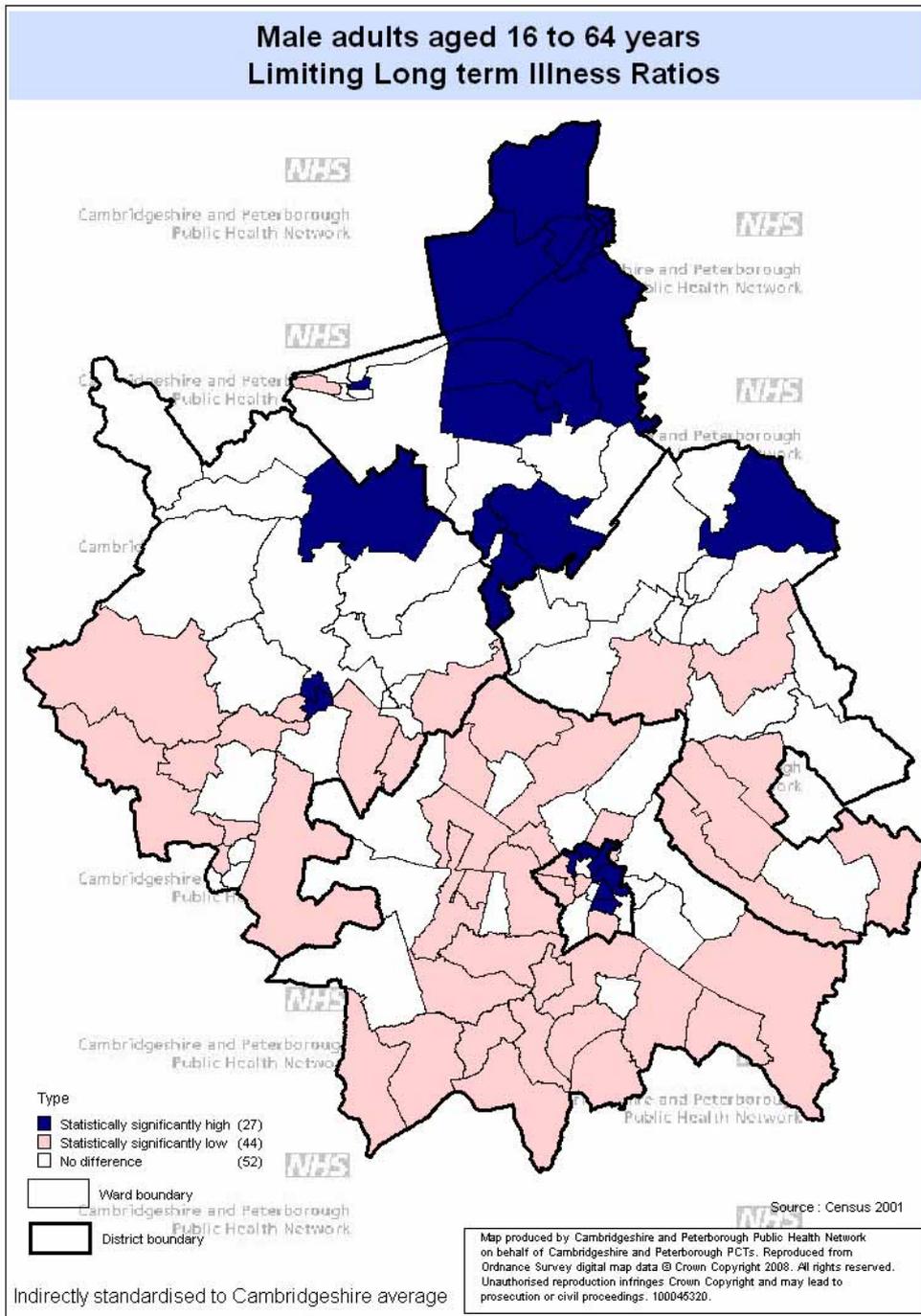
Limiting long-term illnesses (LLTI) impact upon an individual's ability to work and be economically active, which increases the risk to one's mental health. The 2001 Census demonstrated that people who have never worked or are long term unemployed have the highest rates of limiting long term illness of all socio-economic groups, at 37%.

Serious physical illness is one of a number of stressful events that can be linked to a high prevalence of suicidal thoughts⁴¹.

There is considerable variation within Cambridgeshire in the proportion of the population with LLTI as seen in the maps below.

⁴¹ Meltzer H, Lader D, Corbin T, Singleton N, Jenkins R and Brugha T. Non-fatal Suicidal Behaviour Among Adults aged 16 to 74 in Great Britain. The Stationery Office. 2002.

Figure 12: Limiting long-term illness by ward, Males



Source: 2001 Census National Statistics. © Crown Copyright 2003

The maps show the variation in self-reported health status across Cambridgeshire, taking the age and sex structure of the population into consideration. There is a fairly consistent pattern across the county, with residents being more likely to have a limiting long-term illness or to perceive their health to be poor in wards to the north of the county particularly in and around Wisbech, Huntingdon North, and in parts of Cambridge City. The pattern of poor health, as measured by the 2001 Census, is broadly similar to the pattern of deprivation as measured by the Index of Multiple Deprivation.

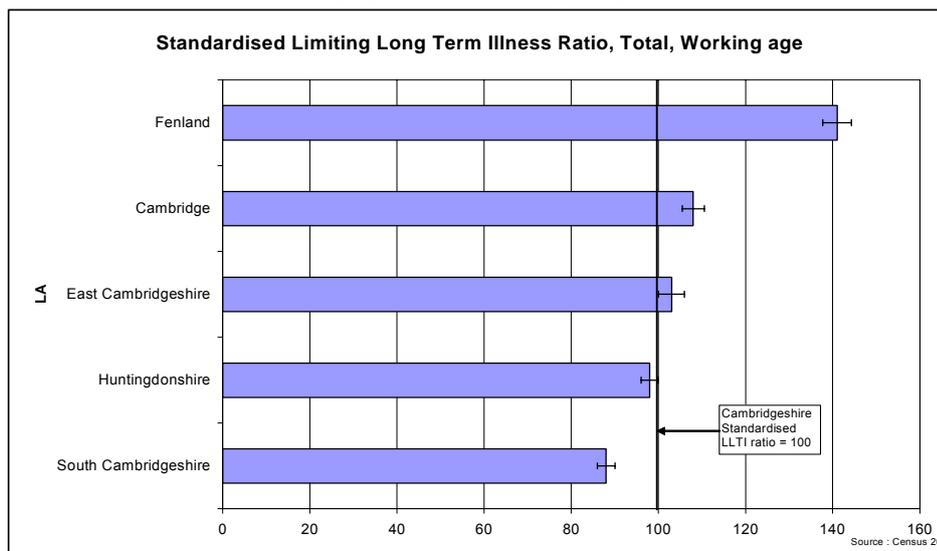
The 2008 East of England Lifestyle Survey⁴² showed that a significantly higher proportion of adults in Cambridgeshire report their health as good compared with the regional average, and a significantly lower proportion have a limiting long term illness (LLTI) or disability. However, inequalities exist within the PCT, with significantly more people in the most deprived areas reporting a LLTI.

In England, one in six people consider themselves to have a limiting long-term illness (17.9%). There is little difference between genders, whilst proportions increase steadily with age.

Figure 13 compares the proportion of people living in a household who consider themselves to have a limiting long term illness (LLTI), health problem or disability that limits daily activities and work that the individual can undertake as a standardised LLTI ratio.

This ratio compares the actual number of all people of working age with LLTI in a district to the number that would be expected for that district given their population size and age structure (based on the overall Cambridgeshire rate). A ratio of over 100 indicates more people of working age with LLTI than would be expected.

Figure 13: Adults of working age with a limiting long-term illness



Source: Census 2001 © Crown Copyright 2003 and Cambridgeshire County Council Research Group

Cambridge City and East Cambridgeshire have a high standardised Limiting Long Term Illness (LLTI) ratio indicating that the districts have a higher number of people of working age with LLTI than would be expected given their population size and structure. Fenland has a ratio (just over 140) that is highly statistically significant

⁴² The 2008 East of England Lifestyle Survey (reference <http://www.erpho.org.uk/viewResource.aspx?id=18628>)

Huntingdonshire and South Cambridgeshire have a low ratio but only South Cambridgeshire has a statistically significantly low LLTI rate indicating that the district has a lower number of people of working age with LLTI than would be expected given their population size and structure.

Social Cohesion and Social Capital

Much research indicates that social integration and social cohesion contribute to health. Social cohesion is the extent of connectedness and solidarity among groups in society. A cohesive society has abundant mutual support, leading individuals to share in the collective energy and which supports their own energy, when it is exhausted.

There are a number of definitions of social capital, but the main aspects that are included are citizenship, neighbourliness, social networks and participation. The Office for National Statistics⁴³ uses a definition from the Office for Economic Co-operation and Development⁴⁴ which is "networks together with shared norms, values and understandings that facilitate co-operation within and among groups."

Social capital is important as research has shown that higher social capital is associated with better levels of health, better educational attainment, better chances of employment and lower crime rates^{45, 46, 47, 48}

The Place Survey conducted in Cambridgeshire in 2008 asked questions about whether people felt they belonged to their neighbourhood. Data from the *Place Survey 2008* are available for Cambridgeshire, the districts and wards and can be located on the CCC website at <http://www.cambridgeshire.gov.uk/business/research/consultations/placesurvey.htm> and <http://www.cambridgeshire.gov.uk/business/research/researchmaps.htm>.

The proportion of people in Cambridgeshire who felt 'very' or 'fairly' strongly that they belonged to their neighbourhood was similar to the England average. However, the majority of counties that are national comparators to Cambridgeshire showed higher percentages.

Within Cambridgeshire, the proportion in Cambridge City was substantially lower than the other districts and county average with fewer than half of those responding feeling 'very' or 'fairly' strongly that they belonged to their neighbourhood.

⁴³ <http://www.statistics.gov.uk/CCI/nugget.asp?ID=314>

⁴⁴ Cote S, Healy T (2001) *The Well Being of nations. The role of human and social capital.* Organisation for economic Co-operation and Development, Paris.

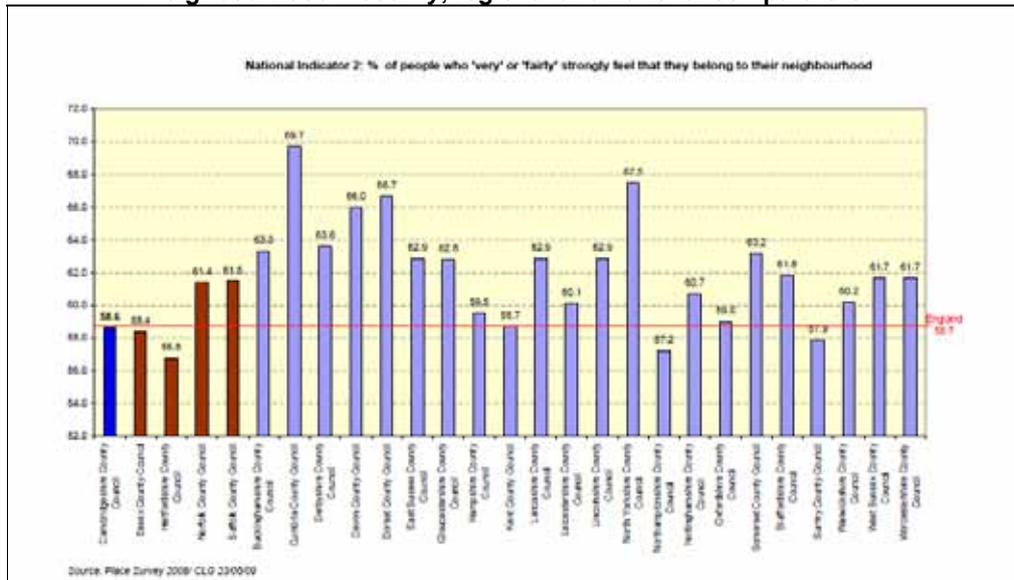
⁴⁵ Putnam R D. *Making democracy work: civic traditions in modern Italy.* Princeton, NJ: Princeton University Press, 1993.

⁴⁶ Cote S, Healy T. *The role of human and social capital.* Organisation for economic co-operation and development, Paris. 2001.

⁴⁷ Woolcock M. The place of social capital in Understanding Social and Economic Outcomes. *ISUMA Canadian Journal of Policy Research* 2001; 2(10): 11-17.

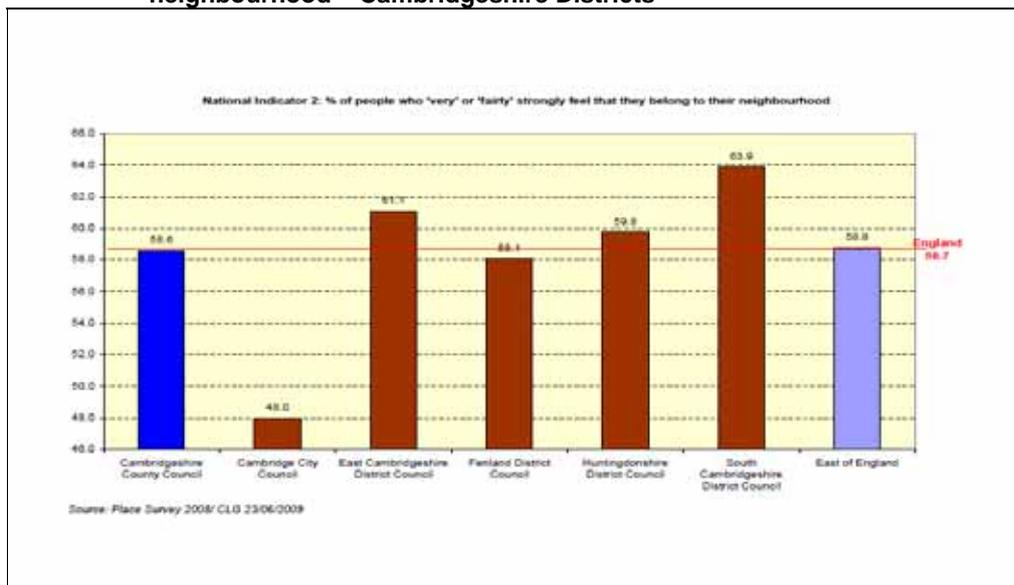
⁴⁸ Coulthard M, Walker A, Morgan A. People's perceptions of their neighbourhood and community involvement: Results from the Social Capital Module of the General Household Survey 2000. The Stationery Office. 2002.

Figure 14: % of people who 'very' or 'fairly' strongly feel that they belong to their neighbourhood – county, regional and national comparators



Source: Place Survey 2008 from Cambridgeshire County Council Research Group reports at <http://www.cambridgeshire.gov.uk/NR/rdoonlyres/31D72C1E-1044-4CEE-AB1E-A03E6927B661/0/PlaceSurveyCountyCharts.pdf>, 27/08/10.

Figure 15: NI2: % of people who 'very' or 'fairly' strongly feel that they belong to their neighbourhood – Cambridgeshire Districts



Source: Place Survey 2008 from Cambridgeshire County Council Research Group reports at <http://www.cambridgeshire.gov.uk/NR/rdoonlyres/E81831ED-DACC-41EE-ACC6-3697EC5125A3/0/PlaceSurveyDistrictCharts.pdf>, 27/08/10.

Violence and Safety

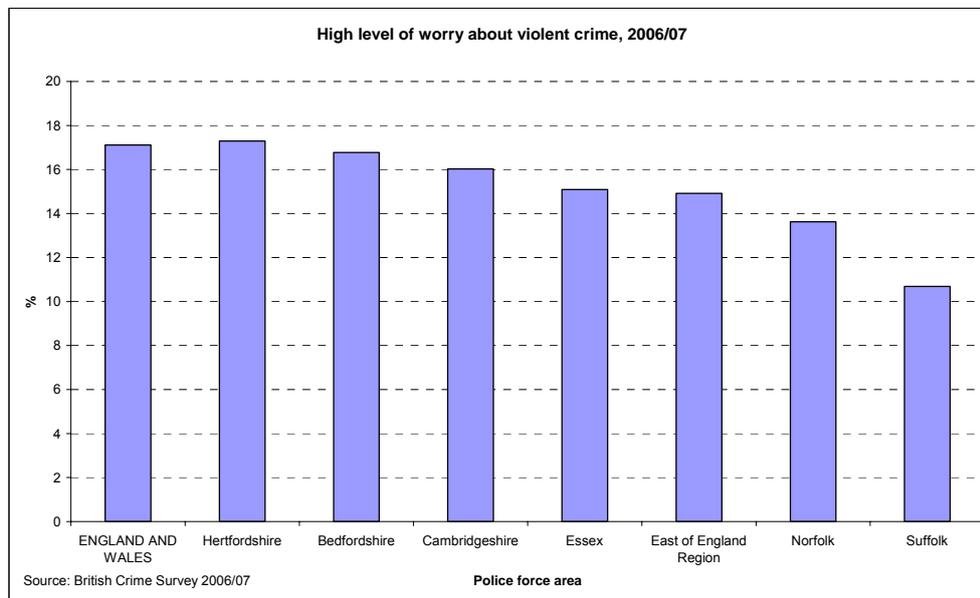
Poor mental health and wellbeing in childhood and adolescence is associated with a broad range of poor adult health outcomes which includes involvement in crime. There is good evidence for school based violence prevention programmes that improve life skills to deal with conflict and promote respectful relationships and to prevent bullying, youth violence and dating violence.

Crime, particularly violent crime, is linked to mental health in a number of ways. They may have similar determinants such as drugs, alcohol and deprivation and victims of crime are more likely to suffer mental health problems such as depression. Those who suffer from mental illness are more likely to be victims of crime than commit crime although violent crimes committed by people with mental illnesses are more frequently reported.

We would therefore expect areas with higher levels of violent crime to have higher levels of mental health problems. We have used 'all violent crime' to allow comparison between fear, reporting, and recording.

People in Cambridgeshire have a relatively higher level of worry about violent crime (about 16% of the population) compared with the regional average. The figure for East of England was about 15% and that for England and Wales was about 17%.

Figure 16: Percentage of the population with a 'high level of worry about violent crime', 2006/07



However, the recorded rate of violent crime against the person is lower in Cambridgeshire compared to England and Wales. Rates in Cambridge City and Fenland are significantly higher than the Cambridgeshire average.

The 2010 national health profiles also indicate that Cambridge City's rate of violent crime is statistically significantly higher than in England (reference <http://www.erpho.org.uk/viewResource.aspx?id=18628>).

Linked to this Cambridge's rates of alcohol related recorded crimes and alcohol related violent crimes are statistically significantly worse than the national averages (reference <http://www.nwph.net/alcohol/lape/>).

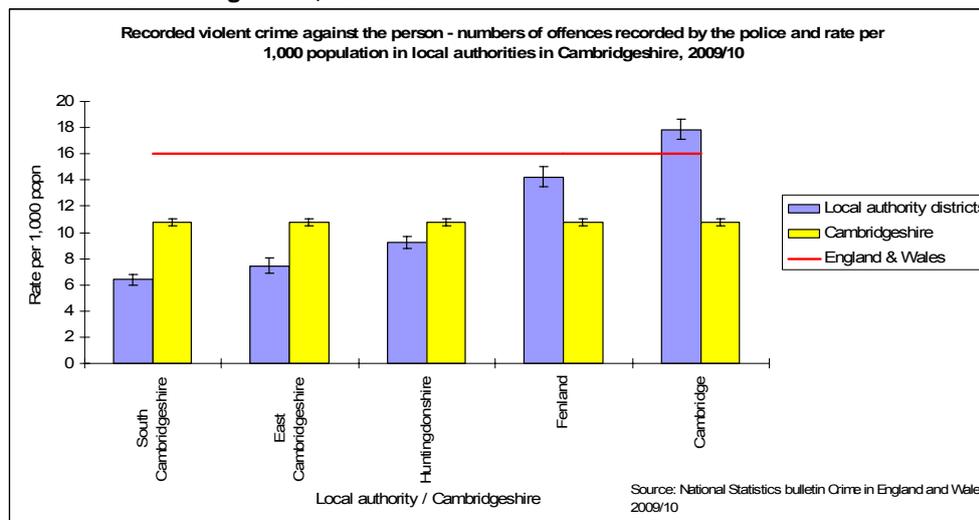
Having said that the trend in violent crime in Cambridge City shows that recorded offences are decreasing, with the rate of offences per 1,000 population at their lowest level in 2009/10 since 2002/03 (Reference: National Statistics bulletin Crime in England and Wales 2009/10, <http://rds.homeoffice.gov.uk/rds/pdfs09/rec-crime-la-data.xls>, 29/07/10).

Table 19: Recorded violent crime against the person - numbers of offences recorded by the police and rate per 1,000 population in local authorities in Cambridgeshire, 2009/10

Local authority district / Area	Number of recorded offences	Rate per 1,000	95% CI	
			Lower	Upper
South Cambridgeshire	910	6.4	6.0	6.8
East Cambridgeshire	612	7.4	6.8	8.0
Huntingdonshire	1,527	9.2	8.8	9.7
Fenland	1,304	14.2	13.5	15.0
Cambridge	2,118	17.8	17.1	18.6
Cambridgeshire Police Area (excluding Peterborough)	6,471	10.8	10.5	11.0
England and Wales	871,712	16.0	16.0	16.0

Source: National Statistics bulletin Crime in England and Wales 2009/10, <http://rds.homeoffice.gov.uk/rds/pdfs09/rec-crime-la-data.xls>, 29/07/10

Figure 17: Recorded violent crime against the person - numbers of offences recorded by the police and rate per 1,000 population in local authorities in Cambridgeshire, 2009/10

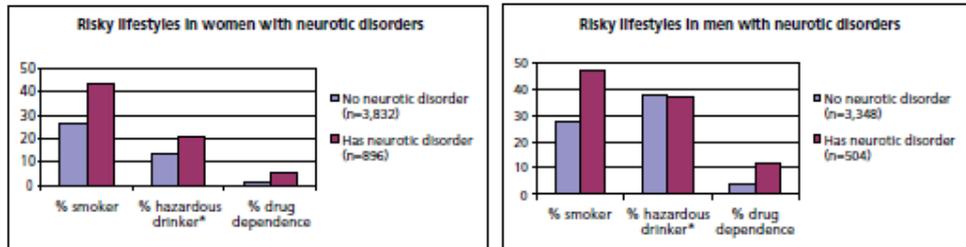


Source: National Statistics bulletin Crime in England and Wales 2009/10, <http://rds.homeoffice.gov.uk/rds/pdfs09/rec-crime-la-data.xls>, 29/07/10

Health Related Risk Behaviours

There is overwhelming evidence that changing people's health related behaviour can have a major impact on some of the largest causes of mortality and morbidity. Behaviour change is influenced by a wide range of factors for which the motivation and the opportunity to adopt a healthy lifestyle are strongly influenced by mental health. A key aspect of changing behaviour is the need to ensure approaches that promote self efficacy and good mental health whilst addressing poor mental health that potentially contributes to health risk behaviours.

Figure 18: Risk behaviours in men and women with neurotic disorders (anxiety and depression)⁴⁹



* Hazardous Drinker – above safe levels however person has avoided significant alcohol related problems

Source: New Horizons, Confident Communities

Risk behaviours, alcohol and drug misuse, high-risk sexual behaviour, lack of exercise, unhealthy eating and obesity, and smoking do not affect discrete population groups. As shown above there is an association between mental illness and high-risk behaviours. Frequently, high-risk groups are exposed to multiple health risks and have multiple health-risk behaviours to which poor mental health contributes as an underlying factor. Low income and deprivation are also important factors and are particularly associated with the 20–25% of people in the UK who are obese or continue to smoke⁵⁰. This population also experiences the highest prevalence of anxiety and depression.

Alcohol

Evidence suggests an association between increased alcohol consumption and mental ill health. Alcohol consumption can be a cause of mental ill health, or a resulting factor.

- The risk of developing hazardous drinking increases following two or more stressful life events⁵¹.
- People with a common mental disorder are twice as likely to have a dependency on alcohol compared to those without a mental health problem⁵².
- People with a severe and enduring mental illness are at least three times more likely to be alcohol dependant compared to the general population.
- Dementia; heavy drinking may cause up to one in four cases⁵³.

⁴⁹ Coulter M, Farrell M, Singleton N, Meltzer H (2002). Tobacco, alcohol and drug use and mental health. ONS. London:TSO. <http://www.voluntaryarts.org/uploaded/map1070.pdf>.

⁵⁰ Gordon D, Levitas R, Pantazis Cetal Poverty and Social Exclusion in Britain. York, Joseph Rowntree Foundation. 2000. <http://www.bris.ac.uk/poverty/pse/Poverty%20and%20Social%20Exclusion%20in%20Britain%20JRF%20Report.pdf>

⁵¹ Singleton N, Melzer H, Gatward R *et al.* (1998) Psychiatric Morbidity Among Prisoners in England and Wales. London: Stationary Office.

⁵² Cornah D, Cheers? Understanding the relationship between alcohol and mental health. Mental health Foundation 2006

⁵³ Marshall J, Guerrini I, Thomson A(2009) Introduction to This Issue: The Seven Ages of Man (or Woman) *Alcohol & Alcoholism*, 44 (2), 106–107

- Over 50% of all suicides are related to alcohol or drug dependence. In adolescents alcohol or drug misuse plays a role in up to 70% of suicides^{54,55}.

Less than 1% of the general population were classified as being moderately or severely dependent on alcohol, this increased to 2% in people with neurotic disorders, 5% among those with phobias and 6% among those with two or more neurotic disorders. Alcohol dependence is often treated within mental health services.⁵⁶

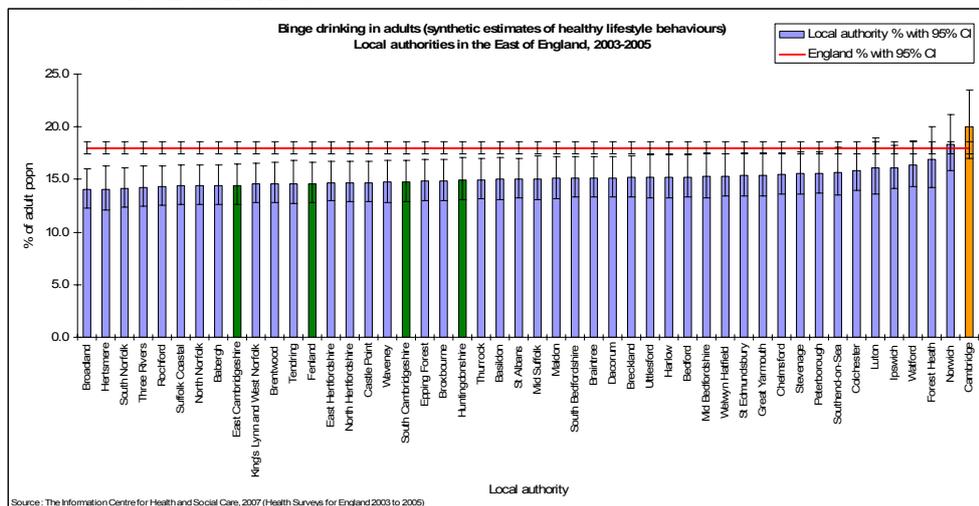
Alcohol is responsible for much psychiatric co-morbidity – with chronic heavy drinkers likely to suffer from depression, anxiety, and/or more serious cognitive impairment and psychosis.

The data shown in the figure below are synthetic estimates of binge drinking in adults, derived from the *General Household Survey*, binge drinking defined as drinking more than eight units in one day in the past week for men and six units or more for women.

Cambridge City has the highest percentage of adult population (20%) with a binge drinking problem in the East of England. The figures for East of England and England are 16% and 18%, respectively.

National prevalence studies have estimated that 38% of men and 16% of women (age 16-64 years) have an alcohol use disorder – equivalent to approximately 8.2 million people in England.

Figure 19: Synthetic estimates of binge drinking in adults, 2003-2005 – East of England local authorities



Source: The Information Centre for Health and Social Care, 2007 (Health Surveys for England 2003 to 2005)

⁵⁴ Miller, NS; Mahler, JC; Gold, MS (1991). "Suicide risk associated with drug and alcohol dependence". *Journal of addictive diseases* 10 (3): 49-61. doi:10.1300/J069v10n03_06. ISSN 1055-0887. PMID 1932152.

⁵⁵ Louis Appleby (Foreword), David Duffy (Editor), Tony Ryan (Editor) (25 August 2004). *New Approaches to Preventing Suicide*. Jessica Kingsley Publishers. pp. 31-32. ISBN 978-1843102212.

⁵⁶ Alcohol and Mental Health. IAS Factsheet. The Institute of Alcohol Studies (2007)

Table 20: Synthetic estimates of binge drinking in adults, 2003-2005 – Cambridgeshire local authorities

Local Authority	% of population	95 % CI	
		LL	UL
Cambridge City	20.0	17.0	23.5
East Cambridgeshire	14.4	12.6	16.5
Fenland	14.6	12.8	16.6
Huntingdonshire	15.0	13.1	17.1
South Cambridgeshire	14.8	12.9	16.8

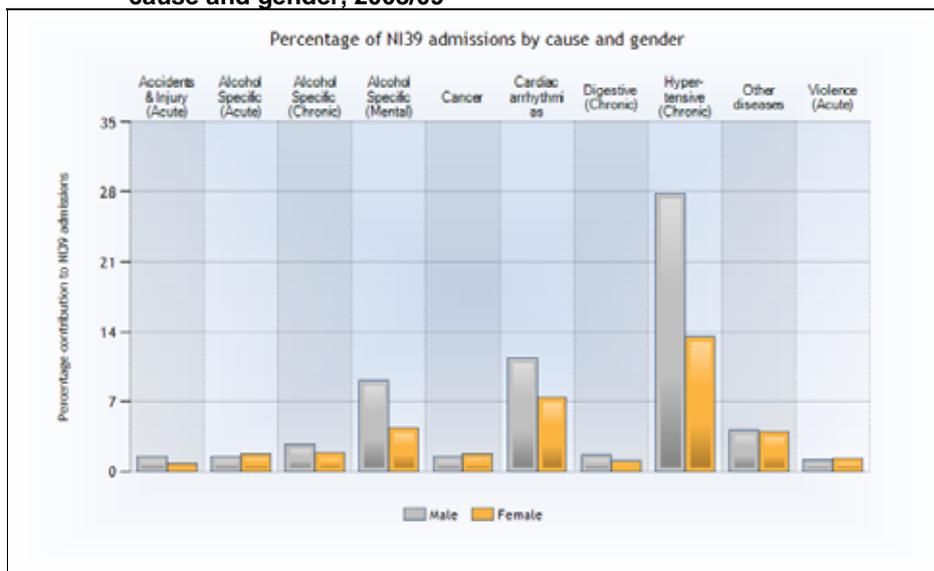
Source: The Information Centre for Health and Social Care, 2007 (Health Surveys for England 2003 to 2005)

(reference <http://www.nwph.net/alcohol/lape/>). In addition Fenland has significantly high rates of hospital stays for alcohol related harm. In Cambridgeshire as a whole hospital stays for alcohol related harm are no longer significantly higher than in England, but this is because the rate in England has increased. The rate in Cambridgeshire has increased between 2007/08 and 2008/09.

In terms of trends in alcohol-related hospital admissions – Cambridgeshire and all the Districts have generally increasing levels of admissions (reference national alcohol profiles at <http://www.nwph.net/alcohol/lape/>). The ‘JSNA summary’ contains some specific data that shows recent trends.

The national alcohol profiles provide some further data on the contribution that alcohol specific mental and behavioural disorders make to alcohol-related hospital admissions (reference <http://www.nwph.net/alcohol/lape/NI39By10Conditions.aspx>). The chart below shows this for NHS Cambridgeshire by age and gender for the 200/09 financial year.

Figure 21: NHS Cambridgeshire - percentage of alcohol related hospital admissions by cause and gender, 2008/09



Source: Local alcohol profiles for England, <http://www.nwph.net/alcohol/lape/NI39By10Conditions.aspx>, 30/07/10.

The figure above shows that for NHS Cambridgeshire 8.3% of alcohol related hospital admissions are caused by alcohol specific mental and behavioural disorders in men (529 actual admissions) and 2.5% in women (number of admissions 159). Most of these alcohol specific mental and behavioural admissions occur in the 30-39 year old age group (over 40%). Data for the districts within Cambridgeshire is in the table that follows.

Table 21: NHS Cambridgeshire - percentage of alcohol related hospital admissions attributable to alcohol specific mental and behavioural disorders by local authority district, 2008/09

Local authority	Male		Female	
	Mental & behavioural % of all NI39 admissions	Number of alcohol specific mental & behavioural admissions	Mental & behavioural % of all NI39 admissions	Number of alcohol specific mental & behavioural admissions
Cambridge City	16.0%	331	6.5%	134
East Cambs	7.2%	94	3.3%	43
Fenland	8.5%	193	4.7%	106
Huntingdonshire	6.9%	223	3.8%	124
South Cambs	7.6%	186	3.9%	95

Source: Local alcohol profiles for England, <http://www.nwph.net/alcohol/lape/NI39By10Conditions.aspx>, 30/07/10.

The 2008 East of England Lifestyle Survey for NHS Cambridgeshire (reference <http://www.erpho.org.uk/viewResource.aspx?id=18628>) indicates that the PCT overall has similar rates of hazardous and harmful drinking as the East of England as a whole. In terms of any differences between the most and least deprived areas of Cambridgeshire the least deprived area tends to have higher rates of hazardous and harmful drinking, but these differences are not statistically significant. More males than females consume alcohol at hazardous and harmful levels. The table below shows the specific data related to alcohol from the 2008 Lifestyle Survey.

Table 22: NHS Cambridgeshire – levels of hazardous and harmful drinking by gender from the East of England Lifestyle Survey, 2008

Indicator	20% most deprived MSOAs	80% least deprived MSOAs	NHS Cambs	East of England
Male Hazardous drinkers (22-50 units per week)	22.5%	23.3%	23.1%	20.6%
Male Harmful drinkers (51+ units per week)	5.8%	6.8%	6.6%	6.6%
Female Hazardous drinkers (15-35 units per week)	12.3%	12.5%	12.5%	12.6%
Female Harmful drinkers (36+ units per week)	1.8%	2.8%	2.6%	2.6%

Source: East of England Lifestyle Survey, 2008 (erpho) at <http://www.erpho.org.uk/viewResource.aspx?id=18628>.

Substance Misuse

Nationally, Class A drug use costs an estimated £15.4 billion to crime and health services each year, of which 99% is accounted for by heroin and crack use. Between a third and a half of acquisitive crime is estimated to be drug-related. Therefore, for every £1 spent on drug treatment there is a saving of £9.50 to society as a whole. According to the Home Office report entitled *Drug Misuse Declared: Findings from the 2007/08 British Crime Survey – England and Wales*⁵⁸, the proportion of 16-59 year olds reporting the use of Class A drugs in the last year in the East of England was 2.4 %. When this is applied to the local population aged 16-64 years old at the time (387,700), we have an estimated number of 9,300 people in Cambridgeshire who have used Class A drugs in the last year. A problematic drug user (PDU) is identified as being an opiate and/or crack cocaine user. As we can see from the estimated population increase of 6% by 2011, this number of PDUs could increase by 563 to 9,863, which should be considered when examining future capacity planning for services.

⁵⁸ [British Crime Survey](#)

The 2008/09 British Crime Survey is awaiting analysis and will therefore be of benefit for future analysis during 2010.

There are several drug misuse prevalence measures available, however any conclusions drawn from these must be taken with caution due to data limitations. As a result, estimated numbers of PDUs in the county has a significant margin of error, with a confidence interval of 95%. The treatment bullseye is an illustrative tool that helps to define and better understand the level of PDU engagement with structured treatment. Clients aged from 15 are included in the data. Since no estimates of Class A users were made for 2007/08, an average of the data recorded from 2004/05 to 2007/08 is used and average of 1654 should be treated with caution.

The table below summarises the estimated number of PDUs within Cambridgeshire in 2007/08. The treatment bullseye breaks down the 1654 Class A clients identified above to allow us to identify the degree of unmet need in the region. As with last year, there is a significant overlap between crack and opiate populations, with a minority only taking one of the two substances.

Table 23: Estimated number of PDUs within Cambridgeshire in 2007/08

Category	Estimate	95% CI Lower	95% CI Upper
Opiate and Crack	1654	985	2381
Crack	964	370	1612
Opiates	1448	868	2120
Injecting	1009	621	1457

Source: Estimated prevalence of opiate and/or crack cocaine use, Glasgow 'smoothed' estimates⁵⁹

On examination of substance trends as measured by the National Drug Treatment Monitoring System (NDTMS), we find that in the 2008/09 period, 1122 PDUs were identified at triage. This is equivalent to 32% of all those triaged and 0.29% of Cambridgeshire's population aged 16-64. This is an increase from 2007/08 and as a result continues with the gradually increasing numbers of PDUs since records began in 2004/05 (866 clients). However, statistically, the numbers of PDUs as a percentage of all cases triaged is actually decreasing, from 50% in 2004/05 to 35% in 2008/09.

Physical activity

There is robust evidence for the impact of physical activity on mental health: as a treatment or therapy for existing mental health problems; to improve the quality of life of people with mental health problems; to prevent the onset of mental health problems; and to improve the mental wellbeing of the general population. This has been well summarised by the *Mental Health Foundation*⁶⁰.

Physical activity should be promoted to benefit mental health and wellbeing as well as physical health. Promotion should be targeted at the general population as well as mental health service users for treatment and recovery. Exercise referral and exercise groups should be promoted in primary and secondary care.

The national health profiles include a measure from the *Sport England Active People Surveys* that is based on a higher level of activity (participation in moderate intensity sport and active

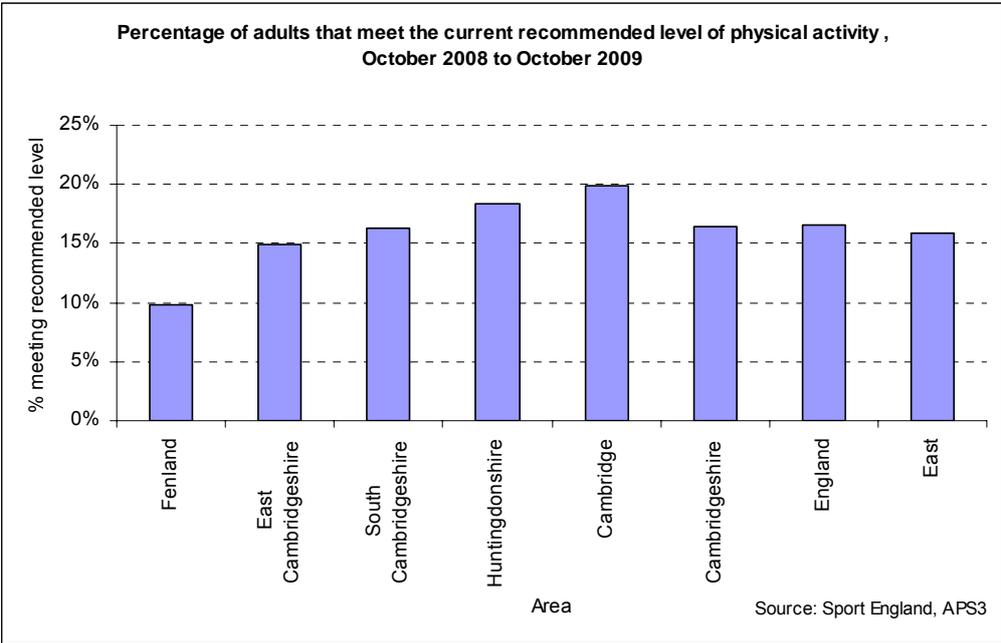
⁵⁹ Glasgow 'smoothed' estimates are an average of the figures produced 2004/05 – 2006/07.

⁶⁰ Halliwell E. Up and Running: Exercise Therapy and the Treatment of Mild or Moderate Depression in Primary Care. Mental Health Foundation. 2005.

recreation on 20 or more days in the previous four weeks, averaging five or more times per week). This indicates no significant differences in physical activity levels for Cambridgeshire and most Districts compared with England, other than for Fenland District, which has a statistically significantly lower level of participation than does England⁵⁷.

The 2008 East of England Lifestyle Survey included a question about adult physical activity that was broadly equivalent to the recommended 30 minutes of physical activity five times a week. This showed that females in Cambridgeshire did significantly more exercise than in the Eastern Region as a whole. Male rates did not differ. In terms of health inequalities there are no significant differences between the most and least deprived two areas within the PCT – male activity rates are higher in the deprived 20% of the population and female rates are higher in the least deprived 80% of the population but, as stated, these differences are not statistically significant (reference East of England Lifestyle Survey 2008 at <http://www.erpho.org.uk/lsr/lsr.aspx>).

Figure 22: Percentage of adults that meet the current recommended level of physical activity (three sessions a week at least 12 sessions of at least moderate intensity for at least 30 minutes in the previous 28 days), October 2008 to October 2009



Source: Active People Survey 3, Sport England at http://www.sportengland.org/research/active_people_survey/active_people_survey_3.aspx, 30/07/10.

In terms of trends in physical activity there has been no significant changes between *Sport England's Active People Survey (APS) 2* and the following survey, *APS3* (for Cambridgeshire, any of the Cambridgeshire Districts, England or the Eastern Region) (reference Sport England APS3 at http://www.sportengland.org/research/active_people_survey/active_people_survey_3.aspx)

However, measures of recommended levels of physical activity over more recent rolling periods to April 2010, the period April 2008 to April 2010 shows a significant increase in levels of activity from *APS1* (October 2005 to October 2006) for South Cambridgeshire. Equivalent data for Cambridge City indicates a statistically significant decrease (reference: Sport England

http://www.sportengland.org/research/active_people_survey/national_indicator_8.asp). The specific data for the National Indicator 8 trend is included in the 'JSNA summary'.

Healthy Eating

What we eat can influence our moods and overall mental health. There is sufficient evidence to suggest that nutrition may have an important part to play in our mental health.

Compared with the rest of the population, those with mental illness have less healthy diets and make poorer dietary choices⁶¹. People with mental health problems eat less fresh fruit and vegetables, and are less likely to have breakfast, compared to those with no mental health problems. Those with schizophrenia eat more than the general population⁶². A higher national dietary intake of refined sugar and dairy products predicted a worse two-year outcome of schizophrenia⁶³.

Relief from depression has been demonstrated from whole food diets and folic acid⁶⁴. Artificial food colours have been shown to affect hyperactivity of children in the general population⁶⁵, and a study on 10 year old children who ate sweets daily showed them to be significantly more likely to have been convicted for violence at the age of 34⁶⁶. A study on young prisoners who were given nutritional supplements showed an association with fewer disciplinary offences⁶⁷. A lack of sufficient safe and nutritious food has been associated with maternal depression and elevated rates of children's behaviour problems⁶⁸.

Effective interventions include:

- **Interventions to tackle food insecurity.** For example the *Healthy Start programme* which supplements poor families' income to help them purchase nutritious foods.
- **Breakfast** - Children who eat breakfast have improved daily and long-term academic performance⁶⁹. Breakfast clubs, Cook and Eat and Luncheon Clubs also provide opportunities to strengthen social networks.
- **Food supplements** - school children who receive supplements of essential fatty acids show less aggression when they are placed under stress⁷⁰.
- **Whole- food diets** – showed a protective effect for depression in middle age people when compared with highly processed diets⁷¹.

⁶¹ McCreddie R et al (2005). Dietary improvement in people with schizophrenia. *British Journal of Psychiatry*, 187, 346-351.

⁶² Strassnig M et al (2003). Body mass index and quality of life in community-dwelling patients with schizophrenia. *Schizophrenia Research* 2003;62:73-6

⁶³ Peet M. (2004). International variations in the outcome of schizophrenia and the prevalence of depression in relation to national dietary practices: an ecological analysis. *British Journal of Psychiatry*, 184 404-8.

⁶⁴ Miller AL. The methylation, neurotransmitter, and antioxidant connections between folate and depression *Altern Med Rev.* 2008 Sep;13(3):216-26.

⁶⁵ D. McCann et al Food additives and hyperactive behaviour in 3-year-old and 8/9-year-old children in the community: a randomised, double-blinded, placebo-controlled trial. *The Lancet*, Volume 370, Issue 9598, Pages 1560-1567

⁶⁶ Moore CS et al Confectionery consumption in childhood and adult violence *The British Journal of Psychiatry* (2009) 195: 366-367. doi: 10.1192/bjp.bp.108.061820

⁶⁷ Gesch C Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behaviour of young adult prisoners *The British Journal of Psychiatry* (2002) 181: 22-28 The Royal College of Psychiatrists

⁶⁸ Melchior M Mental Health Context of Food Insecurity: a Representative Cohort of Families With Young Children *PEDIATRICS* Vol. 124 No. 4 October 2009

⁶⁹ Wesnes et al. Breakfast reduces declines in attention and memory over the morning in schoolchildren *Appetite* 41(3) 329-331 2003

⁷⁰ Itomura et al. The effect of fish oil on physical aggression in schoolchildren - a randomized, double-blind, placebo-controlled trial. *J Nutr Biochem.* 16(3) 163-71. 2005

⁷¹ Akbaraly et al 2009 Dietary pattern and depressive symptoms in middle age *The British Journal of Psychiatry* (2009) 195: 408-413.

Further resources:

British Nutrition Foundation - <http://www.nutrition.org.uk/>

Parliamentary report, 2008– “The links between diet and behaviour: The influence of nutrition on mental health” - http://www.fhf.org.uk/meetings/inquiry2007/FHF_inquiry_report_diet_and_behaviour.pdf

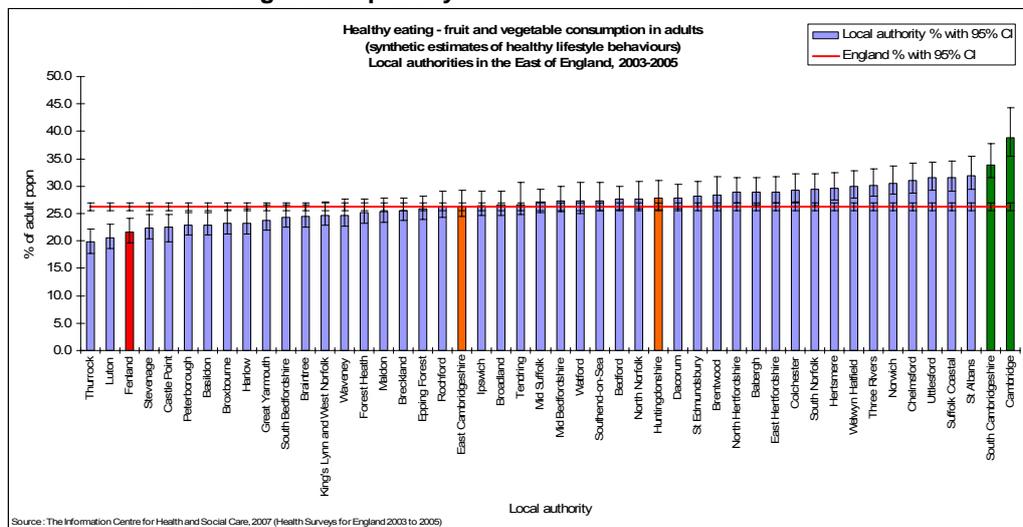
The Foresight review for Mental Capital (2008) – examined the association between specific nutrients and cognitive development and decline - <http://www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/Welcome.asp>

The Food and Mood Project – web-based, user-led, self-help service to help individuals explore the relationship between food, emotional and mental health: www.foodandmood.org

The most relevant regional data available is the percentage of people consuming at least five portions of fruit and vegetables a day, which we present here as a proxy for the percentage of the population likely to heed public health messages about healthy eating. Synthetic estimates of healthy eating measures the proportion of adults aged 16 and over who consume five or more portions of fruit and vegetables per day. The numerator is an estimate based on the *Health Survey for England data 2003 to 2005* and the denominator is based on the *2001 Census*.

In the East of England about a quarter of the adult population consumes five or more portions of fruit and vegetables per day. The proportion is similar in Huntingdonshire, but lower in Fenland and East Cambridgeshire. More than 30% adults consume five or more portions in Cambridge City and South Cambridgeshire.

Figure 23: Synthetic estimates of healthy eating in adults, 2003-2005 – East of England local authorities. Percentage of adults who consume 5 or more portions of fruit and vegetables per day



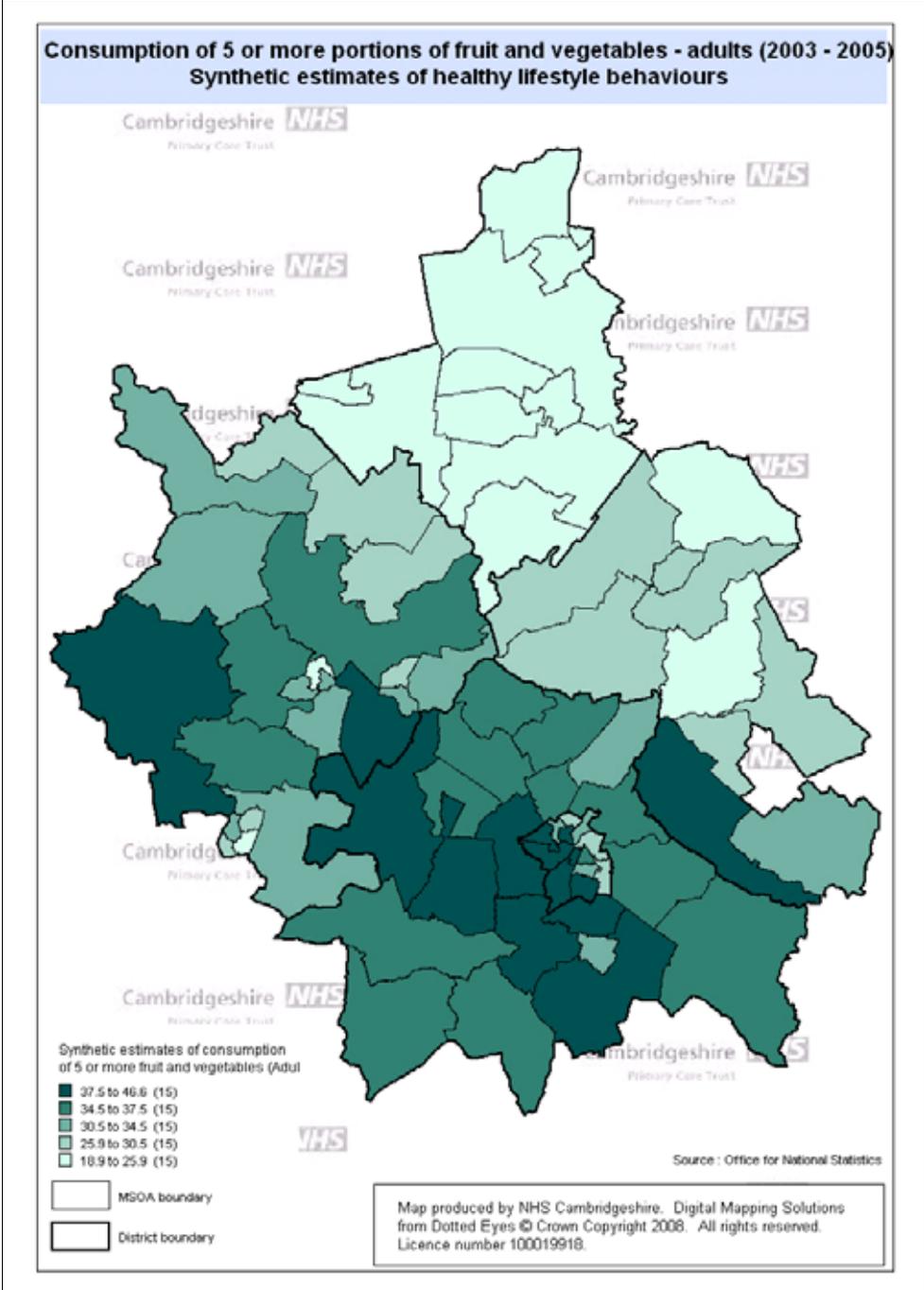
Source: The Information Centre for Health and Social Care, 2007 (Health Surveys for England 2003 to 2005)

Table 24: Synthetic estimates of healthy eating in adults, 2003-2005. Percentage of adults who consume 5 or more portions of fruit and vegetables per day – Cambridgeshire local authorities

Local Authority	% of population	95 % CI	
		LL	UL
Cambridge City	38.9	33.7	44.3
East Cambridgeshire	26.3	23.6	29.3
Fenland	21.7	19.4	24.1
Huntingdonshire	27.8	24.7	31.1
South Cambridgeshire	33.9	30.3	37.8

Source: The Information Centre for Health and Social Care, 2007 (Health Surveys for England 2003 to 2005)

Figure 24: Synthetic estimates of healthy eating in adults, 2003-2005. Percentage of adults who consume 5 or more portions of fruit and vegetables per day - Cambridgeshire middle super output areas



Source: The Information Centre for Health and Social Care, 2007 (Health Surveys for England 2003 to 2005)

The 2010 National Health Profiles for Cambridgeshire and the Districts include some more recent data related to healthy eating based on the Health Survey for England, 2006-2008. As with the 2003-2005 data that the above estimates are based on, these data show that Cambridge City and South Cambridgeshire have significantly higher rates of consumption of five or more portions of fruit and vegetables per day than found in England as a whole. It appears that there has been some improvement in Fenland and in East Cambridgeshire, with Fenland now no longer significantly different to the national average and with East Cambridgeshire now with significantly higher consumption. Huntingdonshire continues to show no significant difference with the national proportion of adults consuming five or more portions a day⁵⁷.

The 2008 East of England Lifestyle survey (reference <http://www.erpho.org.uk/lsr/lsr.aspx>) indicated that in Cambridgeshire almost half of adults eat five portions of fruit and vegetables on at least five days per week. The Cambridgeshire rate is significantly better than the East of England level. However, there are lower levels of consumption of five a day on at least five days per week in the most deprived area of Cambridgeshire compared with the least deprived, with 42% of people in the most deprived area compared with 49% in the least deprived area. However, this difference between deprived areas is not statistically significant (reference <http://www.erpho.org.uk/lsr/lsr.aspx>).

Obesity and mental health

Associations exist between mental health and obesity:

- Mental illness, intellectual disability and physical disability increase the risk of obesity^{72,73,74}
- The association between common mental disorders and obesity has been found to become stronger with increasing age⁷⁵.
- Antipsychotic medication can cause significant weight gain and diabetes⁷⁶.

This highlights the need to address the mental health of those who are overweight or obese. Additionally, these studies suggest that there would be value in identifying poor mental health in adolescence and young adulthood to target early interventions to reduce obesity.

Being under prolonged levels of stress frequently increases levels of cortisol. The action of cortisol is known to increase appetite and insulin resistance, which explains some of the mechanism behind poor mental health and increased risk of obesity and diabetes. Mental health problems are frequently associated with lower levels of physical activity, less healthy and increased food consumption. The side effects of many psychiatric medications often include weight gain.

Synthetic estimates of adult obesity measure the proportion of adults aged 16 and over who are classified as obese. The numerator is an estimate based on the *Health Survey for England data 2003 to 2005* and the denominator is based on the *2001 Census*.

⁷² White M, Adamson A, Chadwick T, et al (2007) The Changing Social Patterning of Obesity: An Analysis to Inform Practice and Policy Development. Public Health Research Consortium
<http://www.york.ac.uk/phrc/B1-06%20PHRC%20Obesity%20final%20report%202008.pdf>

⁷³ Simon GE, Von Korff M, Saunders K, et al. Association between obesity and psychiatric disorders in the US adult population. *Archives of General Psychiatry*, 63, 824–830. 2006

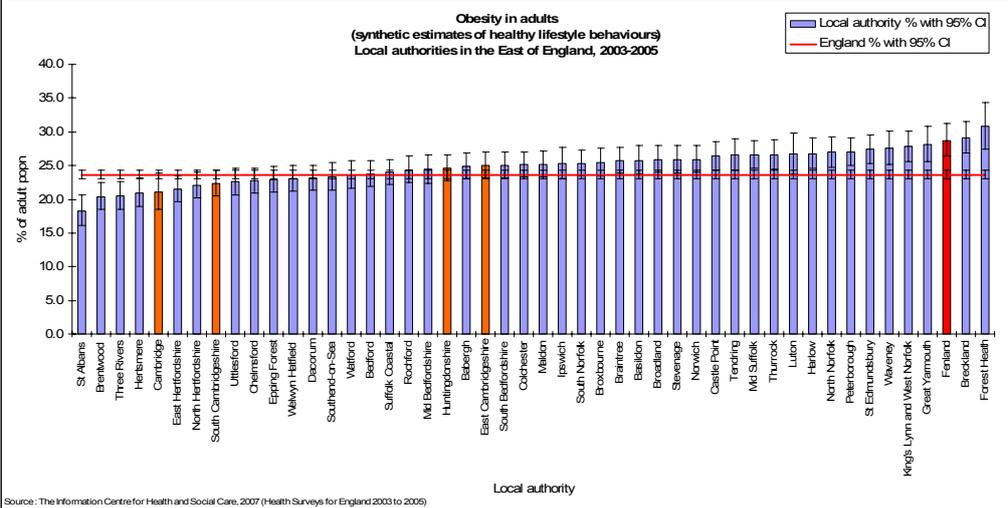
⁷⁴ Petry NM et al. Overweight and Obesity are Associated With Psychiatric Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions *Psychosomatic Medicine* 70:288-297 2008

⁷⁵ Kivimaki M. Association between common mental disorder and obesity over the adult life course. *The British Journal of Psychiatry* 195: 149-155 2009.

⁷⁶ Newcomer JW. Second-generation (atypical) antipsychotics and metabolic effects: a comprehensive literature review. *CNS Drugs*. 2005;19 Suppl 1:1-93.

In the East of England just under a quarter of the adult population are classified as obese and in England the levels are similar. In Cambridgeshire, other than in Fenland, the estimated levels of obesity do not differ significantly from the national level, but range from around 21% in Cambridge to 25% in East Cambridgeshire. Levels of adult obesity in Fenland appear to be higher at almost 29% and here the level of obesity is statistically significantly higher than in England as a whole. The map below at smaller area level illustrates this with higher levels of obesity generally found in the north of the county.

Figure 25: Synthetic estimates of obesity in adults, 2003-2005 – East of England local authorities. Percentage of adults who are classified as obese



Source: The Information Centre for Health and Social Care, 2007 (Health Surveys for England 2003 to 2005)

Table 25: Synthetic estimates of obesity in adults, 2003-2005. Percentage of adults who are obese – Cambridgeshire local authorities

Local Authority	% of population	95 % CI	
		LL	UL
Cambridge City	21.1	18.5	23.9
East Cambridgeshire	25.0	23.1	27.0
Fenland	28.8	26.4	31.2
Huntingdonshire	24.6	22.8	26.6
South Cambridgeshire	22.4	20.5	24.4

Source: The Information Centre for Health and Social Care, 2007 (Health Surveys for England 2003 to 2005)

not significantly from the national average. However, the 2006-2008 levels in Cambridge and South Cambridgeshire are now significantly lower than national levels, with Cambridge seeing a reduction from 21.1% of adults being obese to 17.2%. Adult obesity levels in Fenland have also decreased from 28.8% to 25.8%, with levels now not significantly different to that estimated nationally. In Cambridgeshire as a whole the 2006-2008 data suggests that adult obesity⁵⁷

The 2008 East of England Lifestyle survey (reference <http://www.erpho.org.uk/lsr/lsr.aspx>) indicated that in Cambridgeshire almost half of adults eat five portions of fruit and vegetables on at least five days per week. The Cambridgeshire rate is significantly better than the East of England level. However, there are lower levels of consumption of five a day on at least five days per week in the most deprived area of Cambridgeshire compared with the least deprived, with 42% of people in the most deprived area compared with 49% in the least deprived area. However, this difference between deprived areas is not statistically significant (reference <http://www.erpho.org.uk/lsr/lsr.aspx>).

The 2008 East of England Lifestyle survey (reference <http://www.erpho.org.uk/lsr/lsr.aspx>) indicated that in Cambridgeshire, in general, prevalence of overweight and obesity are similar to the East of England average. However, the prevalence of obesity in females is higher in the most deprived parts of the PCT compared with the rest, although this difference is not statistically significant (reference <http://www.erpho.org.uk/lsr/lsr.aspx>).

Smoking

Smoking exacerbates stress, anxiety and sleep disorders; all of which will be detrimental to most mental health conditions^{77,78}. Studies have shown that smoking increases the risk of first developing a mental disorder⁷⁹ and can increase the risk of depressed mood in young people^{80,81}. Smokers are also more likely to commit suicide^{82,83}.

Smoking has a serious impact on the physical and financial wellbeing of smokers with mental health problems and smoking-related diseases more prominent among mental health patients than in the general population. This, along with the physical health inequality that exists for people with mental health problems, shows the necessity to tackle smoking in this at-risk population. Many smokers with mental health problems want to stop smoking, but do not receive the advice and support they need to do so. Good evidence exists that smokers with mental health problems can be helped to stop smoking.

Smoking rates are much higher among people with mental health problems than among the general population. Figure 27 illustrates that rates of smoking are much higher than the general population and in some cases twice that of the general population. The smoking rates are higher in people with phobias and depressive illnesses, and relatively lower in neurotic illnesses.

Over 70% of mental health inpatients with psychotic illness smoke, as shown below.

⁷⁷ Parrott A, Garnham N, Wesnes K, Pinock C. Cigarette Smoking and Abstinence: Comparative Effects Upon Cognitive Task Performance and Mood State over 24 Hours. *Human Psychopharmacology: Clinical and Experimental*, Volume 11, Issue 5, Pages 391 – 400. 1996.

⁷⁸ West R Hajek P. What Happens to Anxiety Levels on Giving Up Smoking? *Am J Psychiatry* 154:1589-1592. 1997.

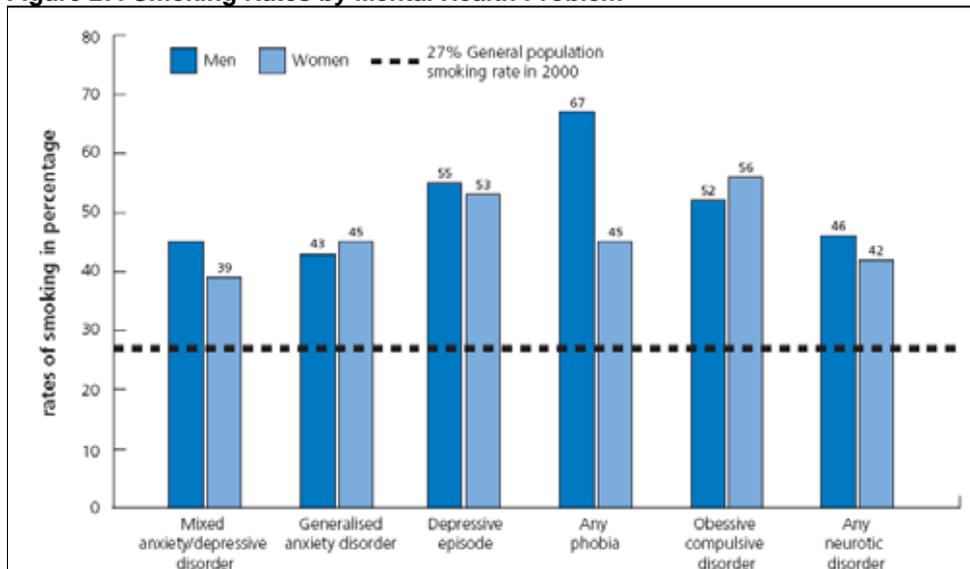
⁷⁹ Cuijpers P et al (2007). Smoking is associated with first-ever incidence of mental disorders: a prospective population based study. *Addiction*. 102(8): 1303-9

⁸⁰ Goodman E and Capitman J, Depressive Symptoms and Cigarette Smoking Among Teens *PEDIATRICS* Vol. 106 No. 4 October, pp. 748-755 2000

⁸¹ Wu LT et al Tobacco smoking and depressed mood in late childhood and early adolescence. *American Journal of Public Health*, Vol. 89, Issue 12 1837-1840, 1999

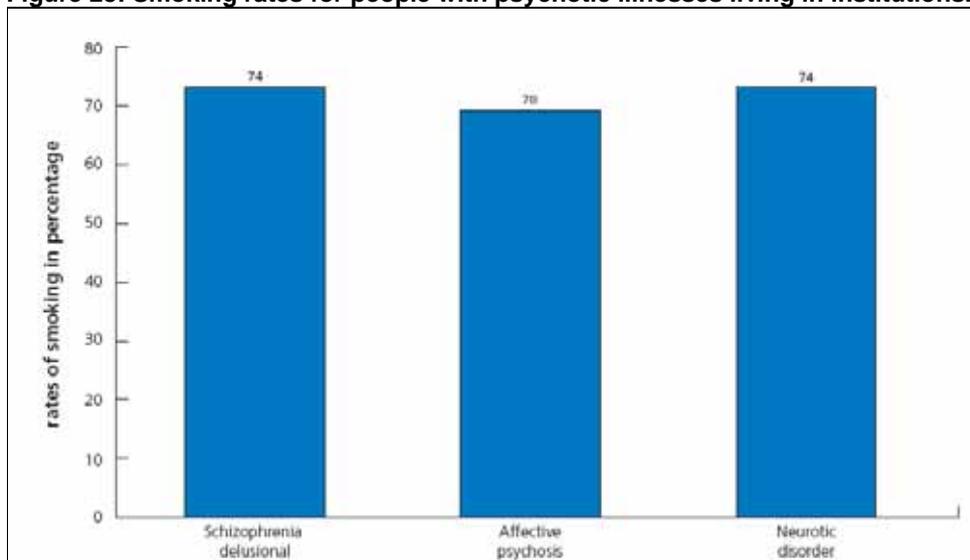
⁸² Malone KM et al. Cigarette Smoking, Suicidal Behavior, and Serotonin Function in Major Psychiatric Disorders *Am J Psychiatry* 160:773-779, April 2003

Figure 27: Smoking Rates by Mental Health Problem



Source: Smoking and Patients with Mental Health Problems. Health Development Agency report. 2004.

Figure 28: Smoking rates for people with psychotic illnesses living in institutions.



Source: Smoking and Patients with Mental Health Problems. Health Development Agency report. 2004.

The 2008 East of England Lifestyle Survey for NHS Cambridgeshire (reference <http://www.erpho.org.uk/viewResource.aspx?id=18628>) indicates that smoking prevalence is generally low, at just 15.6%. However, the rate varies from 13.8% in the less deprived part of the PCT to 21.8% in the most deprived communities and this is a statistically significant difference (reference <http://www.erpho.org.uk/viewResource.aspx?id=18628>).

As most smoking starts before adulthood, adolescents, especially those with emotional and behavioural disorders, are at much greater risk; six times higher smoking rates are found in those with conduct disorder and four times higher rates are found in those with emotional

disorder. Prevention and early intervention in adolescents with such disorders will also reduce the uptake of smoking.

3.3 THE IMPORTANCE OF MENTAL HEALTH AND WELLBEING

“There is no health without mental health”⁸⁴. Good mental health is the foundation for wellbeing and for the effective functioning of individuals and communities.

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.

Promoting mental health and wellbeing has multiple benefits. It improves health outcomes, life expectancy, productivity and educational and economic outcomes and reduces violence and crime.

The following facts⁸⁵ illustrate some of the many reasons why it is important to actively promote wellbeing in the whole population.

1. Impact of mental illness

Common: One in four people will experience a mental health problem at some point in their lives, and 10% of children are known to have a mental health problem.

23% of the adult population have at least one mental health problem at any one time.

Around 50% of lifetime mental illness starts by the age of 14 and continues to have a detrimental effect on individuals and their families for many years.

Largest cause of disability: Mental illness accounts for 22.8% of disability-adjusted life years (2008), far more than cardiovascular disease (16.2%) and cancer (15.9%).

Suicide: Suicide is a leading cause of death in all under 35 year-olds and in all ages for those with mental illness. It reflects levels of overall population distress and has a considerable impact on families and society.

2. Cost

To individuals and society: Poor mental health is linked to poor educational attainment, lower productivity, increased substance misuse, antisocial behaviour and crime.

To the economy: Mental health problems are estimated to cost England around £77 billion a year.

To the health service: Mental health problems represent the single largest cost to the NHS, some 11% of overall annual spend.

Evidence suggests early intervention and promoting mental wellbeing saves money.

⁸⁴ WHO. Mental health: facing the challenges, building solutions. Report from the WHO European Ministerial Conference. Copenhagen, Denmark: WHO Regional Office for Europe, 2005.

⁸⁵ New Horizons: Confident Communities, Brighter Futures – A framework for developing wellbeing Summary March 2010

3. Inequalities in health

Mental and physical health:

Depression increases the risk of dying from cardiovascular disease by 67% and cancer by 50%. On average, the life expectancy of a person with schizophrenia is 25 years shorter compared with the general population.

Wider health inequalities: Poor mental health can be seen as a hidden determinant or risk factor as well as an outcome in its own right, with higher rates of obesity, risky sexual behaviour, smoking, and drug and alcohol misuse.

Socio-economic inequalities:

Relative deprivation reduces overall population wellbeing, while stigma and discrimination reduce the protective factors.

4. Change, insecurity and uncertainty

Ageing population: An increase in the percentage of older people is predicted, accompanied by a 61% increase in dementia cases by 2026.

Depression at age 65 is linked with a 70% increased risk of dying early. As a risk factor for mortality, depression is estimated to be comparable to smoking.

Economic downturn: Increases in debt, unemployment, homelessness and fuel poverty all impact negatively on mental health, with the potential to make the economic situation worse.

Impact of climate change: Flooding is associated with a four-fold increased risk of depression; the development of wellbeing needs to be linked to our ability to become more resilient in the face of climate change.

Key Messages

There are substantial cost savings to be made by promoting mental health and wellbeing

Ensure a Positive Start: potentially a quarter to a half of mental health problems are preventable through interventions in early years.

Poor mental health is both a contributor to and a consequence of wider health inequalities. It is associated with increased health-risk behaviours and increased morbidity and mortality from physical ill health.

Promoting good mental health has multiple potential benefits. It can improve health outcomes, life expectancy and educational and economic outcomes and reduce violence and crime.

3.4 EVIDENCE BASE FOR PROMOTING WELLBEING

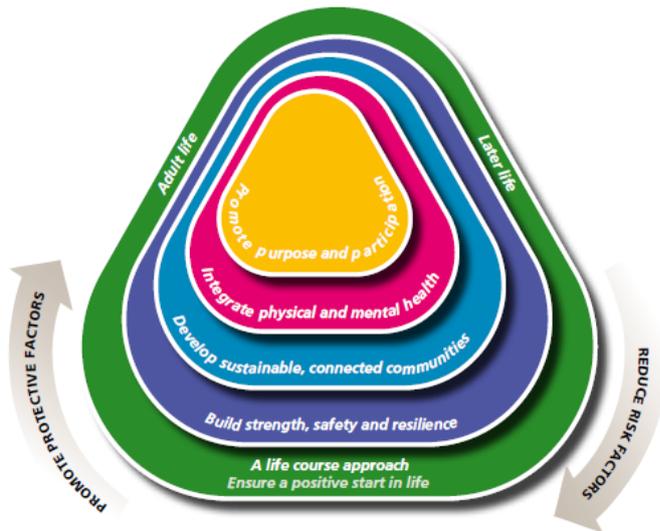
There is a developing evidence base on the risk factors for both mental illness and mental wellbeing. Importantly, the evidence is also growing on what can be done, cost effectively, to create the right conditions for good mental health and wellbeing, and on early interventions when things start to go wrong (promoting protective factors and reducing risk factors). The

evidence base for this is reviewed in the Confident Communities, Brighter Futures report¹. The report looks at a number of dimensions to understand the risk factors associated with poor mental health and the evidence on potential cost effective interventions.

These dimensions/domains are described in a 'public mental health framework for wellbeing' and the dimensions included in the framework are:

- a life course approach: ensure a positive start in life and healthy older years,
- build strength, safety and resilience,
- develop sustainable, connected communities,
- integrate physical and mental health,
- promote purpose and participation.

Figure 29: A framework for developing wellbeing (public mental health framework)



Source: New Horizons, Confident Communities Brighter Futures

For the purposes of the framework⁸⁶ the following definition of wellbeing was developed: “A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the environment”.

The framework for developing wellbeing (fig 29) illustrates a structured approach to understanding how we can influence the mental health and wellbeing of individuals and communities. It takes a public health approach with a life course perspective. It seeks to make sense of the complex interplay between the many social, economic and environmental factors that influence individual and community mental health and wellbeing by organising interventions into the five key domains.

The **key facts and risk factors** associated with poor mental health and the evidence on potential cost effective interventions can be summarised under these five domains:

⁸⁶ New Horizons Confident Communities, brighter futures: a framework for developing wellbeing Summary, March 2010 DH

1. A life course approach

Ensure a positive start in life. Half of all mental health problems, excluding dementia, start by the age of 14. Childhood and early adulthood are key periods in the development of personal resilience and educational and social skills that will provide the foundations for good mental health across the whole life course.

A positive start in life

- Estimates suggest that between a quarter and a half of adult lifetime mental illness may be preventable through prevention of and early intervention in mental problems and disorders in childhood.
- At any one time 10% of children and young people have a mental health problem, most commonly emotional and conduct disorders.
- There is more development in mental, social and physical functioning during the first years of life than at any time across the lifespan.
- Universal and targeted interventions during the first few years of life can influence the entire life course and can reduce inequalities.
- Key interventions to promote good mental health and wellbeing are:
 - promoting parental mental and physical health
 - supporting good parenting skills
 - developing social and emotional skills
 - preventing violence and abuse
 - intervening early with mental disorders
 - enhancing play
- Considerable lifetime savings can be achieved through early interventions.

Healthy later years

- Wellbeing in older age is associated with both cognitive ability and reduced mortality
- An increasing proportion of the population are living longer. By 2020, one in five people will be 65 or older; by 2026, the increased costs of dementia alone will be an extra £9 billion per year.
- Interventions that particularly help to maintain mental health in later years include reducing poverty, keeping active, keeping warm, lifelong learning, social connections and community engagement, such as volunteering.
- Early intervention benefits those affected by mental illnesses such as depression and dementia and their carers. Early diagnosis and treatment of physical conditions is also important.

2. Build strength, safety and resilience

- Prevent suicide by addressing individual resilience.
- Build community resilience through interventions aimed at preventing violence; reducing poverty, debt, unemployment, poor housing and homelessness; and mitigating the impacts of climate change and adverse weather events such as flooding.

3. Develop sustainable, connected communities

Reduce social exclusion by addressing stigma and discrimination. Enhance sustainable communities by promoting social and environmental engagement to develop connected, inclusive communities.

- The communities and environment in which we live affect mental health and wellbeing.
- Sustainable development promotes a healthy environment to support the wellbeing of a population.
- Sustainable interventions that promote mental health and wellbeing include insulating homes, healthy eating, active transport and access to green spaces.
- Social isolation increases the risk of developing mental health problems. Promoting social capital ⁸⁷ connects communities and supports sustainability and wellbeing. Interventions that enhance social capital and build social networks include volunteering and social prescribing.
- Increasing access to green spaces can enhance wellbeing, increase social interaction and increase physical activity.
- Discrimination and stigma create social exclusion and contribute to mental and physical ill health as well as socio-economic inequalities.
- Evidence-based interventions to promote wellbeing and prevent mental ill health need to combine universal measures with targeted approaches aimed at socially excluded populations.

4. Integrate physical and mental health

Ensure good overall health by integrating approaches to promoting physical and mental health to reduce health-risk behaviours and health inequalities and improve health outcomes.

- Physical and mental health are intimately linked – physical ill health affects mental health and vice versa.
- People with mental illness are less likely to have their physical health problems diagnosed and treated; people with physical health problems often have undiagnosed mental health problems.
- Excess mortality and morbidity are both mediated by higher levels of health-risk behaviour such as smoking and excessive alcohol consumption.
- Depression is two to three times more common in people with chronic physical health problems.
- Depression is associated with a 50% increase in mortality, comparable with the effects of smoking, and is associated with increased rates of coronary heart disease, cancer and strokes.
- Key interventions include targeted health improvement programmes and physical health checks for people with mental health problems.
- Early intervention and treatment of mental health problems, including referral for psychological therapies, can improve health outcomes for people with physical

⁸⁷ Social capital can be described as the collective value of a person's social networks which are a key aspect of mental wellbeing and stronger, healthier, connected communities.

illnesses. Early physical health promotion in those with mental illness increases wellbeing and also prevents development of physical health problems.

5. Promote purpose and participation

Enhance wellbeing through a balance of physical and mental activity, a positive outlook, creativity and purposeful community activity.

- Promote activities that balance physical and mental activity – including physical activity, lifelong learning, relaxation and sleep.
- Positive psychological interventions include psychological therapies, which promote positive thoughts and emotions, appreciation, goals and a sense of purpose.
- Mindfulness interventions promote awareness, quality of life, positive mood and reduce psychological distress; for some people, spirituality plays an important role.
- Participation in the arts and creativity can enhance engagement in both individuals and communities, increase positive emotions and a sense of purpose.
- ‘Good Work’ can provide meaningful activity and enhance wellbeing. Examples of healthy workplace practices include flexible working and initiatives to reduce workplace stress.
- Education and lifelong learning promote wellbeing and resilience and reduce the risk of mental illness.
- Leisure promotes wellbeing through associated meaningful engagement, self-expression, creativity and the opportunity to experience control and choice over such activities.
- Purposeful community activity, such as volunteering can help to develop values within communities and organisations.

Summary of key messages for promoting wellbeing

- Adopt a life course approach – ensure a positive start in life and healthy older years – develop and share skills to continue learning and have positive social relationships throughout life.
- Build strength, safety and resilience – address inequalities and ensure safety and security at individual, relationship, community and environmental levels.
- Develop sustainable, connected communities – create socially inclusive communities that promote social networks and environmental engagement.
- Integrate physical and mental health – develop a holistic view of wellbeing that consists of both physical and mental health, reduce health risk behaviour and promote physical activity.
- Promote purpose and participation – enhance positive wellbeing by a balance of physical and mental activity, relaxation, generating a positive outlook, spirituality, creativity and purposeful community activity.

Mental Health Promotion is a positive approach and involves any action to promote mental health and wellbeing. It is relevant to people with and without mental health problems.

Mental Health Promotion involves strengthening individuals and communities, and reducing barriers to mental health. It involves *strengthening protective factors* for mental health (eg social support, good physical health) and *reducing risk factors* (eg unemployment, violence) as illustrated in the wellbeing framework.

To support the key messages for promoting wellbeing, the *New Horizons Confident Communities Report* provides a comprehensive summary of evidence based interventions. These range from interventions that are more traditionally associated with mental health promotion such as stress reduction programmes, parenting programmes and school bullying based prevention to those that promote for example physical activity programmes, green space with its associated benefits of play, activity, crime reduction and social interaction, and interventions that increase participation in culture and arts, enable volunteering and tackle poverty.

The National Institute for Health and Clinical Excellence (NICE 2007) has published an evidence briefing on the effectiveness of public health interventions related to MHP for adults⁸⁸. The report sets out interventions that are most strongly supported by the evidence base. These include: interventions for older people, carers and parenting, the workplace, primary care, mass media and physical health.

NICE guidance⁸⁹ published in 2009 provides guidance on promoting mental wellbeing in the workplace. The business benefits in terms of cost and productivity are well documented^{90,91} and this is a key intervention to promote mental wellbeing in adults of the working age population.

3.5 MONITORING INDICATORS FOR WELLBEING

Given the range and diversity of factors that influence wellbeing, the monitoring indicators that are relevant to wellbeing are wide. The range of indicators that are relevant to the areas in the key messages summarised above are listed in the *Confident Communities Report*. There are 25 indicators alone that are cited in relation to making a Positive Start.

In July 2010 the North East Public Health Observatory (NEPHO) published some work on the plausibility of creating an index of mental wellbeing, as well as an atlas based on the input variables to this index. This work can be found at <http://www.nepho.org.uk/publications.php5?rid=805>

The prototype index of mental wellbeing is based on a range of suggested protective and risk factors that are grouped together under the following broad categories (as described in the framework for developing wellbeing - Figure 29).

- Positive start in life
- Resilience and a secure base
- Integrated physical and mental health
- Sustainable connected communities

These are then grouped into an overall score that is suggestive of overall relative mental wellbeing in the population.

⁸⁸ NICE. Public health interventions to promote positive mental health and prevent mental health disorders among adults – Evidence briefing. NICE. 2007.

⁸⁹ Nice Public Health Guidance 22 :Promoting mental wellbeing through productive and healthy working conditions: guidance for employers. November 2009

⁹⁰ Boorman, S. NHS Health and Wellbeing Final Report DH November 2009

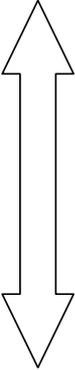
⁹¹ Black, C. A Dame Carol Black's Review of the health of Britain's working age population :Working for a Healthier Tomorrow. TSO March 2008

Maps are provided at upper tier local authority and regional levels and are standardised nationally, and so the usefulness for Cambridgeshire is limited in terms of directly using the data or maps. However, the inventory of variables included is useful in terms of further potential input data for the JSNA. In reviewing this list of data we have already used some of the same measures or very similar measures in our work to date – indeed the previous MH JSNA utilised an inventory of suggested data for MHNA provided by NEPHO and so this is not surprising.

However, while the index must be viewed as a prototype, and it would be useful if it was available at sub upper tier local authority levels, there is an overall score available for each upper tier local authority. Cambridgeshire tends to come out fairly well against many areas, which is not a surprise, but it is useful to compare its score alongside the scores for its ONS cluster authorities and this is provided below.

The higher the score the better the predicted mental wellbeing in the population. Nationally for upper tier local authorities scores range from -121.3 in Liverpool to +123.8 in Rutland. Cambridgeshire’s score is 75.5. In terms of its CIPFA comparison group Cambridgeshire ranks fifth poorest out of the 16 upper tier local authorities in the group.

Table 26: Prototype index of ecological factors affecting mental wellbeing in the population – overall scores for Cambridgeshire and its CIPFA comparator group of upper tier local authorities

Area	Mental health wellbeing score	Interpreting the score
Cumbria	46.0	
Northamptonshire	66.7	
Staffordshire	72.8	
Warwickshire	73.4	
Cambridgeshire	75.5	
Essex	76.8	
Somerset	80.4	
Worcestershire	80.9	
Gloucestershire	88.7	
Oxfordshire	89.2	
Hertfordshire	95.5	
West Sussex	96.8	
North Yorkshire	99.9	
Hampshire	101.3	
Buckinghamshire	116.4	
Leicestershire	118.5	

Source: The development of a prototype index of ecological factors affecting wellbeing in the population. Professor Gyles Glover, Rebecca Lee, Alison Copeland. North East Public Health Observatory (NEPHO), July 2010. http://www.nepho.org.uk/securefiles/100826_1702/Doc1.pdf, 26/08/10.

Indicators for monitoring community wellbeing are further discussed in the New Communities JSNA 2010.

Most recently, the Office for National Statistics (ONS) has launched a public consultation⁹² to inform the development of a national set of indicators to measure wellbeing. The aim is that these new measures will cover the quality of life of people in the UK, environmental and sustainability issues, as well as the economic performance of the country.

⁹² <http://www.nmhd.org.uk/news/measuring-national-wellbeing/>

Some of the aspects that are covered in the consultation include:

- Income and wealth
- Job satisfaction and economic security
- Ability to have a say on local and national issues
- Having good connections with friends and relatives
- Present and future conditions of the environment
- Crime
- Health
- Education and training
- Personal and cultural activities, including caring and volunteering

The consultation runs from 25 November 2010 to 15 April 2011.

3.6 COMMISSIONING MENTAL WELLBEING

Building on the evidence base (including that set out in *Confident Communities*), a new report *Commissioning Mental Wellbeing for All: A toolkit for Commissioners*¹⁵ specifically identifies 10 commissioning areas where evidence based interventions have been shown to make a significant contribution to improving mental wellbeing. The report identifies the opportunity for the proposed Health and Wellbeing Boards to build on existing arrangements and catalyse a new shared approach to wellbeing.

The accompanying leadership briefing *Commissioning Mental Wellbeing for All: A leadership brief for Boards and Senior Managers*⁹³ describes five key areas that can enable commissioners to make early progress in improving the overall health and wellbeing of communities with reasonably good cost effectiveness and relatively well evidenced effect. The areas are

- Children (pre and post-natal)
- Children (pre-school)
- Children/adolescents (school)
- Employment and working life - improving working lives
- Older people/retirement

The newly published report *The role of local government in promoting wellbeing*⁹⁴ further stimulates thinking and provides practical examples of good practice, opportunities for change and a guide for action for local authorities.

A new Mental Health Strategy will follow in 2011 that builds on the existing policy set out in *New Horizons*.

⁹³ Newbigging K and Heginbotham C., Commissioning Mental Wellbeing for All: A leadership brief for Boards and Senior Managers. Nov 2010 <http://www.nmhd.org.uk/news/commissioning-for-wellbeing-and-population-mental-health/>

⁹⁴ Aked J, Michaelson J, Steuer N., The role of local government in promoting wellbeing. Nov 2010. Authors from New Economics Foundation (NEF) and commissioned by Local Government Improvement and Development (LG) and the National Mental Health Development Unit. <http://www.idea.gov.uk/idk/core/page.do?pagelId=23692693>

4. PEOPLE WITH MILD TO MODERATE NEEDS — ANXIETY AND DEPRESSION (1 IN 4)

4.1 COMMON MENTAL HEALTH DISORDERS

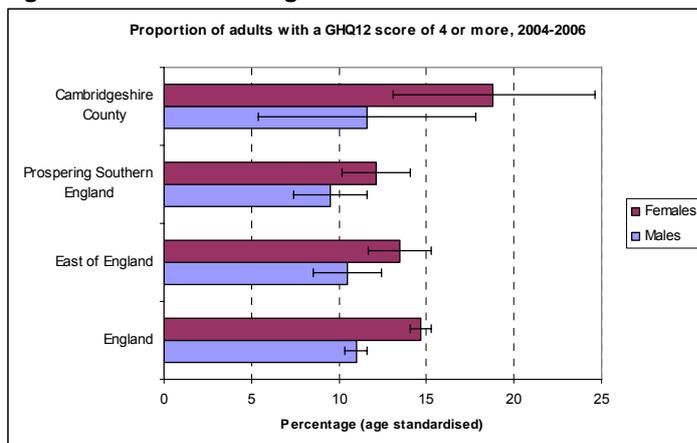
One in six people are thought to suffer from a common mental health disorder at any one time, and mental health is a common reason for people to visit their general practitioner or be off work on sick leave. By common mental health disorders we are referring to anxiety, stress and depression which are generally treated in the primary care setting. Although these disorders are being addressed in the mild to moderate mental health section it is acknowledged that these types of disorder can be severe requiring secondary care.

Psychiatric disorder

Mental health problems are often hard to define and many people suffering from them go undiagnosed and therefore untreated. A measure of population mental health is the General Health Questionnaire (GHQ)12 score. It was developed in the UK and is an epidemiological measure of possible mental health problems in the general population. This questionnaire consists of 12 questions concerning happiness, depression, anxiety, sleep disturbance, and ability to cope over the four weeks preceding the survey interview. The figure below shows the data taken from the Health Survey for England which surveyed people aged 16+. A score of four or more was used as the threshold to identify respondents with possible psychiatric disorder, and is referred to as a 'high GHQ score'. The questionnaire was administered in self-completion format, to all respondents. Scores were calculated only for those respondents who had answered all 12 questions.

In 2004-06 12.9% (12.4%-13.4%) of the population had a possible psychiatric disorder. The percentage was higher in Cambridgeshire at 15.3% (10.8% -19.9%) but not significantly so. Cambridgeshire county includes Peterborough, which may effect the prevalence observed. The figure below shows that the prevalence of possible psychiatric disorder is higher in women compared with men, although this is only significant nationally in the four areas shown below, probably because the numbers were too small at regional level to find a significant difference. Cambridgeshire County is compared to Prospering Southern England which is NHS Cambridgeshire's ONS cluster comparator group.

Figure 30: The Percentage of adults with a GHQ 12 score of 4 or more, 2004-2006



Source: Compendium of Health and Clinical Indicators (NCHOD) using Health Survey for England data.

Anxiety disorder

- Anxiety is a normal reaction to times of stress for example before sitting an exam or doing a job interview. However people with generalised anxiety disorder (GAD) find it hard to control their worries, which are persistent and affect their every day lives. It will differ from normal worrying through the intensity, frequency and perceived uncontrollability of the worry thoughts. While experiencing such a condition the person may appear restless, anxious, sweat, shake, feel nauseous, dizzy or have a dry mouth.
- General anxiety disorder is the most common type of anxiety disorder affecting around 4-5% of the population. It is more common in men than in women.⁹⁵
- Anxiety disorders often start in the 20s, where it is most common, but may begin earlier. Sometimes they occur in older people.⁹⁶
- The total number of people with anxiety disorders was estimated to be 2.28 million in 2007 and this is projected to rise to 2.56 million by 2026.
- 51% of people with anxiety disorders are not in contact with services and of those who are, 46% do not receive medication or psychological therapy.⁹⁷
- The cost of services for anxiety disorders for the whole of England in 2007 was approximately 1.2 billion. Including lost employment costs brings the total to £8.9 billion. By 2026 it is projected that service costs for anxiety disorders will be £2 billion with total costs at £14.2 billion.

Depression

- Depression is the most common psychiatric disorder. It refers to a spectrum of mental health problems characterised by the absence of positive affect (ie a loss of interest and enjoyment in ordinary things and experiences), low mood, and a range of associated emotional, cognitive, physical, and behavioural symptoms⁹⁸. Day-to-day functioning is often impaired.
- It affects one in ten people at any one time. Depression can vary in severity – it is thought that mild depression accounts for approximately 70% of cases, moderate depression for 20% and severe depression for 10%.
- The identification of major depression is based not only on its severity but also on persistence, the presence of other symptoms and the degree of functional and social impairment⁹²
- Depressive disorders are expected to show a rising trend over the next 20 years, and are expected to become the second most important cause of disability and disease burden by 2020.⁹⁹
- The total cost of services for depression in England in 2007 was estimated to be £1.7 billion. Lost employment brings the total cost to £7.5 billion. By 2026 these figures are projected to be £3 billion and £12.2 billion respectively. Most of this increase is due to expected increases in the cost of services over and above inflation.
- Depression can be difficult to recognise. Often, people do not admit to having psychological symptoms, but present instead with mainly physical or somatic symptoms. At least two-thirds of depressed people who see their GP present with physical symptoms rather than psychological symptoms.

⁹⁵ Psychiatric Morbidity Among Adults Living in Private Households, 2000. Office of National Statistics.

⁹⁶ NHS Choices Available at <http://www.nhs.uk/conditions/Anxiety/Pages/Introduction.aspx> Accessed [12.05.10]

⁹⁷ Paying the Price. The cost of mental health care. Kings Fund 2008 Available at Assessed [18.05.10]

⁹⁸ NICE Clinical Guidance. CG90 Depression in adults: full guidance interim proof copy. 28 October 2009. Available at <http://guidance.nice.org.uk/CG90/Guidance/pdf/English> . Accessed [18.05.10]

⁹⁹ Lopez A D and Murray C C J L. (1998) The global burden of disease, 1990–2020 *Nature Medicine* 4, 1241 - 1243

- Depression is a major cause of impaired quality of life, reduced productivity, and increased mortality. Social difficulties are common (eg social stigma, loss of employment, marital break-up). Associated problems, such as anxiety symptoms and substance misuse, may cause further disability.
- Other psychiatric conditions may coexist with depression, eg anxiety, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, eating disorders.

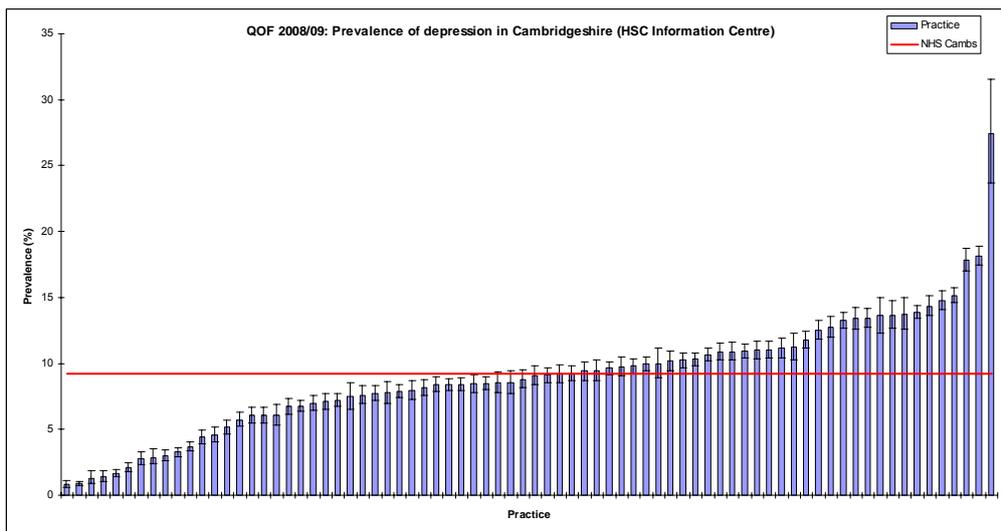
The table below shows the prevalence of recorded depression in the general practice registered population taken from Quality Outcomes Framework (QOF). It shows that NHS Cambridgeshire has a higher recorded prevalence of depression compared to England and the East of England. However, as noted above, there are caveats with this data in that recording varies from practice to practice and not everyone with depression will be captured in this prevalence estimate, as not everyone suffering from depression is registered with a GP or will go on to seek medical help.

Table 27: QOF unadjusted recorded prevalence of depression in 2008/09

Area	Number with depression	Percentage prevalence of depression
NHS Cambridgeshire	56,636	9.20%
East of England	456,630	7.70%
England	4,373,974	8.10%

Source: QOF 2008/09, Health and Social Care Information Centre

Figure 31: QOF 2008/09: Recorded prevalence of depression in Cambridgeshire (HSC Information Centre) by practice with 95% confidence intervals



Source: QOF 2008/09, Health and Social Care Information Centre

The figure above illustrates that the prevalence of depression recorded in 2008/09 ranged from 0.8% to 18.2% in practices serving the general population in Cambridgeshire. The Cambridge Access Centre which has a clientele of homeless people had the highest prevalence of 27.5%.

Estimated (modelled) versus actual observed (reported/recorded/diagnosed) disease prevalence provides a means of identifying potential areas of need, as it has the potential to indicate where undiagnosed or unreported disease may be prevalent. However, it should be noted that, as the observed prevalence is derived from QOF, a system that is prone to a host of factors that may influence accurate prevalence recording, it should not be taken that any apparent under or over prevalence is real.

The observed (QOF 2008/09) prevalence of depression versus the modelled prevalence of depression for adults over the age of 18 show ratios that range from 0.13 to 3.24 across the practices in Cambridgeshire. The smaller ratios indicate that there is less depression recorded than expected and the higher ratios indicate that there is more depression recorded than expected. (Please note that, compared with the QOF 2008/09 data provided by the NHS Information Centre, the denominator for the prevalence is the practice population aged 18 years and over, rather than the total practice list size).

Table 28: QOF 2008/09: Recorded prevalence of depression in Cambridgeshire for the most and least deprived areas based on MSOA level proxy IMD 2007 scores for GP practices

Area	Prevalence of depression		
	Prevalence %	Lower 95% CI %	Upper 95% CI %
Most deprived 20%	11.1%	11.0%	11.3%
Least deprived 80%	8.6%	8.5%	8.7%

Source: QOF 2008/09, Health and Social Care Information Centre. Cambridge Access Surgery is excluded from this analysis.

The above table indicates that the prevalence of depression is significantly higher in the most deprived area of the PCT compared with the remaining less deprived area.

4.2 RISK FACTORS

Several risk factors associated with depression and anxiety are highlighted below. These risk factors are discussed in more detail in the first section of this JSNA.

- **Family:** people with a history of depression are more likely to suffer from depression themselves.
- **Gender:** depression and anxiety have a higher prevalence in women compared to men, although the difference between elderly men and women appears smaller.
- **Age:** the affects of age on depression is less clear, although it appears that depression is higher in younger adults and decreases with age, but then increases again at older age. Depressive episodes in elderly people are often milder but more protracted.
- **Socio-economic factors:** such as unemployment and poverty are strong risk factors for depression. For example unemployed people are twice as likely to have depression compared to people in work.
- **Stressful life events:** such as redundancy, divorce or separation, bereavement may trigger an episode of depression or anxiety
- **Co-morbidity:** depression is more common in people with chronic medical conditions such as diabetes, chronic obstructive pulmonary disease, and cardiovascular disease.
- **Dual diagnosis:** Research indicates that 30-50% of people with mental health problems also have current drug or alcohol issues, and as many as 50-75% of people who come into contact with substance misuse treatment services may also have some kind of

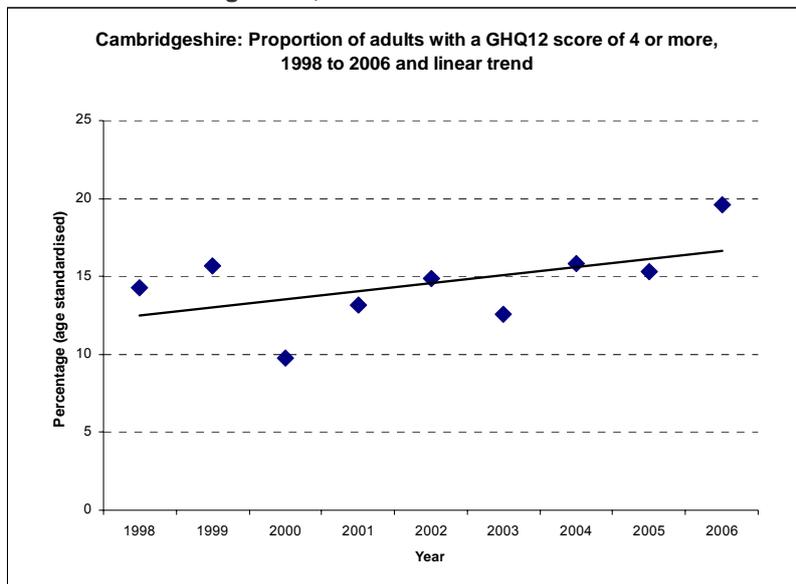
mental health problem. This latter group will not necessarily have contact with mental health services.^{100 101}

- Other risk factors: include **discrimination, disability, sexual orientation, domestic violence and ethnicity.**
- Depression and anxiety are also more common in certain groups in society such as prisoners and young offenders – this is discussed in a later section.

4.3 TRENDS

The lack of reliable data collected on mental health means that there are very little trend data available. In terms of the QOF measure the depression indicator has only been in use for two years. The graph below shows the trend in Cambridgeshire in possible psychiatric disorder taken from the *Health Survey for England*. The table below indicates an increasing trend for Cambridgeshire – however, at county level, it should be noted that the small sample size means that the uncertainty limits (95% CI) around the prevalence estimates are very wide and so data should be interpreted with caution. The equivalent national data shows an overall slight decline in possible psychiatric disorder from 1998 to 2006. No significant trend was shown when looking at the county and East of England level data (Reference: Compendium of Health and Clinical Indicators (NCHOD) using Health Survey for England data).

Figure 32: Trend in percentage of adults with a GHQ 12 score of 4 or more in Cambridgeshire, 1998 to 2006



Source: Compendium of Health and Clinical Indicators (NCHOD) using Health Survey for England data.

¹⁰⁰ Regier et al. Co-morbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (EA.) Study. JAMA, 264, 2511-8

¹⁰¹ Menezes et al 1996 Drug and Alcohol Problems among Individuals with Severe Mental Illness in South London. B.J. Psych, 168, 612-9

5. PEOPLE IN NEED OF SPECIALIST CARE - SEVERE AND ENDURING (1 IN 100)

5.1 SEVERE AND ENDURING MENTAL HEALTH CONDITIONS

Prevalence estimates

Many people with mental health problems do not seek help for them. In order to identify the true extent of mental health problems in the community it is necessary to use the national prevalence figures and estimate the likely prevalence of mental ill health in the local population. The mental health minimum data set will be able to provide information on the number of people accessing services for their illnesses.

The tables show the prevalence estimates for different mental disorders, age groups and sexes from different sources of information. It is important to note that the areas with the highest populations will have the highest prevalence estimates. Thus the numbers are highest in Huntingdonshire and South Cambridgeshire.

If Cambridgeshire residents experienced roughly the national average rate of mental health problems there would be an estimated 9,260 - 34,720 people with anxiety states in Cambridgeshire, 11,570 - 28,930 with depressive disorders, 580 - 2,890 people with schizophrenia, and 1,160 - 2,890 with affective psychosis.

The estimates for neurotic disorders show that 37,640 people have mixed anxiety and depressive disorder in Cambridgeshire, 18,820 people have a generalized anxiety disorder, 11,120 have a depressive disorder, 7,700 have a phobia, 4,710 have an obsessive-compulsive disorder and 2,990 have a panic disorder.

Table 29: Estimate of number of adults with a mental health problem

District	Estimated number of people with a mental health problem
Cambridge City	13,876
East Cambridgeshire	8,095
Fenland	9,231
Huntingdonshire	17,577
South Cambridgeshire	14,871
Cambridgeshire	63,650

Source: Mental Health National Service Framework and Mid 2006 population estimates, Cambridgeshire County Council Research Group

Table 30: Estimated number of people with schizophrenia, affective psychosis, depressive disorders and anxiety states living in each Local Authority, total population

Local Authority	Schizophrenia	Affective psychosis	Depressive disorders	Anxiety states
Cambridge City	230 - 570	110 - 570	2,270 - 5,680	1,820 - 6,820
East Cambridgeshire	150 - 380	80 - 380	1,520 - 3,810	1,220 - 4,570
Fenland	180 - 450	90 - 450	1,800 - 4,490	1,440 - 5,390
Huntingdonshire	320 - 800	160 - 800	3,220 - 8,040	2,570 - 9,650
South Cambridgeshire	280 - 690	140 - 690	2,760 - 6,900	2,210 - 8,280
Cambridgeshire	1,160 - 2,890	580 - 2,890	11,570 - 28,930	9,260 - 34,720

Source: Health of the Nation Mental Illness Key Area Handbook – 2nd Edition, 1994 and Mid 2006 population estimates, Cambridgeshire County Council Research Group

Table 31: Estimated number of people by neurotic disorder, Cambridgeshire

Local Authority	16-19	20-64	65-74	16 to 74 years
Cambridge City	1,000	13,110	650	1,370
East Cambridgeshire	480	7,880	640	1,371
Fenland	530	9,020	890	1,372
Huntingdonshire	1,020	17,220	1,240	1,373
South Cambridgeshire	870	14,500	1,090	1,374
Cambridgeshire	3,900	61,750	4,510	1,375

Source: Psychiatric morbidity among adults living in private households, 2000 and Mid 2006 population estimates, Cambridgeshire County Council Research Group

The Mental Health Data Observatory at <http://www.nepho.org.uk/mho/> includes prevalence estimates for common mental health disorders. Many of these data are based on the 2000 National Psychiatric Morbidity Survey, as with the data in the preceding sections. However, data are provided for further conditions and using alternative presentations, such as rates, and as such may be useful alternatives or additions to the estimates provided above.

Population data underpinning these mental health related estimates are based on the mid 2005 ONS population estimates and are restricted to those aged 16 to 74 years.

Table 32: Estimating the prevalence of common mental health problems in NHS Cambridgeshire and Cambridgeshire local authority districts, people aged 16 to 74 years

PCT / local authority district	Measure	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder
NHS Cambridgeshire	Rates per 1000 population	162.3	15.6	26.5	34.1	95.2	11.0	9.1
	Estimated number of cases	70,243	6,742	11,487	14,757	41,186	4,773	3,948
Cambridge	Rates per 1000 population	225.8	22.1	35.4	41.9	136.0	17.1	11.8
	Estimated number of cases	21,064	2,059	3,302	3,912	12,688	1,596	1,101
East Cambridgeshire	Rates per 1000 population	143.7	13.6	23.8	31.7	83.4	9.2	8.3
	Estimated number of cases	8,163	774	1,354	1,803	4,737	522	472
Fenland	Rates per 1000 population	150.9	14.1	24.9	33.1	87.6	9.7	8.8
	Estimated number of cases	9,685	905	1,602	2,128	5,624	619	562
Huntingdonshire	Rates per 1000 population	144.7	13.9	24.2	31.8	83.8	9.5	8.3
	Estimated number of cases	17,441	1,677	2,916	3,835	10,108	1,139	1,001
South Cambridgeshire	Rates per 1000 population	141.9	13.6	23.6	31.5	82.0	9.2	8.3
	Estimated number of cases	13,890	1,327	2,314	3,080	8,030	896	812

Source: Mental Health Observatory at <http://www.nepho.org.uk/mho/> (04/08/10) based on the 2000 National Psychiatric Morbidity Survey and mid 2005 ONS population estimates

Estimated forecasts of people with mental health problems from the Projecting Adult Needs and Service Information System (PANSI)

The estimated forecasts of people with a mental health problem in the PANSI system (<http://www.pansi.org.uk>) are 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. They provide data that forecasts how many people aged 18-64 are predicted to have a mental health problem, projected to 2030 in five year periods and annually for the next five years. They are based on ONS population forecasts. If necessary these projections of mental health disorders could be amended to be based on CCCRG population forecasts once the mid-2009 CCCRG forecasts are available. Data are available for Cambridgeshire and constituent districts and these data follow below. Further detailed notes covering further definition of the data is provided after the local data.

These forecasts have been need to be compared for consistency against the prevalence estimates provided elsewhere in the MH JSNA, both in terms of disease/disorder categories and estimated prevalence. The categories are rather different, other than the PANSI category of "People aged 18-64 predicted to have a common mental disorder "and the MH NSF estimate for adults with a "mental health problem". For this general category the estimates are not that different.

Although the PANSI data are based on flat estimates of disorders applied to projected population data, their strength is that they do provide these forecasts of future mental health problems. Their other strength is that they provide estimates and projections of further mental health disorders, compared with the prevalence estimates provided in the initial draft of the JSNA.

Table 33: People aged 18-64 years predicted to have a mental health problem projected to 2014 for Cambridgeshire and constituent districts

Area and disorder	2010	2011	2012	2013	2014
Cambridgeshire: People aged 18-64 predicted to have a common mental disorder	62,231	62,617	62,771	62,957	63,227
Cambridgeshire: People aged 18-64 predicted to have a borderline personality disorder	1,737	1,748	1,752	1,757	1,765
Cambridgeshire: People aged 18-64 predicted to have an antisocial personality disorder	1,369	1,377	1,381	1,386	1,392
Cambridgeshire: People aged 18-64 predicted to have psychotic disorder	1,546	1,555	1,559	1,564	1,570
Cambridge: People aged 18-64 predicted to have a common mental disorder	13,985	14,126	14,126	14,223	14,230
Cambridge: People aged 18-64 predicted to have a borderline personality disorder	389	393	393	395	396
Cambridge: People aged 18-64 predicted to have an antisocial personality disorder	318	321	321	323	323
Cambridge: People aged 18-64 predicted to have psychotic disorder	347	351	351	353	353
East Cambridgeshire: People aged 18-64 predicted to have a common mental disorder	8,322	8,399	8,515	8,560	8,669
East Cambridgeshire: People aged 18-64 predicted to have a borderline personality disorder	233	235	238	239	242
East Cambridgeshire: People aged 18-64 predicted to have an antisocial personality disorder	180	182	184	185	188
East Cambridgeshire: People aged 18-64 predicted to have psychotic disorder	207	209	212	213	215
Fenland: People aged 18-64 predicted to have a common mental disorder	8,914	8,959	8,991	9,023	9,048
Fenland: People aged 18-64 predicted to have a borderline personality disorder	249	251	251	252	253
Fenland: People aged 18-64 predicted to have an antisocial personality disorder	193	194	195	196	197
Fenland: People aged 18-64 predicted to have psychotic disorder	222	223	223	224	225
Huntingdonshire: People aged 18-64 predicted to have a common mental disorder	16,649	16,669	16,604	16,597	16,577
Huntingdonshire: People aged 18-64 predicted to have a borderline personality disorder	465	465	464	463	463
Huntingdonshire: People aged 18-64 predicted to have an antisocial personality disorder	366	366	365	365	365
Huntingdonshire: People aged 18-64 predicted to have psychotic disorder	414	414	412	412	412
South Cambridgeshire: People aged 18-64 predicted to have a common mental disorder	14,401	14,485	14,569	14,619	14,696
South Cambridgeshire: People aged 18-64 predicted to have a borderline personality disorder	403	405	407	409	411
South Cambridgeshire: People aged 18-64 predicted to have an antisocial personality disorder	312	314	315	318	320
South Cambridgeshire: People aged 18-64 predicted to have psychotic disorder	358	360	362	363	365

Source: DH PANSI (<http://www.pansi.org.uk/>, 19/08/10). Figures may not sum due to rounding. Crown copyright 2010. 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.

Table 34: People aged 18-64 years predicted to have a mental health problem projected to 2030 for Cambridgeshire and constituent districts

Area and disorder	2010	2015	2020	2025	2030
Cambridgeshire: People aged 18-64 predicted to have a common mental disorder	62,231	63,529	65,103	66,608	67,563
Cambridgeshire: People aged 18-64 predicted to have a borderline personality disorder	1,737	1,773	1,817	1,858	1,884
Cambridgeshire: People aged 18-64 predicted to have an antisocial personality disorder	1,369	1,399	1,436	1,471	1,496
Cambridgeshire: People aged 18-64 predicted to have psychotic disorder	1,546	1,578	1,617	1,654	1,678
Cambridge: People aged 18-64 predicted to have a common mental disorder	13,985	14,242	14,423	14,790	15,164
Cambridge: People aged 18-64 predicted to have a borderline personality disorder	389	396	401	411	422
Cambridge: People aged 18-64 predicted to have an antisocial personality disorder	318	323	327	335	343
Cambridge: People aged 18-64 predicted to have psychotic disorder	347	353	358	367	376
East Cambridgeshire: People aged 18-64 predicted to have a common mental disorder	8,322	8,733	9,132	9,608	9,742
East Cambridgeshire: People aged 18-64 predicted to have a borderline personality disorder	233	244	255	269	272
East Cambridgeshire: People aged 18-64 predicted to have an antisocial personality disorder	180	189	198	209	213
East Cambridgeshire: People aged 18-64 predicted to have psychotic disorder	207	217	227	239	242
Fenland: People aged 18-64 predicted to have a common mental disorder	8,914	9,125	9,395	9,601	9,715
Fenland: People aged 18-64 predicted to have a borderline personality disorder	249	255	263	268	271
Fenland: People aged 18-64 predicted to have an antisocial personality disorder	193	199	205	210	214
Fenland: People aged 18-64 predicted to have psychotic disorder	222	227	233	239	241
Huntingdonshire: People aged 18-64 predicted to have a common mental disorder	16,649	16,622	16,749	16,910	16,915
Huntingdonshire: People aged 18-64 predicted to have a borderline personality disorder	465	464	467	472	472
Huntingdonshire: People aged 18-64 predicted to have an antisocial personality disorder	366	367	371	375	376
Huntingdonshire: People aged 18-64 predicted to have psychotic disorder	414	413	416	420	420
South Cambridgeshire: People aged 18-64 predicted to have a common mental disorder	14,401	14,748	15,288	15,724	16,019
South Cambridgeshire: People aged 18-64 predicted to have a borderline personality disorder	403	412	427	439	447
South Cambridgeshire: People aged 18-64 predicted to have an antisocial personality disorder	312	321	333	344	351
South Cambridgeshire: People aged 18-64 predicted to have psychotic disorder	358	366	380	391	398

Source: DH PANSI (<http://www.pansi.org.uk/>, 19/08/10). Figures may not sum due to rounding. Crown copyright 2010. 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.

The following notes are taken from the PANSI system at <http://www.pansi.org.uk/index.php?pageNo=402&areaID=8249&loc=8249>. They provide further detail on the derivation and definition of the data included above.

Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder. The report found that 17.6% of the population surveyed met the diagnostic criteria for at least one CMD, with women (19.7%) more affected than men (12.5%).

Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.

ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and

violence committed. ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women).

BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour is common. The overall prevalence of BPD was similar to that of ASPD, at 0.4% of adults aged 16 or over (0.3% of men, 0.6% of women).

Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder. The overall prevalence of psychotic disorder was found to be 0.4% (0.3% of men, 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively). The age standardised prevalence of psychotic disorder was significantly higher among black men (3.1%) than men from other ethnic groups (0.2% of white men, no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women.

Table 35: Estimated proportion of population aged 18-64 years with mental health disorders

Disorder	% males	% females
Common mental disorder	12.5	19.7
Antisocial personality disorder	0.6	0.1
Borderline personality disorder	0.3	0.6
Psychotic disorder	0.3	0.5

Source: DH PANSI (<http://www.pansi.org.uk/>, 19/08/10)

The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2030.

Residential and nursing home care

Work undertaken in the 1980s on the closure of old mental hospitals indicated a clear requirement for long-term residential care for a small, but severely disabled group of individuals. Failure to make adequate provision initially gave rise to the problems addressed by the homeless mentally ill initiative and the 24-hour nursed-care bed policy of the early 1990s.

The number of placements required within individual Local Authorities varies considerably and is substantially influenced by the history of re-settlement of former long stay service users. To some extent these should even out between regions. However, in the case of London many of the former Metropolitan Asylums Board hospitals lay outside the current regional boundary and thus many resettled service users would now be in the East of England or South East regions.

In Cambridge City and South Cambridgeshire a high number of supported living schemes were developed in the 1980s to facilitate the closure of long stay beds in Fulbourn Hospital. Initially these were registered care beds, but when the Supporting People initiative was introduced in 2003 most were de-registered to provide supported living.

The report *Supporting People Review of Services for Adults with Mental Health Needs* – a joint review undertaken by the Supporting People Team and Partner agencies – gives full details of the range of supported accommodation and floating support within Cambridgeshire.

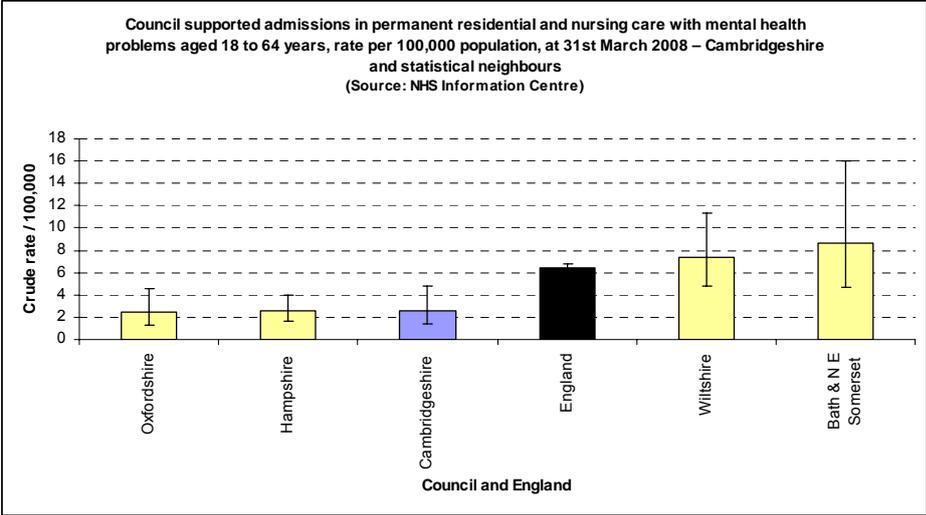
Long term strategies, for adults of working age with mental health needs, in relation to the provision of residential and nursing care, and housing related support have been developed by partner agencies, including the County Council, the Primary Care Trust, the Mental Health Trust, Supporting People and District and City Councils.

Table 36: Council supported admissions in permanent residential and nursing care with mental health problems aged 18 to 64 years, crude rate per 100,000 population, at 31 March 2008 – Cambridgeshire and statistical neighbours

Council	Number	Population (ONS mid 2008)	Rate per 100,000 pop 18-64	Lower 95% CI	Upper 95% CI
Cambridgeshire	10	386,577	2.6	1.4	4.8
Bath & N E Somerset	10	114,903	8.7	4.7	16.0
Hampshire	20	783,047	2.6	1.7	3.9
Oxfordshire	10	407,066	2.5	1.3	4.5
Wiltshire	20	272,868	7.3	4.7	11.3
England	1,320	20,627,100	6.4	6.1	6.8

Source: Community Care Statistics, 2008 (NHS Information Centre at <http://www.ic.nhs.uk/webfiles/publications/commcareSR12007/Annex%20Tables%202008%20rounded%20values%20R2009.xls>, 04/08/10)

Figure 33: Council supported admissions in permanent residential and nursing care with mental health problems aged 18 to 64 years, crude rate per 100,000 population, at 31 March 2008 – Cambridgeshire and statistical neighbours



Source: Community Care Statistics, 2008 (NHS Information Centre at <http://www.ic.nhs.uk/webfiles/publications/commcareSR12007/Annex%20Tables%202008%20rounded%20values%20R2009.xls>, 04/08/10)

The above table and Figure 33 indicate that Cambridgeshire has a statistically significantly lower rate of adult council supported admissions in permanent residential and nursing care for people with mental health problems than in England as a whole. While Cambridgeshire's rate is lower than two of its statistical neighbours, the differences are not significant. Numbers of permanent placements for people with mental health problems in council supported homes are generally low.

Dementia

Dementia is a term used to describe various brain disorders that have in common a loss of brain function that is usually progressive and eventually severe.

The incidence of dementia rises considerably with age particularly among women. With the ageing population, this is an important indicator to plan and provide services, particularly for the older population. Older people with dementia are likely to require a great deal of care, particularly as this condition may accompany physical frailty, making people both physically and mentally dependent.

The estimated and forecast number of people with dementia in Cambridgeshire are calculated as follows:

- Estimates of early onset dementia; literature evidence based estimates for various types of dementia applied to the resident population of Cambridgeshire
- Prevalence estimates for older people; Dementia UK estimates applied to resident population estimating the number of people with dementia in Cambridgeshire.
- Incidence estimates for older people; Dementia UK incidence estimates applied to resident population estimates. This gives the number of new cases estimated in one year.

There is a sizeable population with early onset dementia. The Early-Onset Dementia Development Group in Cambridgeshire did some research in 2003 and calculated the estimates for people with early onset dementia in Cambridgeshire. This was to help plan services for those expected to require care in each locality.

Table 37: Estimated Prevalence of Early-Onset Dementia within the age range 30-64 in Cambridgeshire, 2003

Type of dementia	Cambridge and South Cambridgeshire	Huntingdonshire	East Cambridgeshire and Fenland	Cambridgeshire
Alzheimers	22	15	14	51
Frontotemporal	14	10	9	33
Vascular	14	10	9	33
Huntington's	17	11	10	38
Parkinson's	10	7	6	23
Alcohol	5	3	3	11
Others	7	5	4	16
Total Cases	89	61	55	205

Source: Early-Onset Dementia Development Group

It is estimated that there are around 200 people with early onset dementia in Cambridgeshire. Although these estimates are four years old, they still remain valid. However, these figures are at best indicative and must be interpreted with caution. There will inevitably be fluctuation around the (relatively small) numbers estimated in the table that might require care at any given time.

Table 38: Prevalence - Estimated number of people over 65 years of age with Dementia

LA	65-74	75-84	85+	Total with dementia	% population aged 65+
Cambridge City	100	400	600	1,100	8.3%
East Cambridgeshire	100	400	400	900	7.3%
Fenland	200	500	500	1,200	7.1%
Huntingdonshire	200	600	700	1,600	7.2%
South Cambridgeshire	200	600	800	1,600	7.7%
Cambridgeshire	900	2,600	3,000	6,600	7.5%

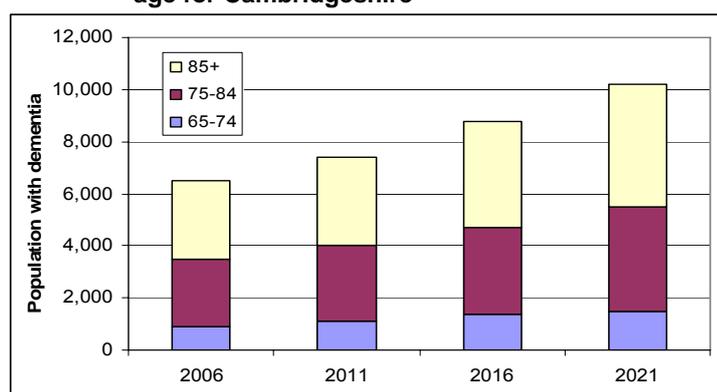
Source: Dementia UK estimates (2007) and CCCR population estimates (2006). Totals may not add due to rounding.

Table 39: Incidence - Estimated number of new cases of Dementia in people over 65 years of age

LA	65-74	75-84	85+	Total new cases dementia	% population aged 65+
Cambridge City	100	100	100	300	2.1%
East Cambridgeshire	100	100	100	200	1.9%
Fenland	100	100	100	300	1.9%
Huntingdonshire	100	100	200	400	1.9%
South Cambridgeshire	100	100	200	400	2.0%
Cambridgeshire	400	600	700	1,700	2.0%

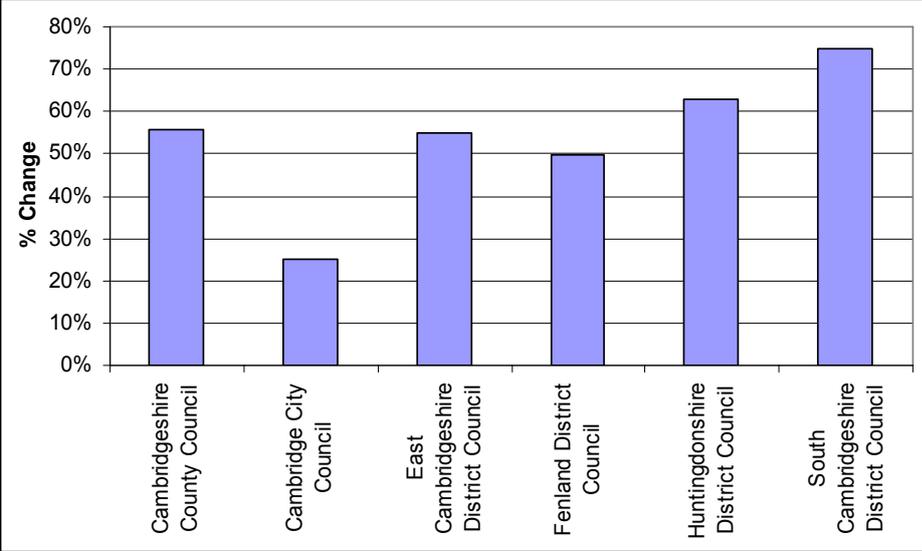
Source: Matthews et al. The incidence of dementia in England and Wales findings from the five identical sites of the MRC CFA study. PLoS Medicine 2005 2: e193. Totals may not add due to rounding.

Figure 34: Estimated and forecast number of people with dementia, over 65 years of age for Cambridgeshire



Source: Dementia UK estimates applied to resident population forecasts (CCC 2006 based forecasts)

Figure 35: Proportional change in number of people with dementia, by local authority, 2006-2021



Source: Dementia UK estimates applied to resident population forecasts (CCC 2006 based forecasts)

Prevalence estimates suggest that, in 2006, there are around 6,600 older people with dementia in Cambridgeshire. By 2021 this is forecast to rise by 56% to 10,200. Further analysis of the forecast figures show that the highest proportional increase will be in South Cambridgeshire, where numbers are forecast to rise by 75% and a 63% increase in Huntingdonshire.

Estimates for both the prevalence and incidence of dementia among people aged 65 and over are given in the tables above. The prevalence provides a measure of the number of people within the population likely to have dementia at a single point in time; this is an indication of the potential number of people requiring support. It is also useful to consider the incidence of dementia as this tells us how many new cases of dementia are likely to occur within a specific time period (one year).

These estimates show that there needs to be flexible provision of services in each locality, with a range of care and expertise available within local services that could be used as appropriate in each case and at different stages of the progression of the illness.

Severe mental illness on the general practice (GP) register

This indicator measures the proportion of people registered with GPs who have severe mental health problems, which are being followed up in primary care.

This indicator records only people who are registered with a GP, have agreed to treatment/follow up in primary care settings and are taking psychiatric medication.

The Quality and Outcomes Framework (QOF) is a method of collecting information on 146 evidence-based health care indicators in primary care. The data used for this indicator comes from QMAS data. QMAS (Quality Management and Analysis System) is the system which records GP practice performance on the QOF targets set in their General Medical Service (GMS) contracts.

There is still uncertainty around the quality of information, particularly around consistency of recording. As such, caution should be used when interpreting data as actual disease prevalence. The data are also not standardised for age and sex composition of the practices. It is not possible to interpret this in terms of prevalence of mental illness, the recording issues, or access to primary care services. It may be more appropriate initially to consider the indicator a measure of utilisation and quality of service at primary care level for people with severe mental health problems.

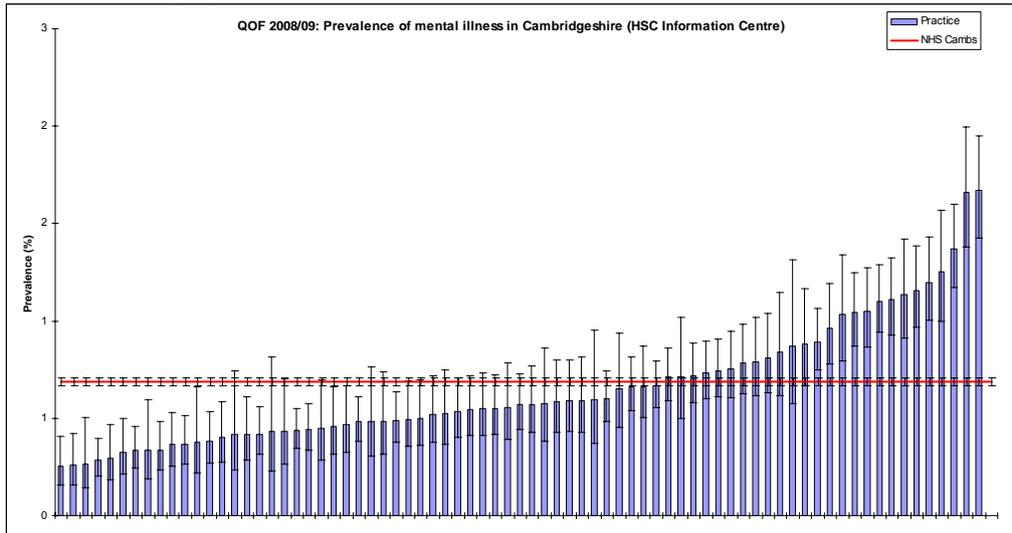
Table 40: Mental health disease register by district – QOF recorded prevalence 2008/09, excluding the Cambridge Access Surgery

District	Disease Register Mental Health 2008/09	Unadjusted Recorded Prevalence (95% CI)	Range in GP Practices
Cambridge City	1,646	1.1% (1.0% - 1.1%)	0.3% - 1.7%
East Cambridgeshire	410	0.5% (0.5% - 0.6%)	0.4% - 0.7%
Fenland	503	0.5% (0.5% - 0.5%)	0.3% - 0.8%
Huntingdonshire	985	0.6% (0.5% - 0.6%)	0.3% - 1.1%
South Cambridgeshire	680	0.6% (0.6% - 0.6%)	0.3% - 0.9%
Cambridgeshire	4,224	0.7% (0.7% - 0.7%)	0.3% - 1.7%

Source: QOF 2008/09, Health and Social Care Information Centre. The table above excludes the Cambridge Access Surgery due to that practice's high prevalence rate of 13.7%

There is no significant difference between Cambridgeshire and any of the districts for the prevalence of mental health. The recorded prevalence of mental health in England and in the East of England, from QOF 2008/09, is 0.7% - the same as in Cambridgeshire (source: Health and Social Care Information Centre).

Figure 36: Unadjusted recorded prevalence of severe mental illness by practice, with 95% confidence intervals, QOF 2008/09 (excluding Cambridge Access Surgery)



Source: QOF 2008/09, Health and Social Care Information Centre. The table above excludes the Cambridge Access Surgery due to that practice's high prevalence rate of 13.7%

Figure 36 illustrates the range of prevalence of severe mental illness across the practices serving the Cambridgeshire population

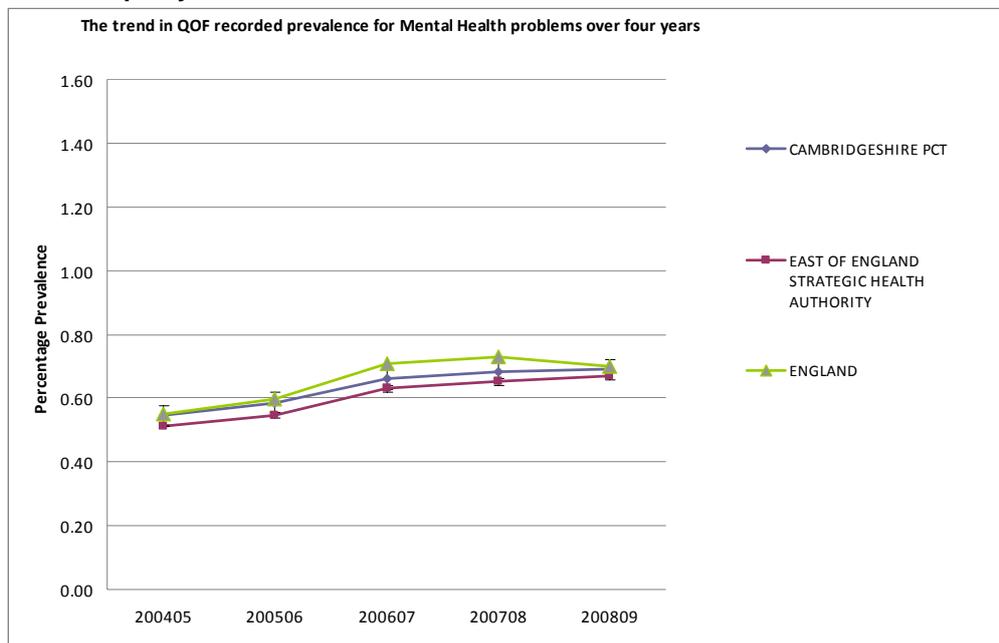
Table 41: QOF 2008/09: Recorded prevalence of severe mental illness in Cambridgeshire for the most and least deprived areas based on MSOA level proxy IMD 2007 scores for GP practices

Area	Prevalence of mental illness		
	Prevalence %	Lower 95% CI %	Upper 95% CI %
Most deprived 20%	0.80%	0.75%	0.84%
Least deprived 80%	0.60%	0.62%	0.67%

Source: QOF 2008/09, Health and Social Care Information Centre. Cambridge Access Surgery is excluded from this analysis.

The above table indicates that the prevalence of mental illness is significantly higher in the most deprived area of the PCT compared with the remaining less deprived area.

Figure 37: QOF 2008/09: Trend in recorded prevalence of mental health problems (people with schizophrenia, bipolar disorder and other psychoses) Cambridgeshire for the most and least deprived areas based on MSOA level proxy IMD 2007 scores for GP



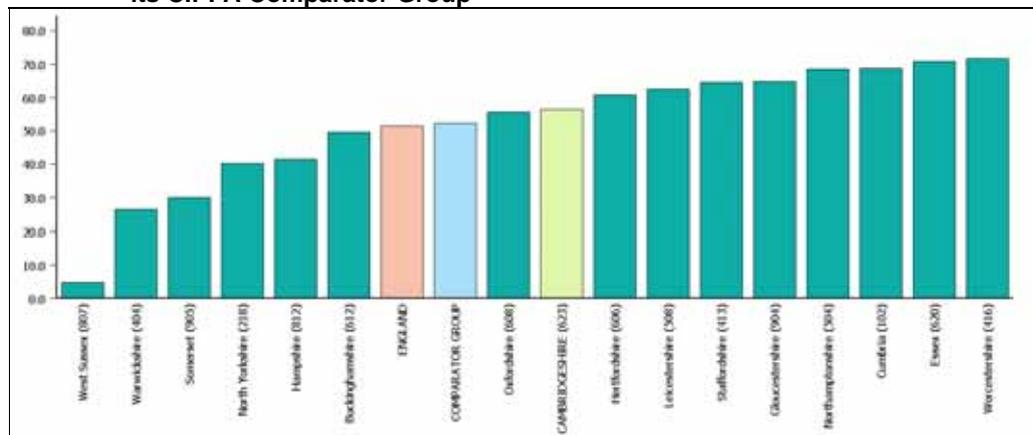
Source: Erpho - Trends in QOF prevalence at PCT level from 2004/05 to 2008/09.

The above chart showing trends for the prevalence of QOF recorded mental health problems indicates that Cambridgeshire has statistically significantly higher prevalence in 2008/09 compared with the earlier periods 2004/05 and 2005/06. However, this is likely to be a data quality and recording issue rather than a material rise in the actual recorded prevalence of mental illness.

Contact with secondary mental health services

The National Adult Social Care Intelligence Service (NACSIS) has made the provisional 2009/10 data available for adults in contact with secondary mental health services in settled accommodation.

Figure 38: Adults in contact with secondary mental health services in settled accommodation (expressed as a percentage), 2009/10 – Cambridgeshire and its CIPFA Comparator Group



Source: NACSIS

(http://nascis.ic.nhs.uk/Portal/Reports/Pdf.ashx?r=N001_623_08_2010.pdf&t=PublishedReport,19/08/10) from Mental Health Minimum Dataset (MHMS).

Data for 2009-10 is provisional. Please note that the England figures currently displayed on the Standard Reports are an average of the indicator values for all councils, as opposed to the sum of all the council numerators over the sum of all the council denominators. The true England figure for this Indicator is 50.1. NIS Guidance: Good performance is typified by a positive increase in percentage.

Suicide

Suicide rates have been used as a target since *The Health of the Nation* in the early 1990s. While reducing the death rate from suicide is obviously worthwhile, and there is good evidence of preventability in many cases, it has more controversially been used as an indicator of the quality of mental health services. Though useful as an easily quantified measure, the relationship between mental health and suicide is complex with many other societal factors playing an important role. There are effective interventions in mental health services such as reducing in-service user risks and improving the follow-up of recently discharged service users but only about a quarter of people who commit suicide have been in contact with services in the preceding year.

Suicide is defined by Coroners in England and has to be proven 'beyond reasonable doubt'. Since there is some variation in practice it is generally considered that the addition of Open Verdicts (cause of injury undetermined) provides a more reliable guide to trends in suicide. It is important to note that the number of deaths are small and therefore prone to annual fluctuations.

Table 42: Mortality: Suicide and Injury Undetermined, all ages by gender, 2006-2008

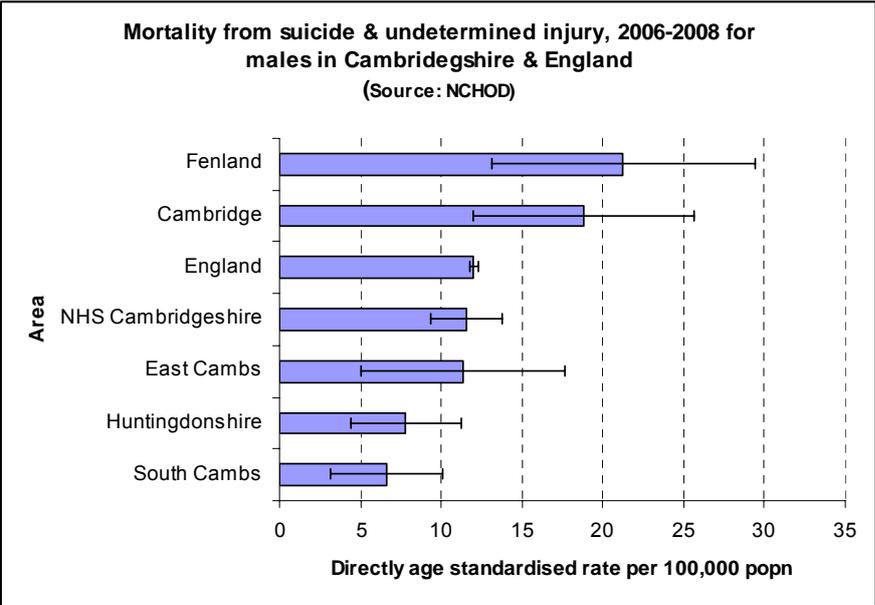
PCT / local authority	Males			
	Average annual deaths	DSR	95% CI	
			Lower	Upper
England	3,150	12.01	11.76	12.25
NHS Cambridgeshire	37	11.59	9.40	13.78
Cambridge	11	18.81	11.95	25.67
East Cambs	4	11.38	5.08	17.67
Fenland	10	21.28	13.18	29.38
Huntingdonshire	7	7.82	4.41	11.23
South Cambs	5	6.63	3.18	10.09

PCT / local authority	Females			
	Average annual deaths	DSR	95% CI	
			Lower	Upper
England	1,009	3.65	3.52	3.78
NHS Cambridgeshire	17	5.29	3.80	6.78
Cambridge	4	8.00	3.49	12.50
East Cambs	2	4.46	0.81	8.10
Fenland	2	4.11	0.61	7.60
Huntingdonshire	5	4.99	2.27	7.71
South Cambs	4	5.11	2.05	8.17

PCT / local authority	Persons			
	Average annual deaths	DSR	95% CI	
			Lower	Upper
England	4,160	7.76	7.63	7.90
NHS Cambridgeshire	53	8.38	7.07	9.70
Cambridge	15	13.41	9.31	17.50
East Cambs	6	7.94	4.29	11.60
Fenland	12	12.47	8.11	16.83
Huntingdonshire	12	6.39	4.22	8.57
South Cambs	9	5.79	3.48	8.09

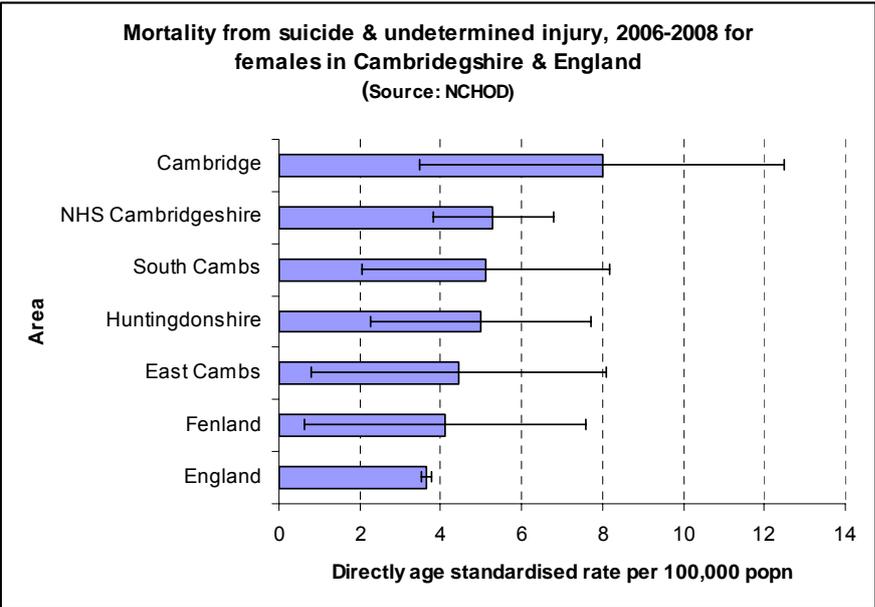
Source: Compendium of Clinical and Health Indicators based on ONS mortality data at <http://www.nchod.nhs.uk>, 06/08/10

Figure 39: Mortality: Suicide and Injury Undetermined, all ages for males, 2006-2008 – directly age standardised rate per 100,000 population and 95% confidence intervals



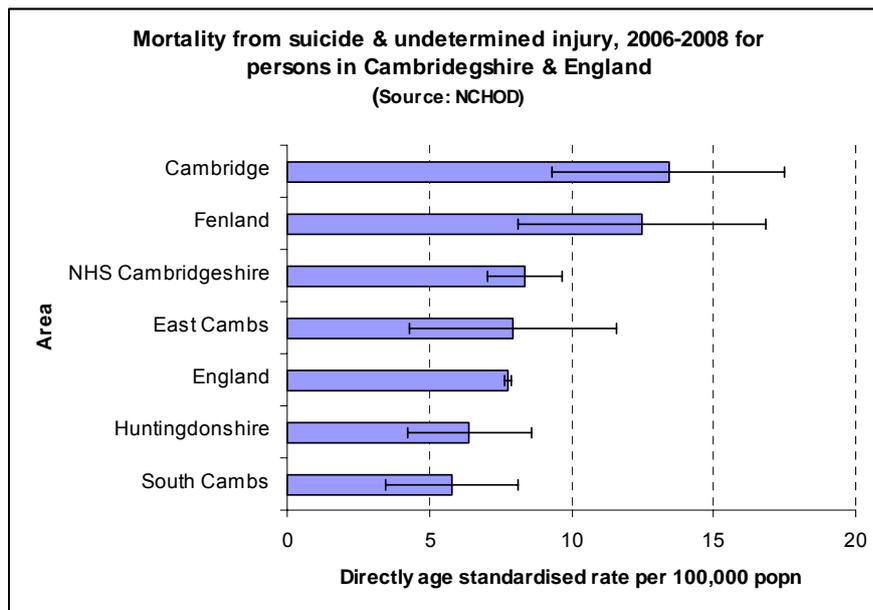
Source: Compendium of Clinical and Health Indicators based on ONS mortality data at <http://www.nchod.nhs.uk>, 06/08/10

Figure 40: Mortality: Suicide and Injury Undetermined, all ages for females, 2006-2008 – directly age standardised rate per 100,000 population and 95% confidence intervals



Source: Compendium of Clinical and Health Indicators based on ONS mortality data at <http://www.nchod.nhs.uk>, 06/08/10

Figure 41: Mortality: Suicide and Injury Undetermined, all ages for persons, 2006-2008 – directly age standardised rate per 100,000 population and 95% confidence intervals



Source: Compendium of Clinical and Health Indicators based on ONS mortality data at <http://www.nchod.nhs.uk>, 06/08/10

For 2006-2008 for mortality from suicide and injury undetermined table 42 and the figures above indicate that the rate for men in Fenland is statistically significantly higher than the England rate and the rates for South Cambridgeshire and Huntingdonshire are statistically significantly lower than the England rate; for females the Cambridge City and NHS Cambridgeshire rates are statistically significant higher than the England rate; for persons the Cambridge City and Fenland rates are statistically significantly higher than the rate for England and the rates for Huntingdonshire and South Cambridgeshire are statistically significantly lower than the national rate.

Table 43: Mortality: Suicide and Injury Undetermined, all ages for persons, 2006-2008 and trend 1993 to 2008 – directly age standardised rate per 100,000 population

Area	2006/08 rate	Trend
Cambridge	13.4	↑
East Cambs	7.9	↑
Fenland	12.5	↑
Huntingdonshire	6.4	↓
South Cambs	5.8	↓
NHS Cambridgeshire	8.4	↓
England	7.8	↓

Key

2006/08 rate

Statistically significantly higher than England	
Higher than England	
Lower than England	
Statistically significantly lower than England	

Trend

Increasing trend	↑
Decreasing trend	↓
Faster rate of change than England	
Slower rate of change than England	
Opposite trend to England	

Source: JSNA phase 4 summary (underlying data from Compendium of Clinical and Health Indicators based on ONS mortality data at <http://www.nchod.nhs.uk>)

6 CURRENT SERVICES AND ACTIVITY

6.1 PRESCRIBING DATA FOR DRUGS USED IN THE TREATMENT OF MENTAL HEALTH CONDITIONS

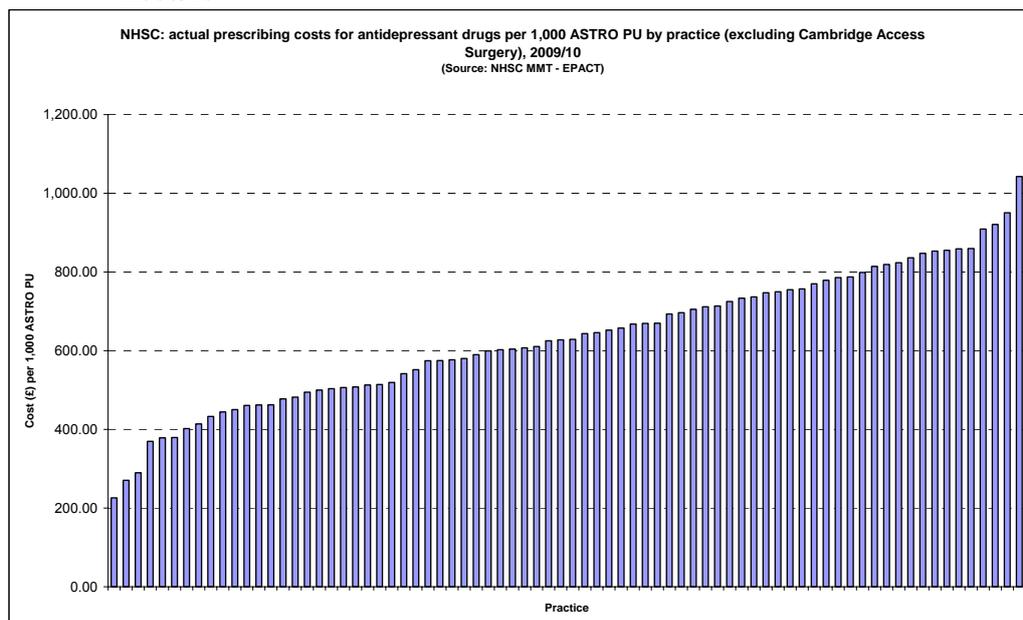
Table 44: NHS Cambridgeshire - prescribing costs related to mental health drugs, financial years 2007/08, 2008/09 and 2009/10

Period (Financial Year)	BNF Name	Total Items Dispensed	Total Actual Cost	Actual Cost per 1,000 ASTRO PU
2007/2008	Antidepressant Drugs	420,301	£2,772,291.79	£805.79
2008/2009	Antidepressant Drugs	447,375	£2,510,323.80	£716.83
2009/2010	Antidepressant Drugs	492,433	£2,303,998.60	£645.90
2007/2008	Drugs Used In Psychoses & Rel.Disorders	74,147	£2,185,385.37	£635.20
2008/2009	Drugs Used In Psychoses & Rel.Disorders	78,144	£2,296,115.70	£655.66
2009/2010	Drugs Used In Psychoses & Rel.Disorders	82,490	£2,331,805.80	£653.70

Source: NHSC MMT from EPACT, 18/08/10

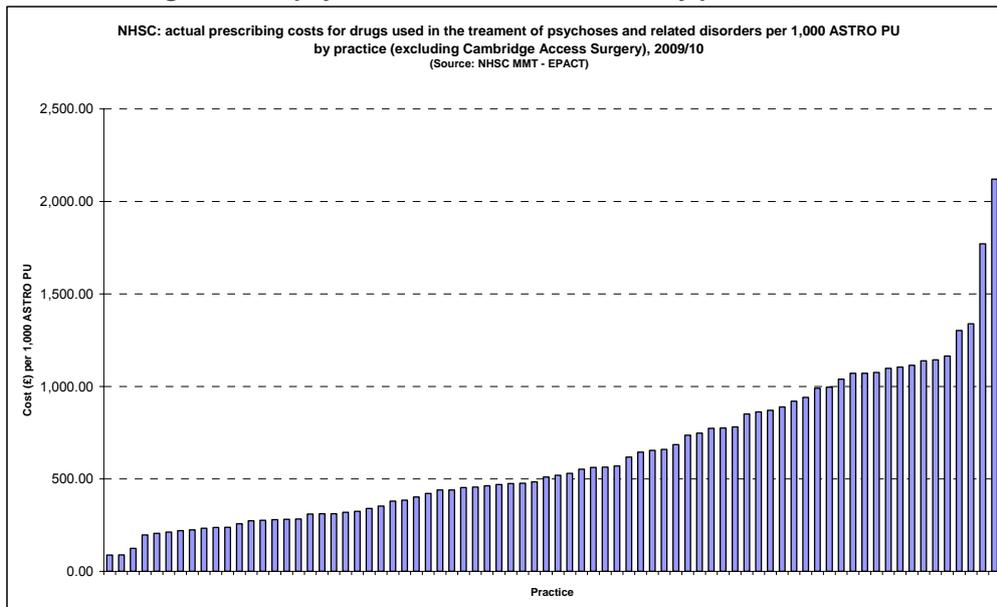
Prescribing costs for antidepressant drugs show a downward trend between 2007/08 to 2009/10. The trend for drugs used in psychoses and related disorders is less clear.

Figure 42: NHS Cambridgeshire - actual prescribing costs per 1,000 ASTRO PU on anti-depressant drugs by practice (excluding Cambridge Access Surgery), 2009/10



Source: NHSC MMT from EPACT, 18/08/10. Note: Cambridge Access Surgery's data have been removed from the above chart, as their costs are much higher than most other practices at £2,192.83 per 1,000 ASTRO PU – this reflects the composition and needs of their practice population.

Figure 43: NHS Cambridgeshire - actual prescribing costs per 1,000 ASTRO PU on drugs used in psychoses & related disorders by practice, 2009/10



Source: NHSC MMT from EPACT, 18/08/10. Note: Cambridge Access Surgery's data have been removed from the above chart, as their costs are much higher than most other practices at £12,225.28 per 1,000 ASTRO PU – this reflects the composition and needs of their practice population.

There is wide variation in prescribing costs between practices even after excluding the Cambridge Access Surgery.

6.2 MENTAL HEALTH SERVICES

NHS Cambridgeshire currently commissions from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) approximately 25 care pathways covering a range of mental health services from primary care (including Improving Access to Psychological Therapies - IAPT), services for people with mild to moderate mental health problems through to secondary care and a range of specialist services for people with severe and enduring mental illness and more complex problems. The pathways are attached in Appendix 1. The services provided are summarised as follows:

Inpatient Services and Activity

Data on inpatient activity is a reasonable indicator of severe and enduring need in each locality. The total number admitted to an inpatient facility according to the Mental Health Minimum Dataset has fluctuated just over 1000 between 2006/07 and 2008/09. Estimated data for 2009/10 show a shift in the trend with fewer inpatient admissions and more care delivered in the community despite an increase in the total number receiving care between 2008/09 and 2009/10.

Comment [IH1]: Rephrase this line?

¹⁰² **Important note:** according to the NHS Information Centre, data are included in the MHMDS for NHS Commissioners on the following basis: "The data used to show NHS commissioner is the PCT derived from the person's postcode of residence or, if that information was not available, the PCT of the person's GP practice. Where no PCT data was available the person's postcode district was mapped to ONS organisation boundaries current at 17 February 2009. In some cases this PCT will not be the same as the organisation that commissioned the patient's care. Trust level rates could not be calculated for people whose postcode or GP practice was not in England, or was not given" (source: <http://www.mhmdsonline.ic.nhs.uk/>, 04/08/10).

Table 45: Number of people using NHS mental health services for NHS Cambridgeshire (patients aged 18 years and over) from Mental Health Minimum Dataset (MHMDS) 2006-2010 annual returns, with estimates for 2009/10

Year	Admitted to inpatient facility	Care delivered in community setting (inc PC)	No further care delivered after initial assessment	Total receiving care
2009/10*	865	10,562	823	12,250
2008/09	1,088	9,886	800	11,774
2007/08	1,127	9,947	1,120	12,194
2006/07	1,088	9,149	785	11,022

Source: Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10 (Downloaded from <http://www.mhmdsonline.ic.nhs.uk> on 11 January 2010). *2009/10 data are estimated.

In comparison to similar PCTs a slightly larger percentage of people using NHS Mental Health services in Cambridgeshire are admitted to inpatient facilities.

Table 46: Comparison of percentage of people using NHS mental health services for NHS Cambridgeshire (patients aged 18 years and over) from Mental Health Minimum Dataset (MHMDS) 2008-2009 compared with average for all commissioning organisation and NHS Cambridgeshire Peer PCTs

2008/09	Admitted to inpatient facility %	Care delivered in community setting (inc PC) %	Not further care delivered after initial assessment %
NHS Cambridgeshire	9.2	84	6.8
Commissioning Average ¹⁰³	8.4	84	7.6
PCT Peers ¹⁰⁴	8.1	87.4	4.5

Source: <http://www.mhmdsonline.ic.nhs.uk>, 04/08/10.

Table 47: Crude rate of access per 100,000 population for mental health services for NHS Cambridgeshire for adult (18-64) and elderly (64+) services, 2008/09 and estimated data for 2009/10. Mental Health Minimum Dataset (MHMDS)

Year	18-64 years rate of access / 100,000	64+ years rate of access / 100,000
2009/10*	1,935	4,377
2008/09	1,990	4,171

Source: Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10 (Downloaded from <http://www.mhmdsonline.ic.nhs.uk> on 11 January 2010). *2009/10 data are estimated and population data based on mid-2008 CCRG estimates.

The rate of access to adult services is very similar to 'benchmark' PCTs but significantly lower than the average for all commissioners. However for older people access rates are relatively high.

¹⁰³ Average of all PCTs in England

¹⁰⁴ Prospering Southern England, a group of PCTs with comparable demographics to Cambridgeshire

Table 48: Crude rate of access per 100,000 population for mental health services for NHS Cambridgeshire for adult (18-64) and elderly (64+) services, 2008/09 compared with average for all commissioning organisation and NHS Cambridgeshire Peer PCTs. Mental Health Minimum Dataset (MHMDS)

2008/09	18-64 years rate of access / 100,000	64+ years rate of access/100,000
Commissioning Average	2564	4324
PCT Peers	1979	3822

Source: <http://www.mhmdsonline.ic.nhs.uk/>, 04/08/10.

Table 49: Number of inpatients detained in hospital for NHS Cambridgeshire, 2006/07 to 2008/09 (CPFT from <http://www.mhmdsonline.ic.nhs.uk>) and estimate for 2009/10 (CPFT).

Year	Formally detained	Informal
2009/10*	247	618
2008/09	123	966
2007/08	14	1,111
2006/07	67	1,025

Source: Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10 (Downloaded from <http://www.mhmdsonline.ic.nhs.uk> on 11 January 2010). *2009/10 data are estimated. Number of people who spent time (at least one day) as an inpatient detained under the Mental Health Act 1983 (formally detained).

Rates of formal detention are relative low in Cambridgeshire despite increases since 2006/07. The numbers detained informally have fallen in the same period.

Table 50: Proportion of inpatients detained in hospital for NHS Cambridgeshire 2008/09 (CPFT from <http://www.mhmdsonline.ic.nhs.uk>) compared with average for all commissioning organisation and NHS Cambridgeshire Peer PCTs.

2008/09	Formally detained %	Informally %
NHS Cambridgeshire	11.3	88.7
Commissioning Average	31.8	68.2
PCT Peers	25.4	74.6

Source: <http://www.mhmdsonline.ic.nhs.uk/>, 04/08/10

Table 51: Number of people on Care Programme Approach (CPA), NHSC Cambridgeshire, 2006/07 to 2008/09 (CPFT from <http://www.mhmdsonline.ic.nhs.uk>) and 2009/10 estimate (CPFT)

Year	Enhanced CPA	Standard CPA	No CPA
2009/10*	5,470	0	672
2008/09	535	5,918	5,321
2007/08	183	255	11,727
2006/07	195	316	10,483

Source: Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10 (Downloaded from <http://www.mhmdsonline.ic.nhs.uk> on 11 January 2010). *2009/10 data are estimated. In 2009/10 all of those on CPA are on enhanced CPA.

The proportion of people with no Care Programme Approach (CPA) has decreased in Cambridgeshire and was lower than in comparative PCTs in 2008/09.

Table 52: Proportion of people with no Care Programme Approach (CPA) for NHS Cambridgeshire 2008/09 (CPFT from <http://www.mhmdsonline.ic.nhs.uk>) compared with average for all commissioning organisation and NHS Cambridgeshire Peer PCTs.

2008/09	Enhanced CPA %	Standard CPA %	No CPA %
NHS Cambridgeshire	4.5	50.3	45.2
Commissioning Average	14	20.8	65.2
PCT Peers	11.1	37.3	51.6

Source: <http://www.mhmdsonline.ic.nhs.uk/>, 04/08/10.

Table 53: Numbers of inpatient admissions and discharges for NHS Cambridgeshire, 2006/07 to 2008/09 (CPFT from <http://www.mhmdsonline.ic.nhs.uk>) and estimate for 2009/10 (CPFT)

Year	Number of admissions
2009/10*	1,750
2008/09	1,683
2007/08	1,883
2006/07	1,747

Source: Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10 (Downloaded from <http://www.mhmdsonline.ic.nhs.uk> on 11 January 2010). *2009/10 data are estimated.

Estimated inpatient and community data for NHSC at CPFT for 2009/10. Data by gender, ethnicity, age band and district council area.

Table 54: Number of inpatients and calculated rates per 100,000 population – aged 15 and over by gender for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS.

Gender	Number of inpatients aged 15 & over	Rate of inpatients aged 15 & over per 100,000 population
Male	443	182.3
Female	432	173.3
Total	875	177.8

Source: Inpatients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on CCCR mid 2008 population estimates for districts by single year of age. NB: Of the 875 inpatients 24 are not NHSC residents but their data cannot be removed as their gender is not known.

Based on the above table, by gender, the 95% confidence intervals of 166.1 to 200.1 for men and 157.7 to 190.4 for women indicate that the difference in the rate between men and women is not statistically significant.

Table 55: Number of inpatients and calculated rates per 100,000 population – aged 15 and over by age band for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS.

Age band	Number of inpatients aged 15 & over	CCCRG population estimates mid 2008	Crude rate of inpatients aged 15 & over per 100,000 population
15-19	26	37,040	70.2
20-24	45	44,640	100.8
25-29	89	38,420	231.7
30-34	66	36,410	181.3
35-39	84	43,230	194.3
40-44	89	46,340	192.1
45-49	72	42,500	169.4
50-54	55	37,290	147.5
55-59	55	36,570	150.4
60-64	29	36,790	78.8
65 & over	265	92,680	285.9
Total	875	491,910	177.9

Source: Inpatients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on CCCRg mid 2008 population estimates. NB: Of the 875 inpatients 24 are not NHSC residents but their data cannot be removed as their age band is not known.

Crude inpatient rates rise from late teens and peak in the late 20s. Rates maintain a plateau of just under 200 per 100,000 population until age 45 then gradually decline through the rest of the working age range before falling sharply at age 60. The early peak may reflect onset of severe illness such as schizophrenia which often presents initially in early adulthood.

Table 56: Number of inpatients and calculated rates and 95% confidence interval per 100,000 population – aged 15 and over by ethnic group for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS.

Ethnicity	Number of inpatients aged 15 & over	Crude rate of inpatients aged 15 & over (population is aged 16+)		
		Rate per 100,000	95% CI lower	95% CI upper
White backgrounds	820	181.5	169.5	194.3
Asian or Asian British backgrounds	15	119.0	72.2	196.3
Black or Black British backgrounds	11	152.8	85.3	273.4
Mixed ethnic backgrounds	9	166.7	87.7	316.5
Other ethnic backgrounds	19	174.3	111.6	272.1
Not Stated	1	n/a	n/a	n/a
Total	875	179.3	167.8	191.6

Source: Inpatients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on ONS mid 2007 ethnic population estimates for residents aged 16+ years. NB: The numerator is based on people aged 15+ and the denominator on those aged 16+, due to the availability of data. Of the 875 inpatients 24 are not NHSC residents but their data cannot be removed as their ethnicity is not known.

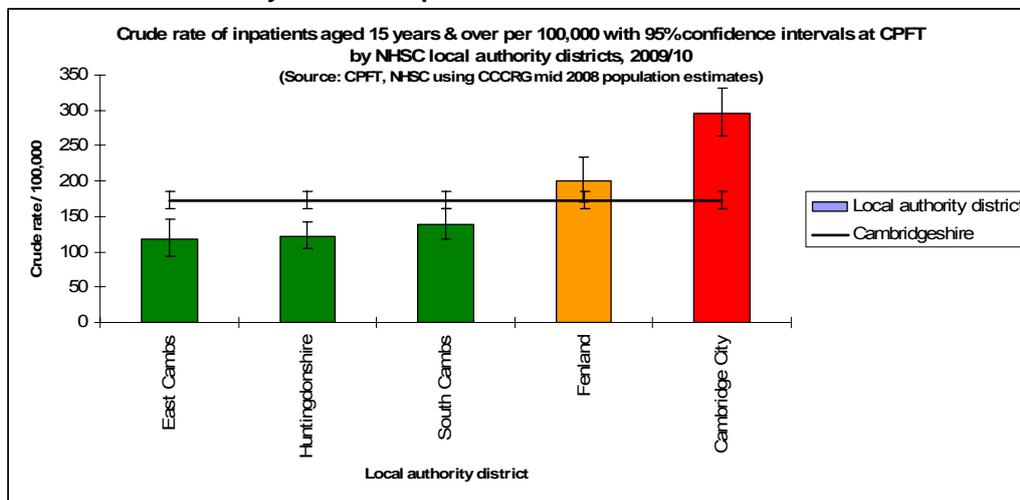
The rates by ethnic group above should be interpreted with caution, as the numbers of inpatients underpinning these rates is actually very small in some cases – this is reflected in the very wide 95% confidence intervals for some of the rates, which should be noted. None of the difference are statistically significant.

Table 57: Number of inpatients and calculated rates and 95% confidence interval per 100,000 population – aged 15 and over by local authority district for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS.

Local authority district	Number of inpatients aged 15 & over	Crude rate of inpatients aged 15 & over		
		Rate per 100,000	95% CI lower	95% CI upper
Cambridge City	299	295.2	263.6	330.5
East Cambs	76	117.1	93.6	146.5
Fenland	153	200.3	171.0	234.6
Huntingdonshire	163	122.2	104.8	142.4
South Cambs	160	137.8	118.0	160.8
Cambridgeshire	851	172.9	161.7	184.9

Source: Inpatients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on CCRG mid 2008 population estimates for districts by single year of age. NB: 24 inpatient records have been removed, as these are not NHSC residents.

Figure 44: Number of inpatients and calculated rates and 95% confidence interval per 100,000 population – aged 15 and over by local authority district for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS.



Source: Inpatients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on CCRG mid 2008 population estimates for districts by single year of age. NB: 24 inpatient records have been removed, as these are not NHSC residents.

The rates in the table and figure above for CPFT inpatients aged 15 and over who are NHSC residents indicate that the rates for East Cambridgeshire, Huntingdonshire and South Cambridgeshire are statistically significantly low compared with the Cambridgeshire rate, that the Fenland rate does not differ and that the rate for Cambridge City is statistically significantly higher. This may be due to one of two reasons; access to beds due to location or more likely a historic legacy of Fulbourn Hospital serving most of Cambridgeshire for many years when community services were less developed than they currently are.

Community Services

In recent years the direction of national policy and local service planning has been to provide more and more services within the community (see Appendix 1 for description of pathways).

Table 58: Outpatient and community activity for NHS Cambridgeshire, 2006/07 to 2008/09 CPFT from <http://www.mhmdsonline.ic.nhs.uk> and estimate for 2009/10 (CPFT) Mental Health Minimum Dataset (MHMDS)

Year	Psychiatrist contacts	CPN contacts	Psychologist contacts	OT contacts	Physio contacts	Psychotherapist contacts	Social worker contacts	All contacts
2009/10*	14,230	78,345	11,782	19,873	7,344	879	7,934	140,387
2008/09	14,792	75,830	10,387	18,743	6,981	617	7,671	135,021
2007/08	16,830	84,049	9,470	20,830	10,286	794	8,825	151,084
2006/07	23,433	74,697	356	216	2,743	383	409	102,237

Source: Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10 (Downloaded from <http://www.mhmdsonline.ic.nhs.uk> on 11 January 2010). *2009/10 data are estimated.

Psychiatric contacts have steadily fallen in Cambridgeshire between 2006/07 and 2009/10. In comparison to other PCTs there were fewer psychiatric contacts in Cambridgeshire in 2008/09 and more contacts with CPNs.

Table 59: Contacts with mental health professionals in Cambridgeshire in 2008/09 compared with average for all commissioning organisation and NHS Cambridgeshire Peer PCTs. Mental Health Minimum Dataset (MHMDS)

Financial year 2008/09	Psychiatrist Contacts (%)	CPN Contacts (%)	Psychologist Contacts (%)	OT Contacts (%)	Physio Contacts (%)	Psychotherapist Contacts (%)	Social Worker Contacts (%)
NHS Cambridgeshire Commissioning Average	11.0	56.2	7.7	13.9	5.2	0.5	5.5
PCT Peers	14.4	51.6	7.0	11.7	1.4	2.5	11.7
	14.5	48.0	9.9	11.3	2.8	5.2	8.3

Source: <http://www.mhmdsonline.ic.nhs.uk/>, 04/08/10.

Table 60: Number of community patients and calculated rates and 95% confidence interval per 100,000 population – aged 15 and over by gender for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS.

Gender	Number of community patients aged 15 & over	Rate of community patients aged 15 & over per 100,000 population		
		Rate/100,000	95% CI lower	95% CI upper
Male	6,605	2718.0	2,654.1	2,783.4
Female	4,898	1965.2	1,911.4	2,020.4
Total	11,503	2336.8	2,295.0	2,379.4

Source: Community patients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates and 95% CIS from NHSC 04/08/10 based on CCRG mid 2008 population estimates for districts by single year of age. NB: Of the 11,503 community patients 242 are not NHSC residents but their data cannot be removed as their gender is not known.

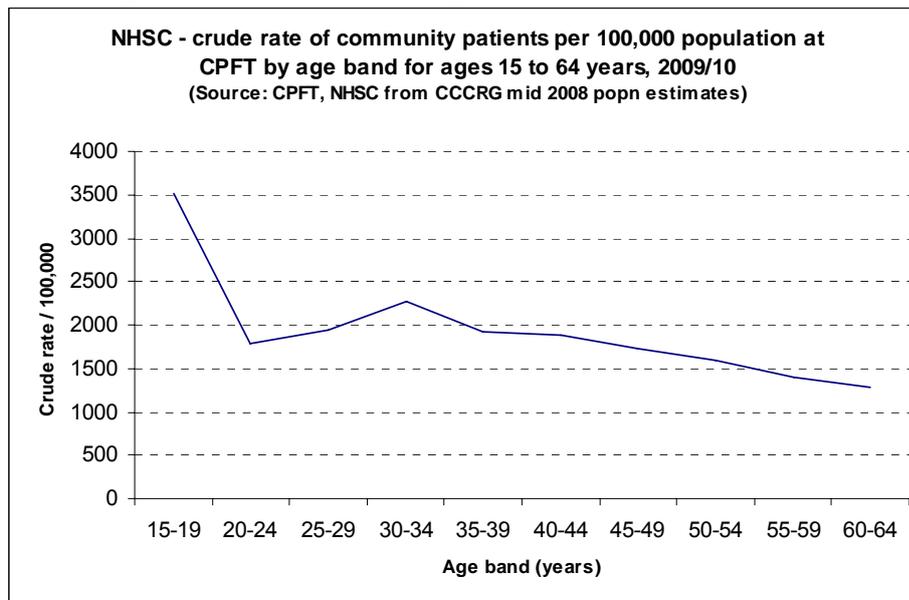
Based on the above table, by gender, the 95% confidence intervals suggests that there are statistically significantly more male community patients aged 15 and over than female community patients in the same age cohort.

Table 61: Number of community patients and calculated rates per 100,000 population – aged 15 and over by age band for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS

Age band	Number of community patients aged 15 & over	CCCRG population estimates mid 2008	Crude rate of community patients aged 15 & over per 100,000 population
15-19	1,304	37,040	3520.5
20-24	797	44,640	1785.4
25-29	745	38,420	1939.1
30-34	830	36,410	2279.6
35-39	833	43,230	1926.9
40-44	876	46,340	1890.4
45-49	736	42,500	1731.8
50-54	593	37,290	1590.2
55-59	510	36,570	1394.6
60-64	471	36,790	1280.2
65 & over	3,808	92,680	4108.8
Total	11,503	491,910	2338.4

Source: Community patients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on CCCRg mid 2008 population estimates. NB: Of the 11,503 community patients 242 are not NHSC residents but their data cannot be removed as their age band is not known.

Figure 45: Calculated crude rates per 100,000 population of community patients – aged 15 to 64 years by age band for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10).



Source: Community patients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on CCCRg mid 2008 population estimates. NB: Of the 11,503 community patients 242 are not NHSC residents but their data cannot be removed as their age band is not known.

The rate of community patients is highest in the 15-19 year age band and fall sharply in the 20-24 year age band. Rates gradually decline throughout the working age period after age 30 years.

Table 62: Number of community patients and calculated rates and 95% confidence interval per 100,000 population – aged 15 and over by ethnic group for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS

Ethnicity	Number of community patients aged 15 & over	Crude rate of community patients aged 15 & over (population is aged 16+)		
		Rate per 100,000	95% CI lower	95% CI upper
White backgrounds	8,388	1,856.2	1817.2	1895.9
Asian or Asian British backgrounds	101	801.6	660.2	973.0
Black or Black British backgrounds	55	763.9	587.4	992.9
Mixed ethnic group backgrounds	75	1,388.9	1109.5	1737.4
Other ethnic group backgrounds	130	1,192.7	1005.4	1414.3
Not Stated	1	n/a	n/a	n/a
Total (exc not stated/not known)	8,749	1,792.8	1,756.0	1,830.4

Source: Community patients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on ONS mid 2007 ethnic population estimates for residents aged 16+ years. NB: The numerator is based on people aged 15+ and the denominator on those aged 16+, due to the availability of data. Of the 11,503 community patients 242 are not NHSC residents but their data cannot be removed as their ethnicity is not known.

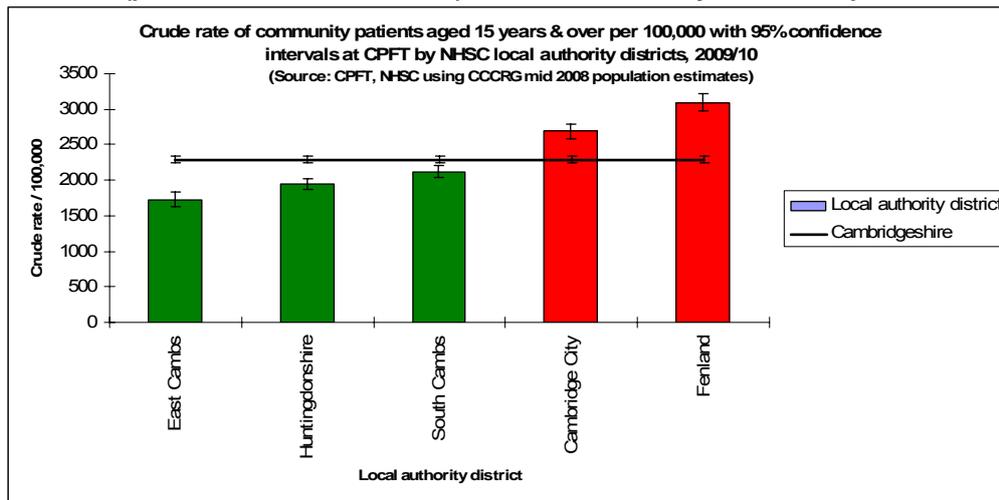
The rates by ethnic group above should be interpreted with caution, as the numbers of community patients underpinning these rates is actually very small in some cases – this is reflected in the very wide 95% confidence intervals for some of the rates, which should be noted.

Table 63: Number of community patients and calculated rates and 95% confidence interval per 100,000 population – aged 15 and over by local authority district for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS

Local authority district	Number of community patients aged 15 & over	Crude rate of community patients aged 15 & over		
		Rate per 100,000	95% CI lower	95% CI upper
Cambridge City	2,721	2,686.3	2,588.6	2,787.7
East Cambs	1,120	1,725.5	1,628.1	1,828.5
Fenland	2,363	3,092.9	2,972.5	3,218.1
Huntingdonshire	2,597	1,946.8	1,874.0	2,022.3
South Cambs	2,460	2,118.5	2,037.2	2,202.9
Cambridgeshire	11,261	2,288.3	2,246.9	2,330.4

Source: Community patients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on CCCR mid 2008 population estimates for districts by single year of age. NB: 242 community patient records have been removed, as these are not NHSC residents.

Figure 46: Calculated rates of community patients per 100,000 population – aged 15 and over by local authority district for NHS Cambridgeshire 2009/10 at CPFT (provisional data at 21/06/10). Rates calculated by NHSC. Not part of MHMDS



Source: Community patients from Cambridgeshire & Peterborough NHS Foundation Trust, 21/06/10. Rates NHSC 04/08/10 based on CCRG mid 2008 population estimates for districts by single year of age. NB: 242 community patient records have been removed, as these are not NHSC residents.

The rates in the table and figure above for CPFT community patients aged 15 and over who are NHS Cambridgeshire residents indicate that the rates for East Cambridgeshire, Huntingdonshire and South Cambridgeshire are statistically significantly low compared with the Cambridgeshire rate and that the Fenland and Cambridge City rates are statistically significantly higher.

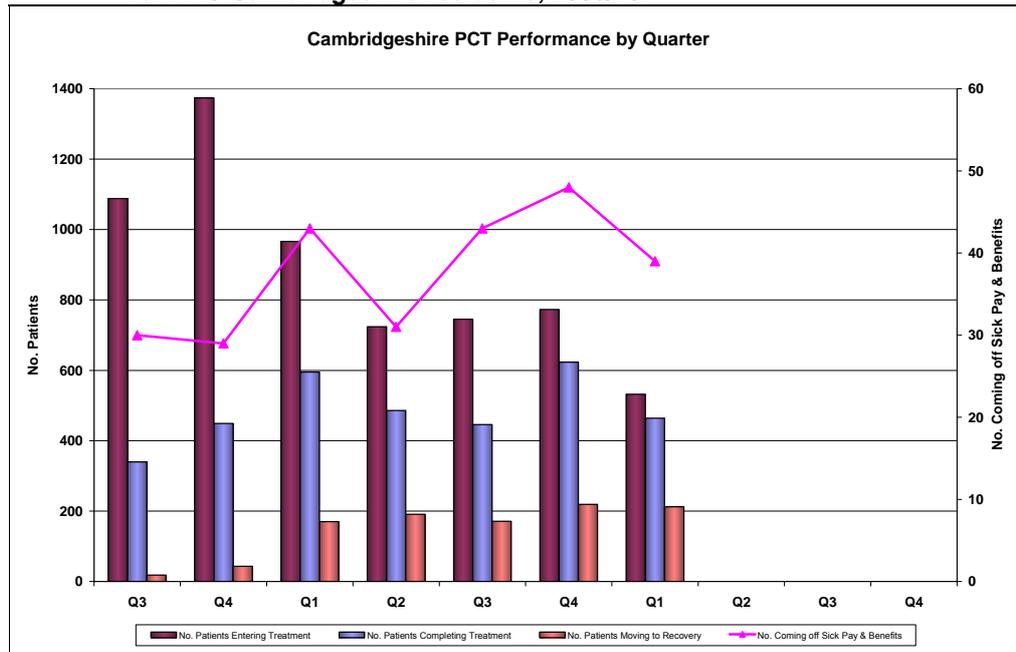
Increased Access to Psychological Therapies (IAPT)

NHS Cambridgeshire was selected to be a first-wave pilot for the 'Increased Access to Psychological Therapies' (IAPT) Programme in May 2008 and the first patients received treatment in October of that year. The programme funded the recruitment of additional low-intensity therapists (now called "psychological wellbeing practitioners"), high-intensity therapists and employment support advisers to work in primary care and other community settings to deliver a range of psychological and other interventions to people suffering from mild-to-moderate mental health problems - especially anxiety and depression. The main focus of the service model was the delivery of cognitive-behavioural therapy (CBT) to enable sufferers currently out-of-work and claiming benefits to regain employment.

In practice, in Cambridgeshire these additional resources enabled the much smaller Primary Care Mental Health Teams created as part of NSF implementation to become much more robust and offer people suffering from mild-to-moderate mental health problems a much wider range of choices of treatment options – including, self-help materials, group and individual therapy both short-term and long-term, signposting to counselling, social inclusion opportunities and advice, and a range of specialist support delivered to help individuals either retain their current employment, find an alternative job, or regain employment after a period away from the workplace. Early indications are that the emerging GP clusters or consortia will further strengthen this trend away from a restrictive model offering only certain forms of psychological therapy to a much more flexible service able to offer a range of help as appropriate to each individual patient's needs.

The early months of the new service witnessed a very high rate of referrals, reflecting the level of historically unmet need in primary care for a service of this nature. The rate of referrals and the numbers of patients completing treatment have now stabilised at approx 5-6,000 patients per annum. The rate of 'recovery' has also stabilised at approx 40% of all referrals. This is a rather narrow target based on the numbers of patients whose mental wellbeing has improved by a fixed amount set nationally – almost all patients referred to the service have recorded an improvement in their mental health. A particular success of the Cambridgeshire service has been the numbers of people helped to either retain their current employment or find new employment after contact with this service.

Figure 47: Primary Care Mental Health Team (IAPT) patients aged 17-65 years by referrals, treatment, recovery and employment status: summary information for NHS Cambridgeshire residents, 2008/10.



Source: East of England Strategic Health Authority IAPT

Voluntary and Community Sector Services from April 2009 - March 2010

In addition to the core CPFT services, a range of voluntary and community (third sector) organisations provide services locally. The following pages summarise the activities reported by the main service providers. A wide range of additional services and interventions to those mentioned below are provided by formal and informal routes through local authorities, eg arts and leisure services and through other community and voluntary groups.

LIFECRAFT

Throughout Cambridgeshire, at least 2000 people have accessed the services of Lifecraft. This excludes people who make contact once with the service but do not require further support. The waiting list for membership and access to services averages 20 people at any one time. The main interventions that Lifecraft offers is a telephone helpline and counselling.

Typical Presentation Needs

- Slight to moderate mental illness - depression, anxiety
- personality disorders; diagnosed schizophrenia/bi-polar
- On-going/longer term mental health issues
- In recovery, in need of counselling/supportive activities - many supported by S/W and/or CPN

Services

1. Mental Health Telephone Helpline

Approximately 1800 callers from Cambridgeshire each year receive advice in a range of mental health problems.

2. Counselling

45 clients, 26 female and 19 male, mostly in the age group 25-54 and 41 of the 45 were of white background accessed the counselling service. The service delivered in 2009/10:

Table 64: Annual Performance Activity - Lifecraft

Number of sessions offered	Number of sessions attended	Agreed Client absence	Client cancelled	Client did not attend
1,110	719	140	149	102

Source: Lifecraft Contract Monitoring

3. Social Club

Lifecraft run four evening Social Clubs and the average attendance is 8.4. Over a week we have an average of 33.6 attendances and for 52 weeks an average of 1,747 'attendances.' Within those numbers there are regulars who come to more than one evening each week .

4. Groups and Activities

We run seven groups each week; Creative Group (Art, Crafts), Creative Writing, Meditation, Music (instrumental), Singing, Womens Group and Computer Skills. From which Lifecraft have had take up of 43.4 group places per week which is 2,256.8 places taken up, across all groups, over 52 weeks.

Local Perspective of Unmet Need

- Support at early stages for people experiencing anxiety/stress.
- Preventative work to support post-natal depression.
- Counselling services are in great demand, suggesting under-supply in community.
- Individual and family debt advice specific to mental health situations.

HUNTS MIND

Throughout Cambridgeshire, at least 596 people have accessed the services of Hunts MIND. This excludes people who make contact once with the service but do not require further support.

Typical Presentation Needs

Hunts Mind offers a range of services, each having different eligibility criteria as outlined below.

Services

1. *Counselling Service*

The counselling service offers up to twelve sessions to people who are usually recommended to the service via their GP. From 1 April 2009 to 31 March 2010, 84 people received a completed period of counselling (up to 12 weeks). 31 people were still receiving ongoing counselling on the 31 March 2010. 925 hours of counselling were delivered between 1 April 2009 to 31 March 2010. As of July 2010 there were 73 people on the waiting list for counselling. The waiting time for an assessment is six weeks and is between six to eight weeks to be allocated a counsellor.

2. *Well Life Project*

There are two aspects to the project. One worker provides mental health promotion, the other healthy living activities and advice. The interventions are aimed at people through the spectrum of need - 70% of recipients do not have contact with the secondary mental health services. In the period 1st April 2009 to 31st March 2010, the mental health promotion work had 196 beneficiaries and the healthy living work had 99, making a total of 295 beneficiaries.

3. *Day Service*

The funding for this project from 'Time to Change' will cease in 2010. The service is aimed at people with moderate to high needs. It is direct access, many people are advised by their GP or the secondary mental health service to contact direct, others find us via our website. In the period 1 April 2009 to 31 March 2010, the day service has worked with 113 individuals aged 18 -65. Mostly these are people who will use our service to provide long term support. We do not currently hold a waiting list.

4. *Volunteer Project*

This project is part of the day service. Most volunteers experience mental ill health and use the opportunity to volunteer for us as part of their recovery journey. From 1 April 2009 to 31 March 2010, 56 people volunteered for Hunts Mind.

5. *Home and Community Support*

This service is spot purchased (by CPFT using social care funding) and only available to people who are on the CPA who meet Fair Access to Care Services eligibility criteria. From 1 April 2009 to 31 March 2010 we worked with 17 individuals.

Local Perspective of Unmet Need

- The counselling service could help many more people if more resources were available to increase the infrastructure to support the counsellors (who work as volunteers), and expand their numbers.
- The Well Life project has proved to be highly successful in reaching people who are vulnerable, and who have low to moderate needs. This includes people from hard to reach groups. This need will not be met should alternative funding not be secured.
- Referrals are received from GPs for specific groups such as anger management and stress management which we are currently unable to provide.
- Community services for people with a diagnosis of personality disorder are very limited.

RETHINK

Throughout Cambridgeshire, at least 470 people have accessed the services of Rethink. This excludes people who make contact once with the service but do not require further support.

Typical Advice Needs

- Carers rights to information concerning the treatment of the one they care for ie confidentiality.
- One to one meetings with the psychiatrist.
- Frequency of CPN visits.
- CPA Care and Risk plans.
- Difficulty of access to secondary services.
- Financial problems caused by out of control spending by the one that care for when living in supporting house of independent.

Services

1. Newsletter

A monthly newsletter is sent to approximately 330 family carers in Cambridgeshire including Fenland, additional to all GP surgeries, psychiatrists, team managers and others involved in the delivery of mental health service.

2. Careline

A telephone helpline is available (24/6) and is accessed by an average 12 new carers annually and contact is also made via e-mail. Callers are sign posted to an appropriate service where possible including PALS.

3. Meetings

An average 15/20 carers attend monthly meetings in Cambridge.

Local Perspective of Unmet Need

- There is still insufficient capacity locally to meet the need for psychologists and counsellors.
- On going support to help people with long term sever and enduring illness post-crisis.

MAKING SPACE

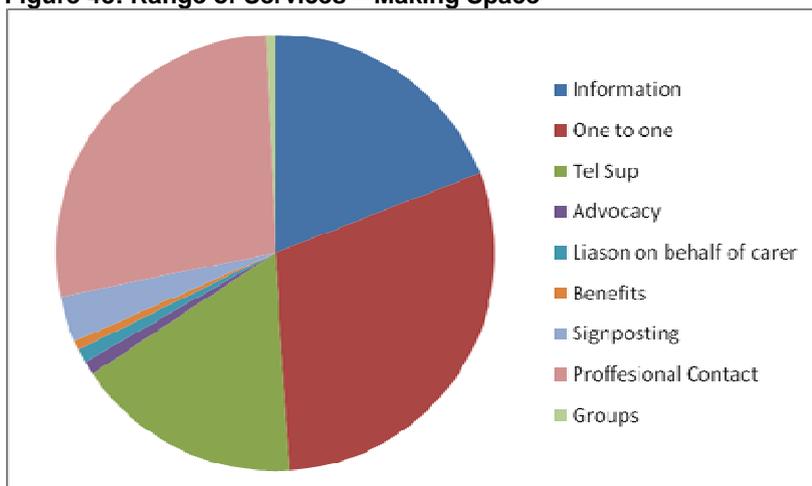
Throughout Cambridgeshire, at least 197 people have accessed the services of Making Space. This excludes people who make contact once with the service but do not require further support. Making Space does not operate a waiting list. The main interventions continue to be one to one support and information.

Typical Presentation Needs

This is a service for carers of adults who suffer from mental ill health, who need additional support.

Services

Figure 48: Range of Services – Making Space



Source: Making Space Contract Monitoring

Table 65: Annual Performance Activity – Making Space

Referrals	Hunts	Cambridge	Fenland	Ely
	66	52	57	22
Age range	Hunts	Cambridge	Fenland	Ely
26-45	26	21	25	7
46-65	38	26	24	12
65+	7	6	8	<6
Gender	Hunts	Cambridge	Fenland	Ely
Male	20	18	13	10
Female	52	36	46	11
Ethnicity	Hunts	Cambridge	Fenland	Ely
White U.K.	50	62	57	21
Refferal Source	Hunts	Cambridge	Fenland	Ely
CMHT	32	20	41	9
Self	37	22	14	12
Childrens Services		6		

Source: Making Space Contract Monitoring

Local Perspective of Unmet Need

- Alternative to hospital admission both in a crisis and for respite.
- Easy/quick access to secondary services when the service user is discharged from mental health services.

CHOICES COUNSELLING

Throughout Cambridgeshire in 2009/10 42 people have accessed the services of Choices Counselling. This excludes people who make contact once with the service but do not require further support. Choices offer specialist counselling for up to two years, therefore completed treatments are expected to be minimal.

Typical Presentation Needs

Individuals who have been victims of sexual abuse both in childhood and adulthood.

Table 66: Annual Performance Activity - Choices

Services	Number
Numbers of Referrals Received	
Male	16
Female	52
Numbers of people who have received treatment	42
Numbers who have completed treatment	14
Number of DNAs	75
Waiting times for initial assessment	TBC
Waiting time for treatment	9 months +
Numbers of counsellors	11
Any complaints	0
Male clients waiting for assessment or counsellor	8
Female Clients waiting for assessment or counsellor	65

Source: Choices Contract Monitoring

ARTS ON PRESCRIPTION

Throughout Cambridgeshire 31 people accessed the services of Arts on Prescription from the Arts and Minds Project during 2009/10. This number covers the pilot phase that ran for less than half a year and excludes people who make contact once with the service but do not require further support.

Typical Presentation Needs

Typical presentations were mild to moderate depression, stress and anxiety. As part of an evaluation meeting with workshop leaders (artists) and counsellors at the end of the pilot phase of Arts on Prescription, it was noted that although aimed mainly at those with mild to moderate levels of depression, stress and anxiety, some individuals presented with slightly more than moderate levels.

Services

During 2009/10, the main activities offered by Arts and Minds on the Arts on Prescription project were arts and crafts activities. There were 68 individuals on the waiting list but one person was offered a place that became free on the workshops when sessions continued after the pilot phase. We now have 67 individuals on our waiting list (August 2010) and this is growing. The first two thirds of this number have been waiting roughly six months. The latter third have been waiting approximately one to four months. All 67 are still on the waiting list. It is hoped that they will not be waiting longer than 10 months in total, as we hope that Arts on Prescription activity will have begun to increase by the end of 2010.

Local Perspective of Unmet Need

- During 2009/10 so far, Arts on Prescription has occurred during the day and has therefore been inaccessible to those who fit the criteria of mild to moderate depression, stress and anxiety but who are still able to work.
- Some potential participants are housebound and find it hard to/cannot access Arts on Prescription, despite being ideal candidates fitting our criteria.

RICHMOND FELLOWSHIP

Cambridge Service. Within the Cambridge Service 163 clients engaged with the Richmond Fellowship service during 2009/10. Richmond Fellowship is funded by Cambridgeshire County Council, Cambridge City Council and NHS Cambridgeshire

Typical Presentation Needs

Typical presentations include:

- People with more severe and enduring mental health problems, often engaged with secondary mental health services.
- People who require a supported intervention around preparing for the workplace in order for them to be able to access and maintain paid or voluntary work.

Services

During 2009/10 the main services offered by Richmond Fellowship in Cambridge are:

- Information, advice and guidance and personalised action planning sessions.
- Training courses including assertiveness, employment skills, IT.
- Psychometric profiling.
- Service User Involvement programmes (examples include clients producing a service newsletter for service users, clients delivering IT training to other clients etc).
- Practical support around career choice, cv's, job searching, application forms, interview techniques etc.
- 'ReFresh' garden maintenance work experience placements. Time bound work experience placements which enable clients to develop work preparation skills including communication skills, team work skills, confidence, structured work activities.

The numbers of individuals accessing each of the services are below:

- Information, advice and guidance and personalised action planning sessions - 100% clients.
- Training courses including assertiveness, employment skills, IT 38% clients.
- Psychometric profiling - 11% clients.
- Service User Involvement programmes (examples include clients producing a service newsletter for service users, clients delivering IT training to other clients etc) - 13% clients.
- practical support around career choice, cv's, job searching, application forms, interview techniques etc - 62% clients.
- *ReFresh* Garden Maintenance work experience placements- 15% clients.

For parts of the year Richmond Fellowship had to operate a waiting list as a result of being at full capacity. Despite this all referrals received are acknowledged within three working days. Both client and referrer are contacted in writing to notify how long a client might need to wait

to be seen. When a waiting list was in operation the typical waiting period was four to six weeks.

Local Perspective of Unmet Need

- Limited capacity means the Richmond Fellowship cannot meet the existing demand for the service.
- Similar to the Huntingdonshire and Fenland service outlined below, there are not enough opportunities to engage with employers to find short-term work placements and voluntary work which we use as stepping stones into paid work. The Richmond Fellowship could do so much more with local training providers (WEA, CRC etc) to provide more of the sort of courses that we know our clients need, such as assertiveness, confidence-building, self-esteem and managing stress and anxiety.
- Labour Market Information (LMI) indicates there is a lack of variety and quantity of unskilled paid jobs in the Cambridge area which a number of our clients would benefit from.

Huntingdonshire and Fenland Service. Within the Huntingdonshire and Fenland Service funded by Cambridgeshire County Council and NHS Cambridgeshire 138 clients engaged with the service in the period 2009/10. This excludes clients on the IAPT service.

Typical Presentation Needs

Individuals who engage with the service are typically people with more severe and enduring mental health problems, often engaged with secondary mental health services.

Services

During 2009/10 the main services offered by Richmond Fellowship in Huntingdonshire and Fenland are:

- Information, advice and guidance
- Training courses including assertiveness, employment skills, IT and budgeting
- Practical support around career choice, cv's, application forms, interview techniques etc

The Richmond Fellowship does not generally have a waiting list and most clients are offered an appointment within 10 working days from initial referral.

Local Perspective of Unmet Need

- Within the Hunts and Fenland area and the area of work Richmond Fellowship provide there is a need for more engagement with employers to provide not only paid employment but also short-term work placements and voluntary opportunities as a part of the journey back into work.
- Richmond Fellowship courses around assertiveness are extremely popular and have a high demand - more group work on issues such as assertiveness, confidence-building, self-esteem and managing stress and anxiety would be welcomed.

OTHER LOCAL VIEWS

GATEWAY WORKERS

Gateway workers act as the main link between primary and secondary mental health services. They receive almost all non-urgent referrals from GPs and signpost them as appropriate to the range of local services both statutory and voluntary. This puts them in an especially good position to identify any major gaps in current local service provision.

A survey was conducted with local **Gateway Workers** regarding their opinions of Local Unmet Need:

- Counselling for people who could not afford to pay.
- Services for adults 17-22 years old for whom current local service models were unattractive.
- Mild eating disorders – it should be possible to reconfigure existing resources to provide something for this group.
- Patients whose needs fell between IAPT and secondary care.
- Dual diagnosis.

7. NHS COMPARATORS DATA

7.1 BACKGROUND INFORMATION

NHS Comparators is a web based system that allows access to a range of routinely collected NHS data principally covering secondary care, QOF and prescribing. The system is located at <https://www.nhscomparators.nhs.uk/NHSComparators/Login.aspx>.

Data are presented for the financial year 2008/09, as this is the latest complete year of data.

Data are presented for the PCT, its practices, its ONS cluster, its ONS cluster constituent PCTs (Berkshire West, Buckinghamshire, Mid Essex, Oxfordshire, Surrey, West Hertfordshire and West Kent) and for England.

Admissions and occupied bed days (OBD) data are presented for adult mental health – treatment specialty code 710: Adult Mental Illness (Grouped Specialty).

Standardised rates

The admission and OBD comparators are indirectly standardised by age and sex to enable comparisons between commissioning organisation. Indirect standardisation involves the calculation of the ratio of an organisation's observed number of events and the number of events that would be expected if it had experienced the same event rates as those of patients in England, given the mix of age and sex of its patients. This standardised ratio is then converted into a rate by multiplying it by the overall event rate of patients in England.

Data quality

There are specific warnings attached to the use of mental health admissions and OBD data from NHS Comparators and these should be considered in interpreting the data presented. There is no guarantee that these data from NHS Comparators will be equivalent to those presented elsewhere in the report on inpatient data provided by CPFT and from the MHMDS. Indeed the adult mental health admissions under specialty code 710 presented here from NHS Comparators show a total of 856 admissions for 2008/09. The MHMDS indicates 1,683 inpatient admissions for 2008/09 for "mental health services" – this includes a wider cohort of services and client groups than the adult cohort included under specialty code 710.

The data quality and interpretation warnings for mental health admissions and OBD copied from the NHS Comparators website are as follows:

"PLEASE INTERPRET WITH CARE: There are particular problems with data from Mental Health providers which impact on the interpretation of mental health comparators. Problems include:

Missing data: Some PCTs have vastly different activity in different quarters indicating missing submissions from their local mental health providers.

Other providers do not appear to send complete data for any submission over time. We suggest that if rates are below following threshold at PCT level they need to be viewed with caution. Note rates higher than this do not necessarily indicate that data is complete. Threshold = <1 admission per 1000 population to be viewed with caution. The missing and incomplete submissions also have the effect of making the national comparative rate too low.

Poor coding:

We have found instances of significant levels of poor or missing coding for many fields including:

- Gender
- Treatment speciality
- Method of admission

These will affect data in comparators” (source:

<https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerQuery.aspx>, 11/08/10).

7.2 WHAT DO WE KNOW?

Adult Mental Health Admissions

Total adult mental health admissions for NHSC, England and its ONS cluster group (Prospering Southern England), 2008/09

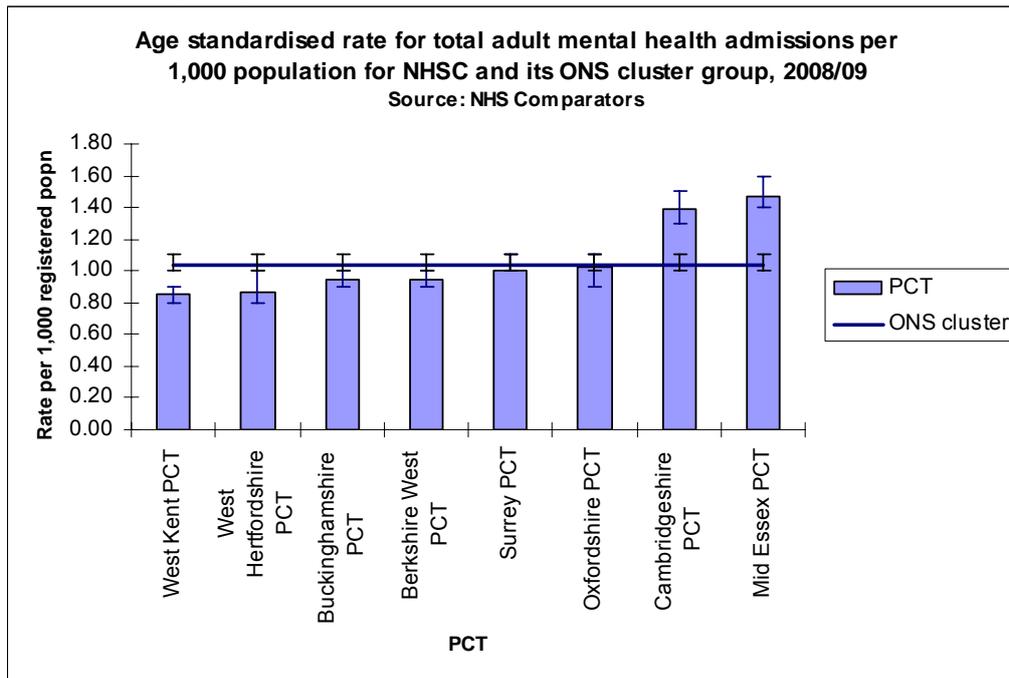
Table 67: Indirectly age standardised rate for total adult mental health admissions per 1,000 population for NHSC, England and its ONS cluster group (Prospering Southern England), 2008/09

Organisation/area	Standardised Rate	Lower Confidence Limit	Upper Confidence Limit	Total Count	Expected Count	% Difference
England ONS Cluster (PSE)	1.54	1.50	1.60	84,040	84,040	0
West Kent PCT	1.04	1.00	1.10	5,308	7,886	-32.7
West Hertfordshire PCT	0.85	0.80	0.90	579	1,055	-45.1
Buckinghamshire PCT	0.87	0.80	1.00	506	898	-43.7
Berkshire West PCT	0.94	0.90	1.00	488	798	-38.8
Surrey PCT	0.95	0.90	1.00	479	780	-38.6
Oxfordshire PCT	1.00	1.00	1.10	1,157	1,777	-34.9
Cambridgeshire PCT	1.02	0.90	1.10	695	1,055	-34.2
Mid Essex PCT	1.39	1.30	1.50	856	947	-9.6
	1.47	1.40	1.60	548	575	-4.7

Source: NHS Comparators at

<https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>, 11/08/10. Data are for adult mental health admissions, treatment speciality code 710. Denominator data: Population based on GP list data.

Figure 49: Age standardised rate for total adult mental health admissions per 1,000 population for NHSC, and its ONS cluster group (Prospering Southern England), 2008/09

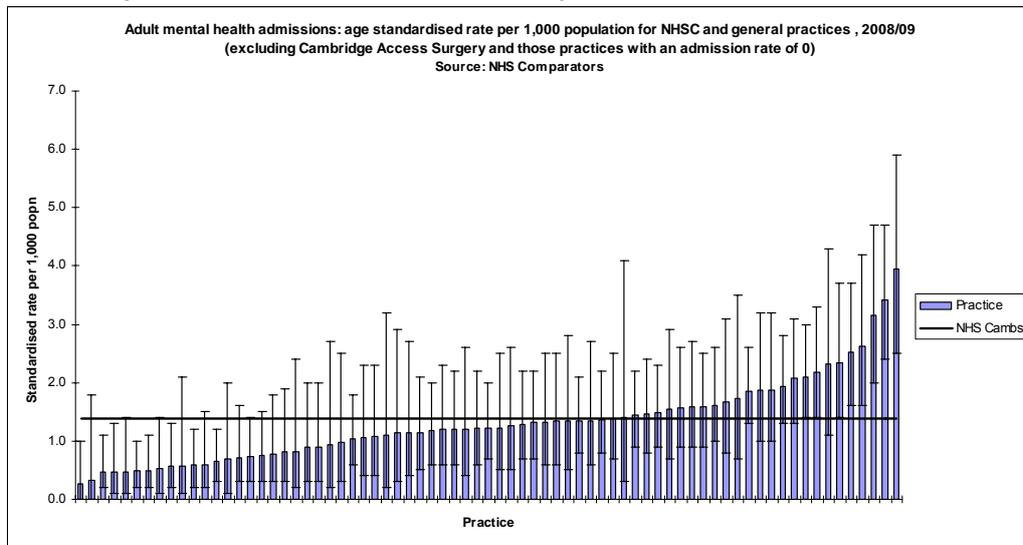


Source: NHS Comparators at <https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>, 11/08/10.
Data are for adult mental health admissions, treatment speciality code 710. Denominator data: Population based on GP list data.

The rate of adult mental health admissions per 1,000 population for NHS Cambridgeshire is significantly below the national figure, but is significantly higher than the average rate for the ONS cluster of Prospering Southern England. Please note the known issues with regard to data quality and interpretation of results: mental health data are particularly prone to issues of incomplete submission of data and poor coding and should be interpreted with caution.

Total adult mental health admissions for NHS Cambridgeshire practices, 2008/09

Figure 50: Indirectly age standardised rate for total adult mental health admissions per 1,000 population for NHS Cambridgeshire, and its constituent general practices, 2008/09 (excluding Cambridge Access Surgery and those practices with an admission rate of 0)



Source: NHS Comparators at <https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>, 11/08/10. Data are for adult mental health admissions, treatment speciality code 710. Denominator data: Population based on GP list data.

The rate of adult mental health admissions per 1,000 population for NHS Cambridgeshire practices is very variable. The range is 0.27 to 3.95 per 1,000. The Cambridge Access Surgery, which serves a clientele of homeless people has a high rate of 38.93 per 1,000 that is statistically significantly higher than the NHS Cambridgeshire rate. However, please note the known issues with regard to data quality and interpretation of results: mental health data are particularly prone to issues of incomplete submission of data and poor coding and should be interpreted with caution. Due to this and the wide range of the practice rates, no further analysis of these data has been undertaken at this stage eg analysis according to deprivation quintile.

Adult Mental Health Occupied Bed Days

Average Adult Mental Health Overnight Occupied Beds per 1,000 Population for NHS Cambridgeshire, England and its ONS cluster group (Prospering Southern England), 2008/09

Table 68: Indirectly age standardised rate for average adult mental health overnight occupied beds per 1,000 population for NHS Cambridgeshire, England and its ONS cluster group (Prospering Southern England), 2008/09

Organisation/area	Standardised Rate	Lower Confidence Limit	Upper Confidence Limit	Total Count	Expected Count	% Difference
England ONS Cluster (PSE)	0.51	0.50	0.50	27,736	27,736	0
West Kent PCT	0.34	0.30	0.40	1,727	2,602	-33.6
Berkshire West PCT	0.17	0.10	0.20	118	350	-66.2
Buckinghamshire PCT	0.31	0.30	0.40	153	255	-39.9
Surrey PCT	0.32	0.30	0.40	164	264	-37.8
West Hertfordshire PCT	0.33	0.30	0.40	385	588	-34.5
West Hertfordshire PCT	0.35	0.30	0.40	201	296	-32
Oxfordshire PCT	0.38	0.30	0.40	261	347	-24.8
Cambridgeshire PCT	0.40	0.40	0.50	247	313	-20.8
Mid Essex PCT	0.53	0.50	0.60	197	190	3.2

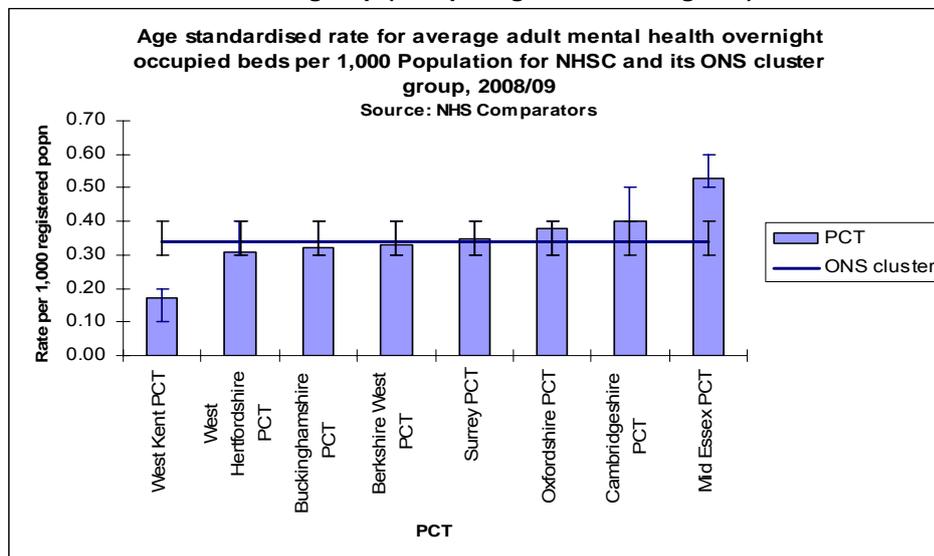
Source: NHS Comparators at

<https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>, 11/08/10.

The average number of beds occupied by patients in Mental Health specialties per 1000 practice population. Shows the average rate of overnight bed occupancy for treatment speciality code 710.

Numerator data: Sum of Length of stay (discharge date – admission date) for completed spells in time period. Denominator data: Number of days in time period x Population based on GP list data.

Figure 51: Indirectly age standardised rate for average adult mental health overnight occupied beds per 1,000 population for NHS Cambridgeshire, England and its ONS cluster group (Prospering Southern England), 2008/09



Source: NHS Comparators at

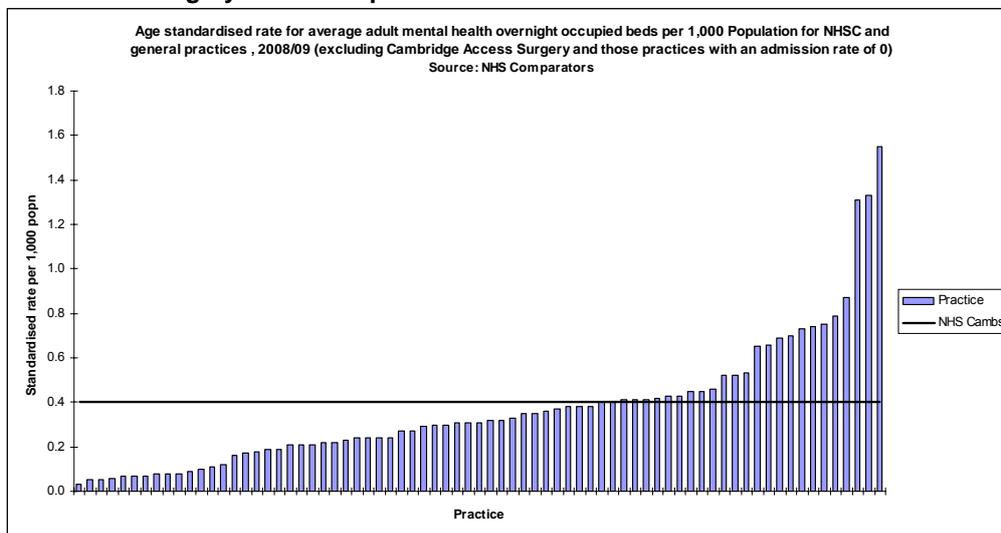
<https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>, 11/08/10.

The average number of beds occupied by patients in Mental Health specialties per 1000 practice population. Shows the average rate of overnight bed occupancy for treatment speciality code 710. Numerator data: Sum of Length of stay (discharge date – admission date) for completed spells in time period. Denominator data: Number of days in time period x Population based on GP list data.

The age standardised rate for average adult mental health overnight occupied beds per 1,000 population for NHS Cambridgeshire is significantly below the national figure. It is slightly higher than the average rate for the ONS cluster of Prospering Southern England, but the difference with the cluster rate is not significant. Please note the known issues with regard to data quality and interpretation of results: mental health data are particularly prone to issues of incomplete submission of data and poor coding and should be interpreted with caution. NB: There may be an issue with the confidence intervals supplied in NHS Comparators for this measure and so statements about significance should be treated with additional caution.

Average Adult Mental Health Overnight Occupied Beds per 1,000 Population for NHS Cambridgeshire, and its constituent general practices, 2008/09 (excluding Cambridge Access Surgery and those practices with an admission rate of 0):

Figure 52: Indirectly age standardised rate for average adult mental health overnight occupied beds per 1,000 population for NHS Cambridgeshire, and its constituent general practices, 2008/09 (excluding Cambridge Access Surgery and those practices with an admission rate of 0):



Source: NHS Comparators at

<https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>, 11/08/10.

The average number of beds occupied by patients in Mental Health specialties per 1000 practice population. Shows the average rate of overnight bed occupancy for treatment speciality code 710. Numerator data: Sum of Length of stay (discharge date – admission date) for completed spells in time period. Denominator data: Number of days in time period x Population based on GP list data.

The rate of average adult mental health overnight occupied beds per 1,000 population practices is very variable and may hint at data quality issues. The range is 0.03 to 1.55 per 1,000. Cambridge Access Surgery serves a clientele of homeless people and has a high rate of 17.23 per 1,000. There is an issue with the confidence intervals that NHS Comparators provides for the practice analysis and thus these intervals are not presented here – as such no statements can be made about statistical differences. Please note the known issues with regard to data quality and interpretation of results: mental health data are particularly prone to issues of incomplete submission of data and poor coding and should be interpreted with

caution. Due to this and the wide range of the practice rates, no further analysis of these data has been undertaken at this stage, eg analysis according to deprivation quintile.

Drugs Acting on Benzodiazepine Receptors per STAR PU

Drugs Acting on Benzodiazepine Receptors per STAR PU for NHS Cambridgeshire, England and its ONS cluster group (Prospering Southern England), 2008/09

Table 69: Drugs Acting on Benzodiazepine Receptors per STAR PU for NHS Cambridgeshire, England and its ONS cluster group (Prospering Southern England), 2008/09

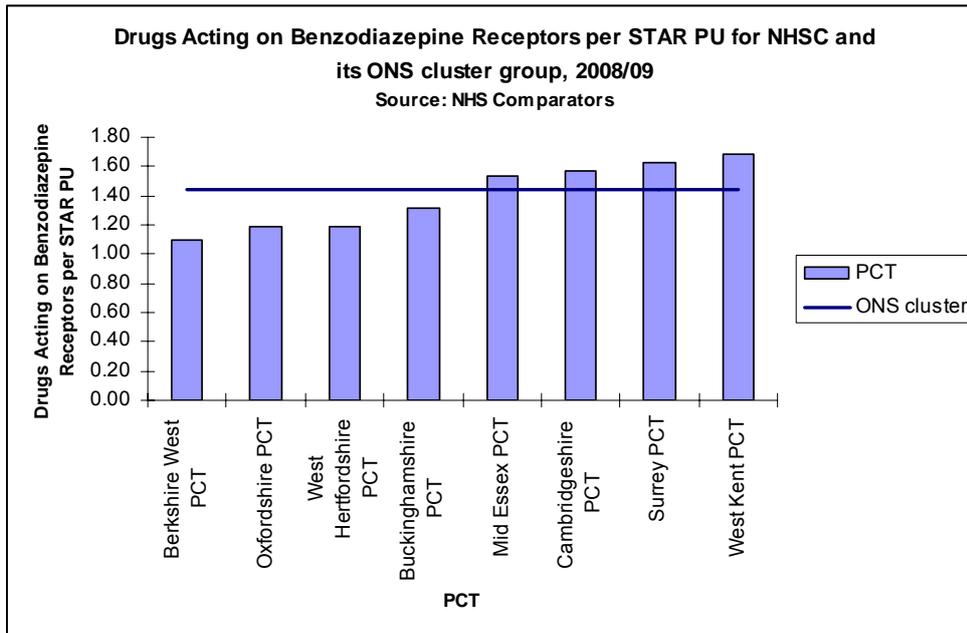
Organisation/area	Rate per STAR PU
England	1.66
ONS Cluster (PSE)	1.44
Berkshire West PCT	1.10
Oxfordshire PCT	1.19
West Hertfordshire PCT	1.19
Buckinghamshire PCT	1.31
Mid Essex PCT	1.54
Cambridgeshire PCT	1.57
Surrey PCT	1.63
West Kent PCT	1.69

Source: NHS Comparators at

<https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>, 11/08/10.

Numerator: ADQs (Average Daily Quantities) of Drugs acting on Benzodiazepine Receptors dispensed within time period. Denominator: STAR-PU (Specific Therapeutic Age-sex Related Prescribing Units). A weighted measure of population.

Figure 53: Drugs Acting on Benzodiazepine Receptors per STAR PU for NHS Cambridgeshire, England and its ONS cluster group (Prospering Southern England), 2008/09

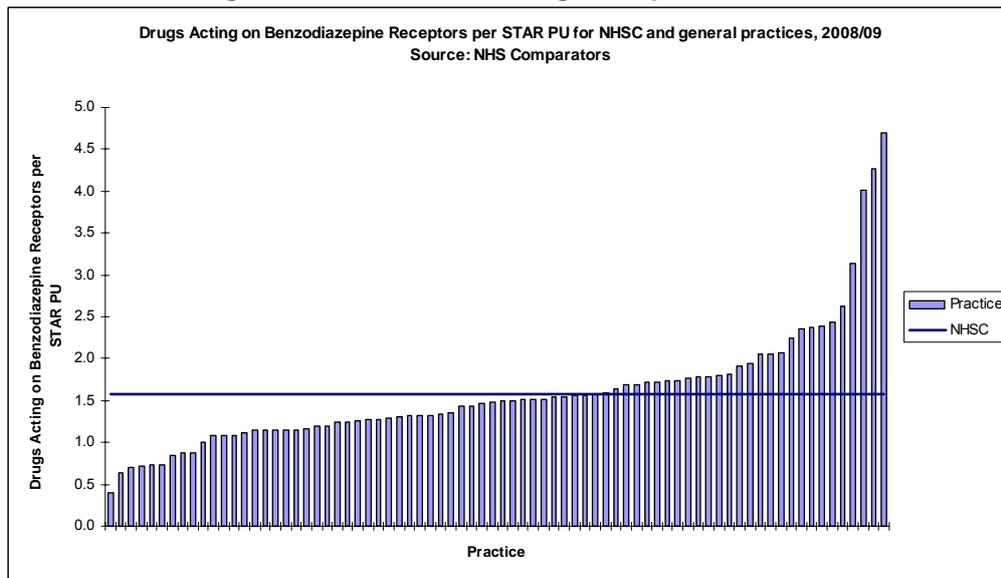


Source: NHS Comparators at <https://www.nhscomparators.nhs.uk/NHSComparators/CommissionerResults.aspx>, 11/08/10. Numerator: ADQs (Average Daily Quantities) of Drugs acting on Benzodiazepine Receptors dispensed within time period. Denominator: STAR-PU (Specific Therapeutic Age-sex Related Prescribing Units). A weighted measure of population.

There is general agreement that there should be a reduction in the use of these drugs. Many people may develop tolerance to them gain little therapeutic benefit from chronic consumption, become dependent and suffer a withdrawal syndrome when they stop taking them. The NHS Cambridgeshire rate is lower than the England rate, but higher than the ONS cluster rate for Prospering Southern England. No confidence intervals are provided and hence it is not possible to make statements about the statistical significance of differences in prescription rates.

Drugs Acting on Benzodiazepine Receptors per STAR PU for NHS Cambridgeshire, England and its constituent general practices, 2008/09

Figure 54: Drugs Acting on Benzodiazepine Receptors per STAR PU for NHS Cambridgeshire, and its constituent general practices, 2008/09



Source: NHS Comparators at <https://www.nhscomparators.nhs.uk/NHSCComparators/CommissionerResults.aspx>, 11/08/10.
 Numerator: ADQs (Average Daily Quantities) of Drugs acting on Benzodiazepine Receptors dispensed within time period. Denominator: STAR-PU (Specific Therapeutic Age-sex Related Prescribing Units). A weighted measure of population.

Table 70: Drugs Acting on Benzodiazepine Receptors per STAR PU for NHS Cambridgeshire and IMD 2007 deprivation quintiles (general practice and MSOA based), 2008/09 (excluding Cambridge Access Surgery)

Organisation/area	Rate per STAR PU
England	1.66
ONS Cluster (PSE)	1.44
Cambridgeshire PCT	1.57
Most deprived 20% practice area	2.18
Least deprived 80% practice area	1.37

Source: NHS Comparators at <https://www.nhscomparators.nhs.uk/NHSCComparators/CommissionerResults.aspx>, 11/08/10.
 Numerator: ADQs (Average Daily Quantities) of Drugs acting on Benzodiazepine Receptors dispensed within time period. Denominator: STAR-PU (Specific Therapeutic Age-sex Related Prescribing Units). A weighted measure of population. Proxy IMD 2007 scores for practices calculated and allocated to deprivation quintiles by NHSC PHI.

Practice rates range from 0.4 to 4.7, including the Cambridge Access Surgery which has the highest rate. Three practices have a rate >4, one practice a rate of between three to four and all other practices have rates that are <3.

Table 70 suggests that the prescription rate of drugs acting on benzodiazepine receptors per STAR PU is higher in the most deprived area of NHS Cambridgeshire than the least deprived area. The rate in the most deprived area is thus higher than the NHS Cambridgeshire average and also higher than the national and ONS Cluster benchmarks. Cambridge Access Surgery is excluded from the deprivation quintiles, as agreed with the practice.

No confidence intervals are provided and hence it is not possible to make statements about the statistical significance of these suggested differences in prescription rates.

These comparisons are influenced not only by the prevalence of mental illness but also by variation in clinical practice and access to health care. In general Cambridgeshire has lower levels of admissions, occupied bed days and prescriptions for mental illness compared to the national averages but compares less favourably to ONS Cluster comparators. Within Cambridgeshire there is wide variation among practices even when the Cambridge Access Surgery is excluded.

The interpretation of these comparisons should take account of the variation in Cambridgeshire between districts. South Cambridgeshire is among the most affluent districts in the country and may compare favourably with ONS Cluster PCTs. However, Fenland is relatively deprived and would be expected to have higher levels of mental health needs compared to the other districts. Some of the variation observed across the county may be due to the underlying variation in deprivation indices but this is not the only explanation. Variation in clinical practice also contributes to the findings.

NHS Cambridgeshire erpho Practice Profiles

Figure 55: Erpho practice profiles 2008/09. Summary of mental health related indicators for NHS Cambridgeshire

Indicator	Practice Value	PCT Value	Reg. Avg	Reg. Worst	Regional Range	Reg. Best
Patients with psychoses QOF prevalence (all ages)	0.7%	0.7%	4.1%	0.1%		0.1%
Exception rate for patients with psychoses indicators	14.7%	12.3%	50.0%	0.0%		0.0%
Severe long-term mental health problems with a full ...	91.9%	92.2%	20.9%	100.0%		100.0%
On lithium therapy with a record of serum creatinine...	98.7%	97.8%	0.0%	100.0%		100.0%
On lithium therapy with a record of lithium levels i...	91.7%	90.1%	0.0%	100.0%		100.0%
On the mental health register with comprehensive car...	83.9%	85.8%	0.0%	100.0%		100.0%
Patient with psychoses who missed their review follo...	91.6%	92.6%	0.0%	100.0%		100.0%
Dementia QOF prevalence (all ages)	0.4%	0.4%	9.7%	0.0%		0.0%
Exception rate for dementia indicators	7.8%	8.1%	66.7%	0.0%		0.0%
Care has been reviewed in last 15mths (dementia)	79.8%	77.9%	0.0%	100.0%		100.0%
Depression QOF prevalence	9.2%	7.7%	21.1%	0.1%		0.1%
Case finding for depression undertaken in last 15m...	89.0%	87.5%	26.4%	100.0%		100.0%
New depression cases with assessment of severity at...	92.0%	92.4%	0.0%	100.0%		100.0%
Exception rate for depression indicators	3.6%	3.6%	28.6%	0.0%		0.0%
Learning disability QOF prevalence (18+)	0.3%	0.3%	2.6%	0.0%		0.0%
Number of Benzodiazepine dispensed per STAR-PU	1.6	1.7	0.1	8.2		8.2

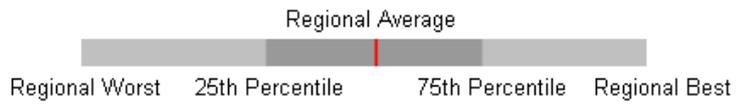
Source: Erpho – Practice profile for Cambridgeshire PCT, <http://www.erpho.org.uk/pracprof>, 05/08/10

Understanding the spine chart above

The light grey bar shows the range of values found in the East of England. The dark grey sections mark out the range within which the middle-half of the observed values lie (25th to 75th percentile). The red line shows where the regional average is. The position of the dot shows the practice value, and the diamond the PCT value, in relation to this scale. The corresponding numbers can be found in the cells next to the chart.

Values are coded:

- Significantly worse than regional average
- Not significantly different from regional average
- Significantly better than regional average
- Significance level not calculated



Unfortunately the above chart does not display all of the text for the measures in its entirety. Therefore the table below provides a summary of the analysis with indicator text in full and providing a colour coded assessment of the PCT value compared with the regional value as per the key for the spine chart above. Data are available at practice level should they be required.

Table 71: Erpho practice profiles 2008/09. Summary of mental health related indicators for NHS Cambridgeshire

Indicator	PCT value	Better or worse than region
Patients with psychoses QOF prevalence (all ages)	0.7%	
Exception rate for patients with psychoses indicators	14.7%	
Severe long-term mental health problems with a full review recorded in the last 15 months	91.9%	
On lithium therapy with a record of serum creatinine & amp, TSH in the last 15 months	98.7%	
On lithium therapy with a record of lithium levels in therapeutic range in the last 15 months	91.7%	
On the mental health register with a comprehensive care plan documented in records	83.9%	
Patients with psychoses who missed their follow-up review followed up within 14 days	91.6%	
Dementia QOF prevalence (all ages)	0.4%	
Exception rate for patients with dementia indicators	7.8%	
Care has been reviewed in the last 15 months (dementia)	79.8%	
Depression QOF prevalence	9.2%	
Case finding for depression undertaken in last 15 months (with heart disease and/or diabetes)	89.0%	
New depression cases with assessment of severity at outset of treatment	92.0%	
Exception rate for patients with depression indicators	3.6%	
Learning disability QOF prevalence (18+)	0.3%	
Number of benzodiazepine dispensed per STAR-PU	1.6	

Source: Erpho – Practice profile for Cambridgeshire PCT, <http://www.erpho.org.uk/pracprof> , 05/08/10

8. PEOPLE WITH ACCESS DIFFICULTIES

8.1 HOMELESSNESS

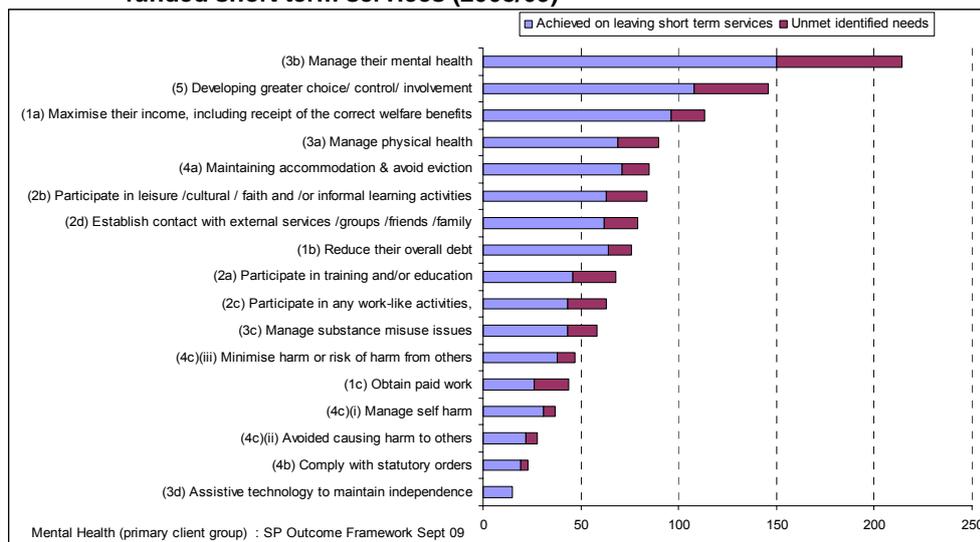
When reading this section please also refer to the *Homelessness JSNA*

The incidence of mental illness, either alone or complicated by any combination of drug misuse, alcohol misuse, personality disorder and learning disability, is disproportionately high amongst the homeless. Previous studies have highlighted that 30-50% of rough sleepers have mental health problems - often major and untreated schizophrenia or bipolar disorder, and often compounded by personality disorder, offending behaviour and substance misuse problems.

Homelessness usually reflects a cycle of deprivation over many generations including mental health problems - including psychosis, personality disorder, depression, anxiety, bereavement, dual diagnosis, self-harm and suicidal ideation, forensic histories (past and present), non-compliance with treatment, non-engagement with services, repeat offending, unplanned discharge from hospital, and release from prison.

The Supporting People needs analysis (Figure 56) identified 'managing their mental health', developing greater choice and control and involvement', 'maximising income' and 'managing physical health' as the main support needs.

Figure 56: Identified needs, and needs achieved by people with mental health problems identified as their primary client group leaving Supporting People funded short term services (2008/09)



Source: Supporting People. Note: 160 outcome forms were completed for people with mental health problems recorded as their primary client group in the period ie people who had left short term funded services.

8.2 GYPSIES AND TRAVELLERS

When reading this section please also refer to the *Cambridgeshire Travellers JSNA 2010*. Key mental health aspects that were highlighted in the report included:

- Mental health problems are frequently mentioned as being high in Traveller population in most available surveys and in research studies.^{105,106,107}
- Gypsies and Travellers are nearly three times more likely to suffer from anxiety than average and just over twice as likely to be depressed. Women are twice as likely to experience mental health problems as men.¹⁰⁵
- ❖ Ormiston Children and Families Trust obtained Department of Health funding to carry out a project on Emotional Wellbeing in the Travelling community. The aim of the project was to empower female Travellers who are identified as experiencing emotional wellbeing difficulties residing in or passing through Cambridgeshire and improve their emotional wellbeing. This project took place between 2005 and 2008. An Emotional Wellbeing Advocacy Worker (EWAW) was recruited for the project and the key findings/outcomes were:
 - Over the project period, 341 people made use of the projects activities and services.
 - Issues included homelessness, child protection proceedings, eviction, benefits, setting up home, debt, racism, support to access services including help with mental health appointments.
 - There were potentially many more clients that could have been supported within the County than the EWAW had capacity to support.
 - Development of a culturally appropriate needs assessment tool
 - Need for information to be provided for members of the Traveller community on pathways and choices in an accessible format
 - Need to improve ethnic monitoring procedures

An exploratory study on illicit drug use among Travellers¹⁰⁸ found:

- Illicit and licit substances most widely used by Travellers are also the same substances that are used by the general population eg cannabis, sedatives, tranquillisers and antidepressants. Many more males than females use these substances. A wide age range of Travellers was perceived to be using illicit drugs.

With regards to access to services

- ❖ According to the 2006 East Cambridgeshire and Fenland Traveller health needs assessment GP registration rates were low in Travellers. However, the 2009 East of England lifestyle survey found, out of the 189 Gypsies and Travellers interviewed, 93% were currently registered with a GP, 84% had visited a GP within last two years and 43% had visited the hospital.
- ❖ Lack of trust, expectations of poor understanding of Travellers' needs, or frank discrimination from health workers featured strongly as barriers to accessing

¹⁰⁵ Inclusion Health Evidence pack. Department of Health and Cabinet Office social exclusion task force, March 2010.

¹⁰⁶ East Cambridgeshire & Fenland Traveller Health Needs Assessment. Suzanne Wood, 2006

¹⁰⁷ Facing the Future? Vivitas East Midland Racial Equality Consortium Vivitas East Midland Racial Equality Consortium February 2007

¹⁰⁸ An overview of the nature and extent of illicit drug use amongst the Traveller community: an exploratory study 2006 available at <http://www.nacd.ie/publications/NACDTravellerReportFinal.pdf> (8N)

services^{109,110}. Reputations of different doctors and their practices, and also of different hospitals, were well-circulated within Traveller communities. Wherever possible, these services were either frequented or avoided accordingly¹¹¹. Error! Bookmark not defined.

With regards to mental health services:^{109,110}

- ❖ ‘invisibility’ of mental health problems and lack of knowledge and understanding about mental health problems constituted clear barriers to care.
- ❖ women had low expectations of the ability of formal mental health services to meet their needs effectively and cultural and lay beliefs on specific health conditions such as mental health restrict the service access.

8.3 PRISON POPULATION

Table 72: Age distribution of the male prisoner population at HMP Littlehey and HMP Whitemoor, 2006

Age	HMP/YOI Littlehey (Hunts)		HMP Whitemoor (Fenland)		Total	
15-24	36	5%	32	7%	68	6%
25-29	104	15%	99	23%	203	18%
30-39	192	28%	125	29%	317	28%
40-49	172	25%	121	28%	293	26%
50-59	99	14%	39	9%	138	12%
60+	94	13%	17	4%	111	10%
All ages	697	100%	433	100%	1,130	100%

Source: HMP Littlehey and HMP Whitemoor

The population in prisons have complex mental health needs. In the local prisons there are about 700 inmates in HMP Littlehey and about 450 in HMP Whitemoor; all males. At HMP Littlehey, 52% of prisoners are aged over 40, and at HMP Whitemoor 48% are aged over 40 years. In 2005, 34% of the national prison population was aged over 40, so the local prison population is an older one. The national data are from 2005, so this assumes that a change has not occurred to the national prisoner population over this time.

The national prison population typically experiences poorer health than the general population; this is shown in the reporting of ill-health, such as a disproportionately higher incidence of mental health need and substance misuse compared to the general population. In terms of socio-economic status, there is a higher representation of the lowest socio-economic groups, which means that prisoners generally suffer greater social exclusion; prisoners are thirteen times more likely to have been taken into care as a child and thirteen times more likely to have been unemployed. 90% of all prisoners have a diagnosable mental health or substance misuse problem and commonly have both (a dual diagnosis).¹¹²

The Bradley Report, published in April 2009, was the result of an independent review of the experience of people with mental health problems and people with learning disabilities in the criminal justice system. Commissioned by the Ministry of Justice, it made some 82 recommendations for change. Among those recommendations were important new proposals to tackle the over-representation of people with mental health problems in prisons

¹⁰⁹ Improving mental health services for Travellers in Cambridgeshire. Treise C, Shepherd G, Cambridgeshire and Peterborough Mental Health Partnership Trust 2005

¹¹⁰ Participatory Health Needs Assessment of Gypsies, Roma and Travellers in Luton. NHS Luton January 2009

¹¹¹ The Health Status of Gypsies and Travellers in England. University of Sheffield 2004 available at <http://www.shef.ac.uk/content/1/c6/02/55/71/GT%20report%20summary.pdf>

¹¹² Health Needs Assessment in HMP Whitemoor and HMP Littlehey. Cambridgeshire PCT. (Personal Communication, 2008.)

in England. They include the proposed creation of a national network of Criminal Justice Mental Health teams to divert people towards support services from police stations, from courts and following release from prison. The report also called for a 14-day maximum wait for people who need to be transferred from prison to hospital for urgent mental health treatment and for the NHS to take on responsibility for providing health services in police stations. Implementation of the Bradley Report should lead to major changes in the way offenders with mental health problems are supported and treated. This should not only improve the mental health of offenders but make communities safer.

8.4 MIGRANT WORKERS

When reading this section please also refer to the Migrant Workers JSNA

Individuals who migrate could be subject to change in culture, food, climate as well as family and friends who may become relatively inaccessible compared with before they migrate¹¹³. They often experience a certain amount of loss through the change which is counterweighed with excitement by the thoughts of a better life. If the fluency of English is used as a proxy for the amount of acculturation a migrant has, it can be shown that the better the language skills are, the less likely one is to show depressive symptoms¹¹⁴.

The losses, or griefs, are considered as a type of stress response. These have been described by a model with seven griefs containing family and friends, language, culture, homeland, loss of status, loss of contact with ethnic group and exposure to physical risks. The griefs could be revived by contact with the country of origin instead of the more normal grief encountered when someone dies¹¹⁵. The treatment of the migrant, especially in the early days, is crucial for the completeness of the grief process.

Post traumatic stress disorder, followed by mood disorders, are the most common, diagnostic conditions found among refugees and asylum seekers¹¹⁶. The Medical Foundation in the UK assesses that people that have been tortured are at an increased risk of nightmares, hallucinations, panic attacks, difficulty in forming relationships, depressive illness and anxiety.

A team of psychiatrists from Barcelona have described the migrants' common symptoms and called it Chronic and multiple stress syndrome, or the Ulysses syndrome. They are treating people who largely have an extremely hard and stressful journey in small, fragile boats to get from North Africa to the countries of southern Europe. Migrants with this syndrome have depressive symptoms mixed with anxious and dissociative symptoms. The syndrome is progressive with the number of obstacles encountered, for example stressful journey, lack of family and friends, difficulties obtaining work and money. A separate group of researchers found that the incidence of Ulysses syndrome is rising across Europe.

Hospital admission rates for schizophrenia are highest among migrant patients with a Caribbean, Irish and Polish background and are higher than UK nationals in people from Pakistan and India as migration is a risk factor for schizophrenia¹¹⁷. However, migrants are not a homogenous group and the risk depends on the conditions under which they emigrate and the conditions which they live in the UK.

Depression and high suicide rates are especially widespread among the migrant, female Indians^{118 119 120}. It is said to be precipitated by family conflict in many cases, rather than

113 Carta et al. (2005). Migration and mental health in Europe. *Clinical practice and epidemiology in mental health*, 1:13

114 Bhugra (2003). Migration and depression. *Acta Psychiatrica Scandinavica*, Supplementum, 418(67-72), 0065-1591

115 Achotegui (2002). La depression en los inmigrantes: una perspectiva transcultural

116 LeTouze et al. (2003). Good practices in mental health and social care provision for refugees and asylum seekers. Report on the United Kingdom

117 London (1986). Mental illness among immigrant minorities in the United Kingdom. *British Journal of Psychiatry*, 149:265-73

118 Bhugra et al. (1999). Attempted suicide in London, II: Inter-group comparisons. *Psychol Med* 29:1131-9

119 Bhugra et al. (1999). Attempted suicide in London, I: rates across ethnic communities. *Psychol Med* 29:1125-30

mental illness. However, the prevalence of common mental disorders could be under-diagnosed, particularly in this population as it could be seen as being stigmatising.

Some countries from which people have migrated to the UK have a high incidence of suicide in the country itself. While suicide rates are a blunt instrument they may be used as a proxy, especially where there is not much data. Lithuania¹²¹ has the highest suicide rate in Europe in 2006. Poland's rate is above Europe's average while the suicide rate in Portugal is lower. The Health Information Unit of the WHO Regional Office for Europe and the Lithuanian Ministry of Health attribute these high suicide levels to high alcohol use and the socioeconomic situation that many Lithuanians find themselves¹²²

Alcohol and drug addiction and migration are associated but these have not been found consistently. Weaker association is probably found with alcohol and drug abuse in the country of origin being a determinant for abuse when in a migrant population but generally little data has been found for migrant addiction¹²³.

Migrants could have two broad areas where diagnosing a mental health problem occurs. One is cultural differences making diagnosing a mental health problem particularly problematical. Misdiagnoses are more common among migrants than with native patients¹²⁴. In psychiatry it is important to consider the patients' ethnic identity, their lay beliefs as to what the problem may be and their overall treatment expectations. Mental health assessments among migrants should be performed with that in mind. The second is the language barrier can become severe with the diagnosis of mental health. Using interpreters within the social group or family has been described as unacceptable. On the other hand, a unfamiliar interpreter might be undesirable as the patient could sense any disapproval of the interpreter¹²⁵.

In April 2008, the Drug & Alcohol Action Team (DAAT)¹²⁶ carried out initial work focussing on ethnic minorities and migrant worker communities in Cambridgeshire. Information about migrant workers and their substance use was obtained from community groups, current substance misuse service providers, a questionnaire targeted at migrant worker groups and the National Drug Treatment Monitoring System.

The findings were that the numbers of ethnic minorities and migrant workers currently accessing services are small although alcohol is the main substance of use, both nationally and locally for these groups. Illegal drug use has also been found. Migrant workers are initially more likely to manage substance misuse problems themselves or within their community rather than access services.

The most significant barriers to accessing services for these groups were identified as language and lack of knowledge about what help is available. Ongoing assessment of need is required to ensure that appropriate measures to reduce ethnic inequalities in substance misuse services can be put in place.

DAAT reports that relapsing into drug use was often triggered by life in the UK as not living up to the migrants' expectations. Alcohol use was the subject of a survey which 27 migrants filled in. 33% said that they were concerned about alcohol use by other migrant workers and

120 Commander et al. (2004). Care pathways for south Asian and white people with depressive and anxiety disorders in the community. *Soc Psychiatry Psychiatr Epidemiol* 39(4):259-64.

121 Eurostat <http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/> (accessed 17/06/09)

122 Sargeant (2005). A health care needs assessment for migrant workers in Wisbech, Cambridgeshire. East Cambridgeshire and Fenland PCT

123 Caballero (2003). Addiction disorders among migrants. In Lecture at the DTGPP Satellite Conference, Ethnicity & Mental Health in Europe

124 Machleidt (2003). Psychosocial issue in the treatment of migrants. In Lecture at the DTGPP Satellite Conference, Ethnicity & Mental Health in Europe

125 Health for all, all in health (2002). Report phase I. "Preparatory measures aimed at combating and preventing discrimination"

126 Cambridgeshire Drug & Alcohol Action Team (2008). Substance Misuse in Ethnic Minority and Migrant Worker Communities from a draft of the Adult Drug Treatment System Needs Assessment

they were worried about violence (63%) and health (52%). 33% thought that an increase in the alcohol use of migrant workers was taking place since arriving in the UK.

Bridgegate in Peterborough and Wisbech have spent five years working towards developing drug services¹²⁷. They describe complex needs around drug misuse including racial discrimination, exploitation, poor working conditions, unemployment, social and economic exclusion, difficulty accessing services and language support, poor family backing and social networks and pre-conceptions of treatment.

Anecdotal evidence suggests that migrants who are working below their skill level and are underpaid are at greater risk of alcohol misuse that can lead to alcohol dependence and mental health issues. In addition one of the results of alcohol and drug misuse can be an increase in domestic violence. Commonly the victims, who are often financially dependent on the perpetrator don't know where to get help and how to access services.

8.5 NEW COMMUNITIES

The *JSNA on New Communities* describes the importance of environmental factors, both physical and social on health and wellbeing and makes recommendations to support mental wellbeing when planning new communities.

There is clear evidence that environmental factors influence health. Many studies identify the effects of poverty, poor housing, work environments and social class as key determinants of health. Durkheim in 1897 described the relationship between social integration and patterns of mortality, especially suicide. Subsequent authors have also confirmed that collective characteristics of communities and societies determine population health status.

The importance of social integration/cohesion is confirmed by a series of studies through the 1970s and 1980s showing that lack of social ties or social networks predicted mortality from almost every cause of death. The focus on 'social' indicates an ecological characteristic external to the individual, reinforcing the importance of looking at the external environment rather than individual characteristics.

Publications reflecting on the lessons from previous New Town developments identified the creation of community as a fundamental New Town objective but also highlighted the tendency for 'built environment' design and physical issues to dominate the planning process, with community and social provision falling off the agenda. These reports identified social facilities and community infrastructure as key requirements.

The term 'New Town Blues' is used to describe the feelings of people who had recently moved into new communities particularly where large new settlements had been built rapidly, and lacked a sense of history, community, and tradition. Reports of loneliness and problems of adjustment faced by families are symptomatic of this syndrome. However, the evidence is mixed as to whether this phenomenon is unique to the New Towns, or whether it was a more widespread occurrence in many different communities in different towns and cities. The report on New Towns concluded that although there were challenges in creating communities, "the existence of 'New Town Blues' appears to have been short-lived, if it existed at all."

However, the need to put in place mechanisms for building social capital and for community support in order to create a sense of belonging for people was identified. Voluntary organisations and the church were seen as means to encourage integrated communities. Posts were developed by corporations involved in the delivery of New Towns in order to foster social relationships, social liaison and community development with a neighbourhood

127 Fenland District Council (2007). Fenland Migrant Population Strategy 2007-2010

base. Their aim was to support the emergence of social networks between the new residents and help them settle into their new homes.

The study concluded that despite the dearth of prospective research about the effectiveness of community workers in improving health and wellbeing, the overwhelming weight of published evidence suggests that more can be done to create safe and healthy communities, particularly when a significant proportion of people move into new locations.

It will be necessary to ensure people (new and existing communities) are informed and involved and supported in decision making in order to create cohesive, healthy communities. This is a core foundation block in building a healthy environment and must be given equal weight with the physical environment. Evidence indicates that a failure to do so will disadvantage people and expose the new community to an avoidable excess risk of distress and disease.

8.6 LEARNING DISABILITY

When reading this section please also refer to the *Adults with Learning Disabilities JSNA*

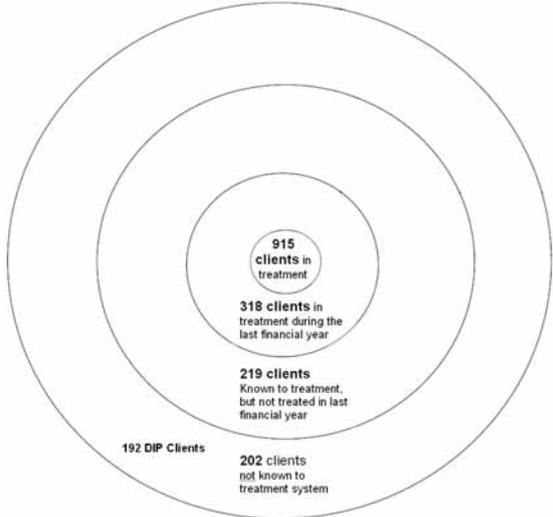
The increase in prevalence of people with learning disabilities in the population is largely due to improved life expectancy – people with learning disabilities are living longer as are those without learning disabilities. This has meant that those illnesses commonly associated with later life, such as dementia, are increasing in prevalence. However, life expectancy still varies depending on the severity of the person's learning disability and sometimes the cause. Thus, the picture is complex and there are many unknowns. In general the life expectancy of those people with mild learning disabilities is approaching that of the rest of the general population and like the general population it is influenced by well recognised socio-demographic factors. People with more severe learning disabilities and/or specific causes for their learning disability may still have a reduced life expectancy – for example, the mean life expectancy of people with Down's Syndrome is approximately 55 years and people with Prader Willi Syndrome appear rarely to live beyond their 50's. For those with severe epilepsy (such as people with tuberose sclerosis) or significant physical disabilities (such as cerebral palsy), there is a risk of premature death across the lifespan. Overall it has been estimated that the number of people with learning disabilities over 65 will have doubled by 2020 and by that time the total population of people with learning disabilities will have increased by 20% and a third of the total will be 50 years or older. Given that dementia is predominately an age-related illness these observations on the increase in life expectancy need to be considered. Whilst the age-related prevalence of illness such as dementia is stable the overall prevalence and the numbers will increase as more people live into the age at risk.

There have been a number of studies investigating prevalence rates for dementia in people with learning disabilities. Such studies are not easy for a number of reasons including ascertaining all people with learning disabilities in one geographic area and the problems of diagnosis because of the person's pre-existing learning disabilities. In general, the findings are that people with learning disabilities (excluding people with DS) have an age-related pattern that is similar to that of the general population but brought forward by a few years. In one study 20% of people with learning disabilities (excluding those with DS) over 65 years had clinical evidence of dementia. People with Down's Syndrome also have an age-related increasing risk for dementia but in this case it is brought forward by about 40 years. In a study in Cambridge it was found that people with DS aged 30 and over had approximately the following rates of dementia: 1% in their 30's; 10% in their 40's; and 40% in their 50's. Other studies have found higher rates. These general observations are illustrated by the graph below.

Problem Drug Users

In the financial year 2008/09, 318 PDU clients have been in treatment in Cambridgeshire. This is an increase of 72 clients from 2007/08. 202 clients are recorded as not being in contact with treatment services but still being in contact with CDIP.

Figure 57: Treatment Bullseye: Opiate and/or Crack Cocaine users, 2008/09



Source: Treatment System NDTMS (2008/09)

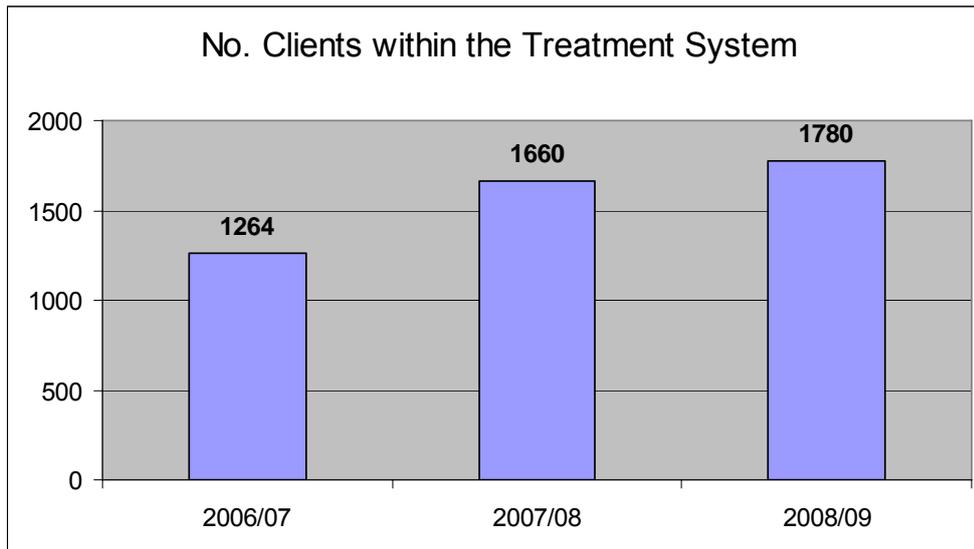
8.7 DATA FROM THE NATIONAL DRUG TREATMENT SYSTEM (NDTMS) 2008/09

A treatment map is a graphical representation of the treatment pathways available to clients. The purpose of mapping the pathway is to identify the numbers and types of clients that are flowing into, out of, and between services. This can then be used to identify areas for improvement within the system, be they to reduce barriers into treatment, maximise efficiency, or to incorporate new services to ensure more effective treatment.

Any interpretation of Cambridgeshire treatment data is difficult due to both the restructure changes within the treatment system in 2008 and the poor quality of data recorded on NDTMS. Therefore any conclusions based on the data must be taken with due care. However, it should be noted that there has been a significant improvement in data recording from the previous year. The drug treatment service delivery map in Cambridgeshire is illustrated overleaf. Please be aware that due to the fact that clients may access services from more than one agency (eg the Access Surgery and Addaction), they may be counted twice.

Each agency records the number of clients it is in contact with, which can therefore mean that some clients are recorded more than once according to the number of services they are in contact with. As a result, by adding the records from each agency from the treatment map above, we identify 1780 client records in 2008/09. However, the actual number of clients may be slightly lower than that.

Figure 58: Number of Clients within the Treatment System



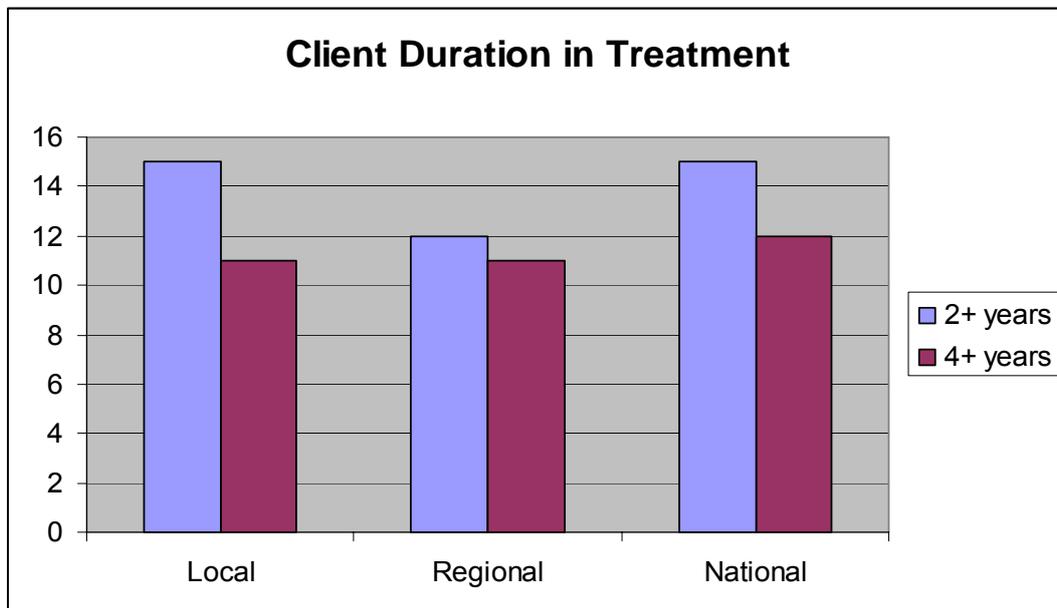
Source: Treatment System NDTMS (2008/09)

In 2008/09, according to the NDTMS, 1780 clients were in treatment, with 751 new referrals. This figure differs from the NTA's 2008/09 Green Report that indicates there were 1341 clients in treatment. The difference is possibly due to the way the data has been captured. The NTA Green Report looks at clients that have been in 'effective treatment' and the NDTMS looks at all clients recorded in treatment. The chart to the left demonstrates the increase in client numbers in treatment since 2006. This includes those sent out of county for treatment – for example, those sent to detoxification services and those in services just outside of the Cambridgeshire border. We expect that client numbers will increase further this year with the opening of new satellite centres and shifts in the focus of treatment. This can be evidenced by the examination of the 2008/09 Quarter 4 data which indicates that more clients started a new treatment journey that in the same period in 2007/08.

Figure 59: Client Duration in Treatment

Source: Treatment System NDTMS (2008/09)

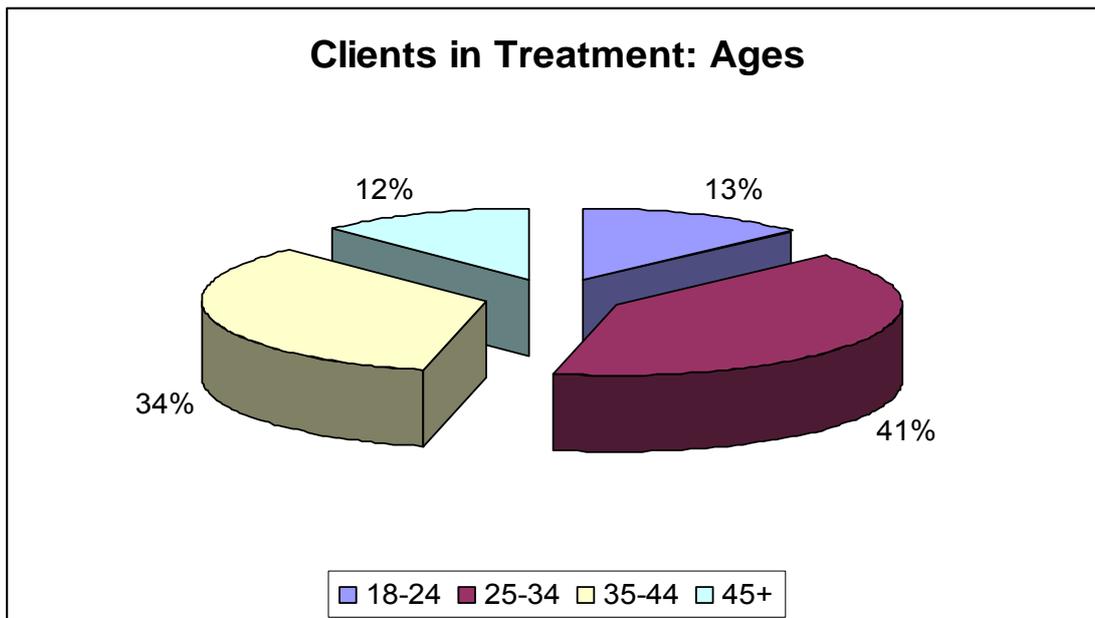
Of the 1780 clients recorded in treatment, 461 have been in treatment for over two years - representing 25.9% of the client population. 187 clients (11%) have been in treatment for over four years. This has improved from last year, when 35% of clients registered as being in treatment for over two years, demonstrating that the reconfiguration of services has helped to streamline the treatment pathway. It should also be noted that these numbers, whilst concerning, are in par with both regional and national pictures. However this is still a significant part of the treatment population, and steps should continue to be taken to improve this.



Overall, 70.5% of those in treatment were male. This balance remains the same for those in treatment over 2-4 and 4+ years. This means that there were approximately 2.4 males to every female in treatment. This is higher than the estimated national gender balance, but is in line with local data from previous years.

There has been a marked improvement in the recording of client ethnicity, with a 99.9% completion rate in 2008/09. The vast majority of clients are White (97%), with 0.5% recorded as Asian/Asian British, a further 0.5% being Black/Black British, and the remaining 2% being categorised as an "other" ethnicity. As with the gender breakdown, this balance remains similar when examining those in treatment for longer periods of time. These proportions are in line with the 2001 Census ethnicity data from Cambridgeshire.

Figure 60: Clients in Treatment – by age group



Source: Treatment System NDTMS (2008/09)

Client age breakdown remains similar to previous years. As highlighted in the chart to the right, the majority are aged between 25 and 44 years. Only three were aged over 65. This division remains similar for those in treatment over longer periods. The main drop is in those aged 18-24 years, whilst the percentage aged over 45 years actually increases (from 11.8% to 25.1%).

9. RECOMMENDATIONS

1. The comprehensive evidence base of what works to promote mental health and wellbeing in communities should be used by the range of partnerships that operate within the Local Strategic Partnerships and Cambridgeshire Together structures when developing and commissioning strategies and plans. Effective interventions for promoting mental health apply throughout the life-course and can be most effective in childhood because of the impact on a range of outcomes throughout life. The Mental Wellbeing Impact Assessment Tool¹²⁸ can be used to ensure that a programme maximises its positive impact.
2. Strengthen and extend partnership working to promote mental health and wellbeing, and provide responsive services by:
 - Obtaining views of local stakeholders on all changes to mental health services to ensure they are patient-centred and socially inclusive.
 - Working with GP Commissioning Clusters to ensure equitable provision and targeting of mental health services based on needs assessments that identify the areas and populations at greatest need.
3. NHS organisations and the Local Authority should take a lead role and work in partnership to promote a healthy workplace for their own and partner organisations.
4. Ensure equitable access to services and mental health promotion for vulnerable groups by:
 - Reviewing and implementing where appropriate the recommendations of the Bradley Report¹²⁹ to reduce inequalities experienced by prisoners.
 - Evaluating the effectiveness of alcohol pilots within A&E, homeless shelters and police stations in improving equitable access for vulnerable groups.
 - Explore best methods to engage with the Travelling communities.
5. Review the availability of counselling services for groups where evidence shows greatest benefit to include:
 - Applying learning and experience from the 14-19s IAPT pilot to implement a 'transition' service for primary care mental health
 - Ensure seamless service for those who do not meet criteria for the IAPT or secondary care services but can benefit from provision of "talking therapies".

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¹²⁸ National Mental Health Development Unit, Improving Mental Wellbeing through Impact Assessment Sept 2009. <http://www.nmhdu.org.uk/news/new-edition-of-the-mental-wellbeing-impact-assessment-toolkit/>

¹²⁹ Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694