LEICESTER CITY HEALTH AND WELLBEING BOARD

DATE 11 December 2014

Subject:	**Joint Specific Needs Assessment on Mental Health in Leicester**
Presented to the Health and Wellbeing Board by:	**Rod Moore, Acting Director of Public Health**
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EXECUTIVE SUMMARY:

1. Summary

This Joint Specific Needs Asssessment (JSpNA) is based on information gathered from a wide range of evidence and key stakeholders and overseen by a Mental Health JSpNA Steering Group. The contributors are listed on the acknowledgement pages 27 and 28.

The first draft of the needs assessment was put on the JSNA webpage for comment in May 2014 and a consultation event, attended by local voluntary and community sector organisations was held on June 18th 2014. Specific views were gathered at separate meetings with stakeholder groups, including those concerned with children and adolescents, transgender people, students, asylum seekers and refugees and homeless people.

Attention is drawn to the attached two summaries, which form the beginning of the Needs Assessment. The full needs assessment is available at www.leicester.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=511401

2. Structure

The JSpNA takes a life course approach to mental illness, beginning with perinatal mental health, followed by children, adolescents, students, adults of working age and older people. There are chapters on special topics of interest, mental health promotion, suicide and dual diagnosis. A chapter on equalities looks at the mental health of black and minority ethnic groups, asylum seekers and refugees, carers, lesbian, gay, bisexual and transgender people, homelessness, and people with learning disabilities. Veterans are also considered.

The document has a one page executive summary (p.3) and a summary of findings and recommendations (pp.5-18).

3. Findings and recommendations

The JSpNA shows that Leicester has high rates of risk factors for poor mental health. Access to services is often poor, and recovery is often worse than the local or national averages.

The Assessment sets ways in which health and social care may work together to address these issues.

Commissioners should find opportunities to deliver a joint health and social care approach to mental health and wellbeing across all areas of health care. Future commissioning should focus on:

- protecting the mental health of children and young people
- prevention of mental illness and promoting wellbeing
- population mental health
- early intervention
- personalisation and social care

The aims of a joint approach to commissioning health and social care should be to develop system wide thinking, multi-agency provision of mental ill health services and ensure that mental wellbeing underpins traditional universal services.

Most health care commissioning focuses on services at specialist level mental health services, whist most people with mental illness are treated in primary care. It is vital, therefore to ensure that commissioners of mental health and social care in Leicester improve the capacity and capability of community and primary care services to meet mental health care needs, as well as improving more specialist services.

4. Use

The needs assessment has already informed the Better Care Together Mental Health workstream. It is currently being used as the basis for the development of the Joint Health and Social Care Commissioning Strategy for Mental Health.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Receive the Joint Specific Needs Assessment on Mental Health in Leicester;
- Promote its use in shaping strategic intentions and defining specific commissioning activities to improve mental health in the city.

Appendix

Executive Summary

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

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

Suicide	In Leicester about 32 people take their own lives each year; the second highest rate in England. Most deaths are from hanging or overdose. Most at risk are males aged 35-54. There is a need for real time surveillance of information to enable better review and response to suicide.
Offenders	Prisoners and offenders have high rates of mental illness compared with the general population. IAPT and the Probation Trust work together to provide better access to mental health care. Local and specialist commissioners should learn from this model, to work together to improve mental healthcare for prisoners and offenders.
Dual Diagnosis	There is an association between mental illness and substance misuse. Mental health services should take the lead in treating people with dual diagnosis.

Key Findings and Recommendations

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

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

Key Findings

Mental health in Leicester

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

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

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

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

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

Risk factors for poor mental health are high in Leicester. Most ward areas experience deprivation. Mental illness is higher in the most deprived areas, with recorded depression being significantly higher in Aylestone, Braunstone Park and Rowley fields, Eyres Monsell, Freemen and Humberstone and Hamilton. However, recorded depression is lower in Belgrave, Castle, Coleman, Latimer, Rushey Mead, Spinney Hills, and Stoneygate ward areas. These areas have similar rates of deprivation, but are characterised by a higher proportion of residents from black and minority ethnic (BME) communities **(Recommendation1.7)**.

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

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

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

Mental Health Promotion

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

Mental wellbeing is integral to health; it is connected to physical health and behaviour. Obesity disproportionately affects people with mental illness, learning and physical

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

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

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

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

Perinatal Maternal Mental Health

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

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

Healthcare professionals (midwives, obstetricians, health visitors and GPs) should screen women for experience of past or present severe mental illness, previous treatment by a psychiatrist/specialist mental health team. They should use assessment tools such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS)

or Patient Health Questionnaire 9 (PHQ9). Public health is well placed to ensure that the development of the Health visitor service can have a positive impact on the mental health of women and families (**Recommendation 2.10)**.

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

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

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

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

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

Child and adolescent mental health

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

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

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

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

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

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

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

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

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

Child and Adolescent Mental Health Services (CAMHS) in Leicester are organised in tiers. Universal health care services and services adjacent to health care, such as schools, all have a part to play in protecting mental health. Health visitors and school nurses are well placed to prevent escalation of mental illness and to ensure that children and young people join

mental health pathways at the appropriate tier, when necessary **(Recommendation 3.3)**. Specialist services care for children with severe and enduring mental illness. They improve access to psychological therapy for children, support victims of abuse and those who have been bereaved, and can improve parenting skills.

Student Mental Health

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

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

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

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

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

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

Mental health of working age adults

Prevalence rates from national surveys show 16-18% of working age adults may experience a common mental health problem at any time. Applied to the 2011 Census population of Leicester aged 18-64 years, this equates to somewhere between 34,000 and 38,000 people. Half of adults with mental health problems have symptoms severe enough to require treatment. Common mental health problems are more frequent among females than males

(19.7% and 12.5% respectively). The estimated number of people in Leicester with serious and enduring mental illnesses, such as schizophrenia, bipolar affective disorder and other psychosis, is about 3,400 people.

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

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

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

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

Mental health of older people

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

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

Equalities and mental health

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

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

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

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

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

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

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

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

health and social care to work with colleagues and key stakeholders to improve the mental health care of carers **(Recommendation 7.4)**.

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

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

People with learning disabilities are amongst the most vulnerable members of society. They have a wide range of social and health care needs, and they may have coexisting conditions which contribute to need, such as physical or developmental disabilities, mental and physical ill-health and a range of behavioural problems. It is often the presence of these conditions that defines need for services. They also have needs which occur as a result of social exclusion, such as poverty, unemployment and lack of adequate accommodation. Health and social care commissioners should work together to consider the mental health of people with learning disabilities, when developing frameworks and care pathways. In addition, they need to work together to implement the findings of the Winterbourne View Concordat which resulted from the report into the emotional and physical abuse of people at Winterbourne View Hospital **(Recommendation 7.6; 7.7)**.

Suicide

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

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

Each case is a tragedy for individuals, their families, friends and colleagues. There is a need to support those who are bereaved by a case of suicide **(Recommendation 8.5)**.

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

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

Offenders

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

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

Studies show a higher level of need for mental health services, and worse outcomes, for offenders in the community than in the general population. There is a need to develop improved care pathways for offenders in the community and on release from prison, with particular focus upon health and social care services **(Recommendation 9.1).**

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

Dual Diagnosis

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

and the healthcare costs of untreated people with dual diagnosis are likely to be higher than for those receiving treatment.

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

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

Number	Commissioners are recommended to:	CCG	Local Authority	Other
	Promoting Mental Health and Wellbeing			
1.1	**Ensure that mental health and wellbeing is everybody's business**	**√**	**√**	**√**
1.2	**Link mental health promotion activity to all health and leisure activities**	**√**	**√**	
1.3	**Confirm commitment to renew, and endorse the spirit of, the Mental Health Charter**	**√**	**√**	
1.4	**Improve the capacity of education, workplaces and universal services to support people with mental health problems**	**√**	**√**	
1.5	**Recognise that services should be contiguous and ensure that they are not developed in isolation**	√	√	√
1.6	**Ensure that there is parity of esteem between mental and physical health care**	√	√	√
1.7	**Ensure equity of access to mental health care across all Leicester ward areas**	√	√	√
1.8	**Recognise the link between deprivation and mental illness, which has worsened with the recession and austerity**	√	√	√
1.9	**Note the similar themes in the 5 year strategy and the JSpNA on mental health in Leicester**	**√**	**√**	
1.10	**Make a commitment to mindful commissioning of services to protect mental health and challenge the stigma of mental illness in the workplace**	√	√	√
1.11	**Use mental health promotion impact assessment tools to ensure strategies and initiatives do not produce unintended negative outcomes for mental health**	√	√	√
1.12	**Influence employers in Leicester to develop robust mental health in the workplace programmes and implement strategies to promote employment of people with mental health problems**	√	√	
1.13	**Promote anti stigma messages and support action to reduce discrimination**	√	√	√
1.14	**Ensure that mental health and wellbeing cuts across all local strategies, such as economic development, transport, arts and culture and the environment**	√	√	
1.15	**Support 5 Ways to Wellbeing**	√	√	√
1.16	**Support human interventions and case management as a way of helping people back to employment**	√	√	√

1.17	**Fund specific mental health promotion projects**	√	√	
	Perinatal Maternal Mental Health			
2.1	**Develop a strategic response to perinatal maternal mental health across Leicester, Leicestershire and Rutland which ensures capacity for perinatal maternal mental health need in Leicester**	√	√	√
2.2	**Ensure that there is an integrated pathway for perinatal mental health in Leicester which covers all levels of service provision and severities of disorder and the mental health of other family members**	√		√
2.3	**Ensure that local perinatal maternal mental health service offers timely access to services compliant with NICE Guidance**	√		√
2.4	**Ensure mother and baby units for Leicester are accredited by the Royal College of Psychiatrists' quality network for perinatal services**	√		√
2.5	**Ensure all women requiring admission in late pregnancy or after delivery are admitted with their infant to a mother and baby unit not an adult mental health admission ward**	√		√
2.6	**Ensure adult mental health services counsel women with serious affective disorder about the effects of pregnancy on their condition and the possible effects of their medication on pregnancy**	√		
2.7	**Support additional training in perinatal mental health and the detection of at-risk patients for providers such as health visitors and midwives**	√		
2.8	**Create capacity in primary care to ensure that mental health promotion can be delivered effectively**	√		
2.9	**Develop a Perinatal Mental Health Outreach Team, including obstetricians, midwives, community, primary care staff, and the voluntary sector, to work across primary and secondary care to allow early identification and prevention of serious problems; plan care for antenatal period, labour, birth and the postnatal period.**	√		
2.10	**Support health visiting to identify women at risk of perinatal depressive illness**		√	
	Child and Adolescent Mental Health			
3.1	**Adopt system wide thinking to ensure that key resources are identified and properly used to improve the health and wellbeing of children (including schools and voluntary sector organisations)**	√	√	√
3.2	**Recognise that support for young people extends beyond teenage years, and should include people up to age 25**	√	√	√
3.3	**Commission a range of services to meet the needs of children, young people and parents, including more integrated work at Tier 1 and improved timely access to specialised services.**	√	√	
3.4	**Ensure all professionals involved in the identification of mental and emotional health receive training to improve the mental health care of children and young people.**	√	√	
3.5	**Work with schools and relevant services to build on efforts to increase child participation in physical activity and to promote healthy lifestyles**			
3.6	**Target prevention resources at ward areas with greater disadvantage**	√	√	
	Student Mental Health			
4.1	**Develop strategic level contact with student welfare services to develop an integrated approach to student mental health in Leicester**		√	
4.2	**Recognise and develop the role of primary care mental health for**		√	

	students in Leicester, focusing on interested clinicians, social support and good liaison with secondary care services.			
4.3	**Develop strategies to enable students to gain appropriate access to mental health services**		√	
4.4	**Investigate whether student mental health support and counselling services have any role to play in the stepped model of care for mental health**		√	
4.5	**Gain an understanding of how the specialist mental health teams in the universities work, and commission services which work in partnership with these services**	√		
Working Age Adults				
5.1	**Facilitate increased support for the involvement of service users and carers in the planning, development and delivery of mental health services**	√	√	
5.2	**Develop the crisis response, including a crisis house, to reduce the number of people with acute mental illness who are treated out of area**	√	√	
5.3	**Improve commitment to the recovery model; for instance by better support of the Recovery College**	√	√	
5.4	**Improve the capacity and capability of primary care teams to manage mental health problems as early as possible**	√	√	
5.5	**Improve timely diagnosis of mental illness**	√	√	
5.6	**Ensure that services offer non-stigmatising support for people with mental illness**	√	√	√
5.7	**Work towards delivering parity of esteem between mental and physical health**	√	√	√
Mental Health of Older People				
6.1	**Ensure mental health services are commissioned on the basis of need; recognise that the needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people**	√	√	√
6.2	**Develop an integrated approach between health, social care and voluntary and community sector services to ensure co-ordination between secondary and primary care and community services**	√	√	
6.3	**Meet the combination of mental and physical health problems which often co-exist in older people**	√	√	
6.4	**Develop a multi-disciplinary approach to older people's mental health; including integrated input from nurses, psychologists, physiotherapists, occupational therapists and speech and language therapists when necessary**	√	√	
6.5	**Ensure older people have access to crisis services, with extended hours of working and intensive crisis management, home treatment workers help to reduce the need for admission, facilitate early discharge and reduce transfer to residential care**	√	√	
6.6	**Develop older person's psychiatric liaison expertise in University Hospitals Leicester**	√	√	
Equalities and Mental Health				
7.1	**Work with key stakeholders to address the needs of people in minority communities, and ensure that they have access to the appropriate level of care and better outcomes**	√	√	
7.2	**Integrate VCS organisations which represent minority communities into the care pathways**	√	√	**√**
7.3	**Develop specialist care for transgender people**	√	√	**√**
7.4	**Work with key stakeholders to improve the mental health and**	√	√	

	wellbeing of carers			
7.5	**Ensure that the mental health care of veterans is commensurate with the obligations under the Armed Forces Covenant**	√	√	√
7.6	**Work together to consider the mental health of people with learning disabilities, when developing frameworks and care pathways**	√	√	√
7.7	**Work together for local implementation of the Winterbourne View Concordat**	√	√	√
7.8	**Establish effective multiagency partnership working, in particular integrating statutory mental health service providers with the local VCS groups involved in the care of asylum seekers**	√	√	
7.9	**Work with the New Arrivals Strategy Group to ensure that the health and social care needs of asylum seekers are included in local development plans and to promote understanding of the needs of asylum seekers**	√	√	
7.10	**Work in partnership with the Homelessness Strategy Group to develop specialist homelessness services and ensure that health and social care needs of homeless people are a considered holistically**	√	√	
Suicide				
8.1	**Work with key stakeholders to develop real time surveillance of information to enable better review and response to deaths from suicide**	√	√	
8.2	**Raise awareness about suicide and self-harm amongst the general public and professionals**	√	√	
8.3	**Support those who self-harm or who are affected by acts of self-harm**	√	√	
8.4	**Implement NICE guidelines on self-harm should be followed so that individuals who self-harm receive an assessment of need and access to relevant support**	√	√	
8.5	**Support people who are bereaved by suicide**	√	√	
8.6	**Audit local trends in order to inform local delivery and actions**	√	√	
Offenders				
9.1	**Develop improved care pathways for offenders in the community and on release from prison, with particular focus upon health and social care services which relate to mental health. This should include improved access and co-ordination with Probation Services and successor organisations**	√	√	√
9.2	**Initiate greater monitoring of services and arrangements for offenders with mental ill-health**	√	√	√
9.3	**Ensure that the mental health needs of offenders are considered and addressed by the main commissioning bodies**	√	√	√
9.4	**Develop accessible pathways into alcohol and drug treatment for offenders in the community, building on treatment which has been undertaken in prison**	√	√	√
Dual Diagnosis				
10.1	**Ensure that mental health teams take the lead in cases of dual diagnosis**	√	√	√
10.2	**Ensure that all staff in mental health and substance misuse teams are trained and equipped to work with dual diagnosis with appropriate support and supervision**	√	√	√
10.3	**Develop integrated governance, roles and responsibilities of the different agencies involved are defined by clear local protocols**	√	√	√