Staffordshire County Council

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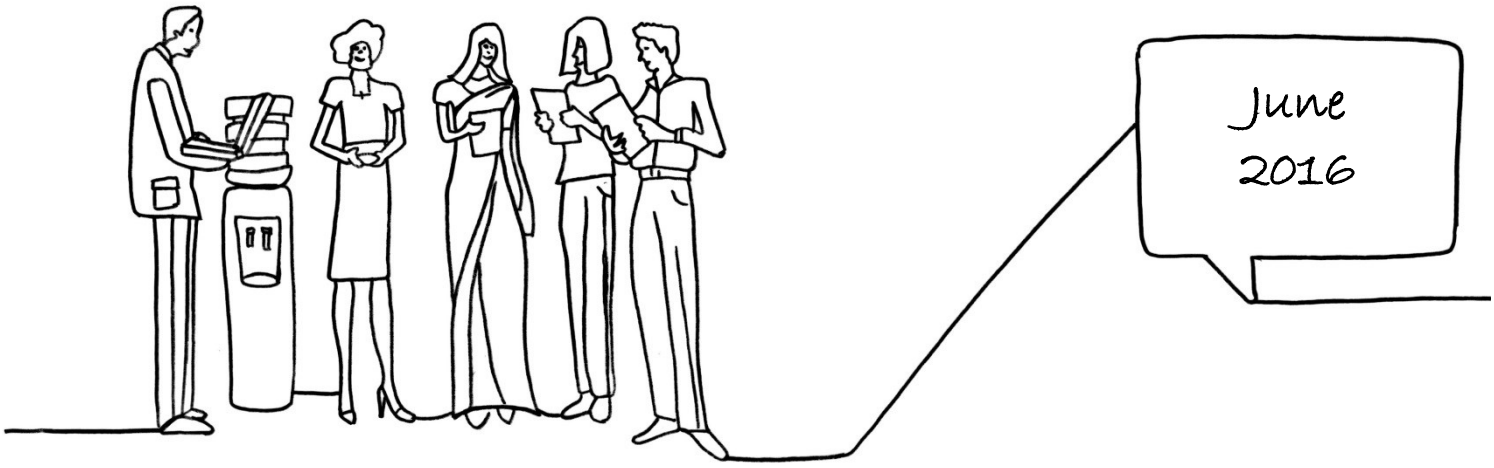
Improving mental health and wellbeing outcomes in Staffordshire: an evidence base

Insight, Planning & Performance Team



Staffordshire Observatory

Document details

Title	Improving mental health and wellbeing outcomes in Staffordshire: an evidence base
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Description	The purpose of this report is to provide health and care commissioners with an understanding of the inequalities in mental health and wellbeing outcomes in Staffordshire. It is intended to help highlight the importance of parity of esteem and the need for further integration between services that deal with mental and physical health. It should be read in-conjunction with the All-Age Disability evidence base (in production). It is one of a series of resources which contribute to the Joint Strategic Needs Assessment for Staffordshire.
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Summary

Good mental health and wellbeing is important for our physical health, relationships, education, training, work and in achieving our potential. However poor mental health is one of the biggest challenges we face today with around one in four people experiencing a mental health problem during their life time and one in six during the year. The economic and social costs of mental health problems in Staffordshire are estimated at around £1.7 billion every year.

Causes of mental illness are complex and include factors relating to the environment, personal and social circumstances and culture. Risk factors or triggers can be both the cause and consequence for poor mental health and include family breakdown, unemployment, debt or poverty, homelessness or poor housing, social isolation and loneliness, bereavement, poor physical health, long-term health conditions or disabilities, domestic abuse and drug or alcohol misuse. About half of mental health problems are established by age 14 and three quarters by age 24.

Poor mental health is common across the life-course and social gradient:

- Around 9% of children aged five to 16 in Staffordshire suffer from a mental health disorder.

- Around one in four will experience a mental health problem during their life time whilst at least one in six people are thought to experience a mental health problem during the year.

- Around 12% of Staffordshire adults aged 18-64 are estimated to have a common mental health disorder.

- Some of the most deprived communities have the poorest health and wellbeing and the highest levels of mental illness.

The complex, dynamic relationship between mental and physical health can be seen in Staffordshire, unsurprising given the ageing population and high levels of people who have their day to day activities limited by their health or disability. There are some stark differences in outcomes between those with a mental illness and the general population in Staffordshire which runs across all areas of life. Some of the inequalities include:

- People with a severe mental illness in Staffordshire are over three times more likely to die early than the general population.

- Staffordshire patients with a long-term mental health condition have much poorer health-related quality of life than people with long-term conditions and the general population.

- There is a large gap in employment rates between those with a mental illness and the general population.

- A third of people in contact with secondary mental health services do not live in settled accommodation.

- Around two-fifths of Staffordshire residents with a serious mental illness smoke. This is more than double the prevalence seen in the general population and compares with only 14% of people with a long-term condition.

- Women in Staffordshire with a severe mental health illness are less likely to have a cervical smear compared to the general population.

- Around two-thirds of people with a severe mental illness in Staffordshire do not have a record of completed physical health checks which can prevent late diagnosis of physical health conditions.

- A third of Staffordshire patients have to wait longer than six weeks for psychological therapies and 13% longer than 18 weeks, both below the national average.

- More adults in Staffordshire access secondary mental health and learning disability services than the national average.

- Overall patient experience at the two Staffordshire mental health providers is good in relation to their mental health care. However both providers score less favourably in terms of supporting patients with other areas of life such as physical health, finances, employment and accommodation.

- Around 16% of all hospital admissions also have a recorded diagnosis of a mental health condition (10% elective; 26% emergency). Emergency rates for people with a mental health condition or a severe mental illness are generally higher than the general population average. However only 3% of patients with a recognised mental health condition are admitted for their mental health condition with the remaining being admitted for a physical illness.

- Once admitted to hospital, people with a mental health condition have longer spells in hospital compared with the general population. The average cost of an admission is on average around £420 more than the general population.

- Readmission rates to hospital for people with a mental health condition are slightly higher than in the general population and only 82% of people in this cohort return to their “usual place of residence” after an emergency admission compared with 87% of patients in the general population.

- Less mental health clients using adult social care felt that services made them feel safe and secure compared with the average for all social care users.

- Stigma and discrimination are also barriers to full participation in health care, education and citizenship.

In terms of solutions to high rates of mental and physical co-morbidities, medically unexplained symptoms and reduced life expectancy for those with severe mental illness, most strategic government policies highlight the importance of parity of esteem and the need for further integration between services that deal with mental and physical health.

1 Introduction

Good mental health and wellbeing is important for our physical health, relationships, education, training, work and in achieving our potential. However poor mental health is one of the biggest challenges we face today with around one in four people experiencing a mental health problem during their life time and one in six during the year.

The economic and social costs of mental health problems in England are estimated at around £105 billion each year equating to £1.7 billion in Staffordshire. The cost of sickness absence due to mental ill-health alone to the UK economy is £8 billion (70 million working days missed each year, or an average of 2.8 days per year per employee). Mental ill-health problems also put additional costs to the education and criminal justice systems and homelessness services.

Despite the size of this cost and the degree to which mental ill-health is known to be widespread, mental health has historically not been held in the same regard as the nation's physical health needs and received less funding and policy attention than other disease areas.

People with mental health are a marginalised and vulnerable group that can experience discrimination and stigma and considerable barriers when accessing services. They also suffer from poorer health and wellbeing outcomes than the general population. On average, life expectancy for people with a mental health illness can be between 15-20 years shorter than a person without a mental health condition. They tend to have poorer physical health and are often unable to access the care they need.

Poor physical health increases the risk of mental illness, while at the same time mental ill health is associated with increased chances of physical illness. By taking account of a person's physical and mental health needs, health and care professionals are able to offer better care and improved outcomes for their patients and service users. In financial terms, at least £11 billion of NHS expenditure can be linked to just two aspects of the relationship between physical and mental health (£174 million in Staffordshire).

In order to address some of these health inequalities the "**parity of esteem"** principle by which mental health must be given equal priority to physical health was introduced in law by the Health and Social Care Act 2012.

Recovery oriented services and peer-led approaches that address underpinning factors of health inequalities will help individuals to maintain social relationships, access good housing, employment and improve wellbeing and resilience, which will have a major impact on physical and mental health.

The NHS five year forward view makes the case for further integration, namely 'triple integration' - integration of health and social care, primary and specialist care, and physical and mental health care. In March 2016, the Kings Fund published "Bringing together physical and mental health" which suggests ten priority areas for improvement (Table 1).

Table 1: Ten priority areas for improvement

Prevention/public health	1. Incorporating mental health into public health programmes 2. Health promotion and prevention among people with severe mental illnesses
General practice	3. Improving management of 'medically unexplained symptoms' in primary care 4. Strengthening primary care for the physical health needs of people with severe mental illnesses
Chronic disease management	5. Supporting the mental health of people with long-term conditions 6. Supporting the mental health and wellbeing of carers
Hospital care	7. Mental health in acute general hospitals 8. Physical health in mental health inpatient facilities
Community/social care	9. Integrated support for perinatal mental health 10. Supporting the mental health needs of people in residential homes

Source: The King's Fund, Bringing together mental and physical health, 2016

Appendix 1 illustrates Staffordshire's mental health outcomes framework. This report explores some of the inequalities seen in mental health and wellbeing outcomes that are seen in Staffordshire.

2 What are the risk factors for poor mental health?

Causes of mental illness are complex and include factors relating to the environment, personal and social circumstances and culture. Risk factors or triggers can be both the cause and consequence for poor mental health and include family breakdown, unemployment, debt or poverty, homelessness or poor housing, social isolation and loneliness, bereavement, poor physical health, long-term health conditions or disabilities, domestic abuse and drug or alcohol misuse.

Mental illness often starts early in life with early years and childhood experiences having a profound impact upon the rest of your life. About half of mental health problems are established by age 14 and three-quarters by age 24. Children at higher risk higher of poor mental health include victims of abuse or neglect, looked after children, those in contact with the criminal justice system, underachievers in school, children who have a parent with a mental illness and those living in poverty.

Older people are at increased risk of depression due to factors such as having a long-term physical health condition or disability, retirement, social isolation, loneliness or bereavement.

Poor mental health and wellbeing can lead to a more defined mental illness with many factors making it harder for people to cope. Physical activity, social interaction, leisure, involvement and awareness all contribute to a wider sense of wellbeing and belonging.

The proportion of people with a long-term physical health condition or disabilities and unpaid carers in Staffordshire is higher than average. The proportion of adults with low levels of education is also high. Estimates of higher risk drinking are also relatively high for Staffordshire. Some of the most deprived communities have the poorest health and wellbeing and the highest levels of mental illness.

Figure 1 illustrates the prevalence of selected risk factors for Staffordshire. Note: There are a number of other risk factors which are not currently included: children with special educational needs, debt, social isolation and loneliness, prisoners, people who suffer significant trauma and armed services veterans.

Figure 1: Risk factors for mental health in Staffordshire, May 2016

Compared with benchmark: Lower Similar Higher

Benchmark Value: Lowest | 25th Percentile | 75th Percentile | Highest

Indicator	Period	Staffs		Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Socioeconomic deprivation: overall IMD score (2015)	2015	-	16.4	-	21.8	5.7		42.0
Socioeconomic deprivation: % of people living in 20% most deprived areas	2014	78,626	9.1%	29.3%	20.2%	0.0%		60.5%
long-term unemployment: % of working age population	Oct 2014	1,395	0.26%	0.93%	0.61%	0.11%		2.05%
Statutory homelessness: rate per 1000 households	2014/15	500	1.4	3.4	2.4	0.1		10.4
Children in poverty: % living in low income households	2013	20,195	14.1%	21.5%	18.6%	6.1%		34.4%
Looked after children: Rate per 10,000 <18 population	2014/15	930	54.8	74.5	60.0	20.3		157.9
Children leaving care: Rate per 10,000 <18 population	2014/15	365	21.5	28.5	26.8	10.9		64.2
Domestic abuse incidents: rate per 1,000 population	2012/13	-	16.8	15.0	18.8	5.6		30.2
Higher risk drinking: % of people drinking at increasing or higher risk levels	2008 - 09	-	23.2%	21.4%	22.3%	15.7%		24.7%
Physical activity: % of population engaging in recommended levels of physical activity	2014	-	54.1%	-	57.0%	45.1%		71.2%
Long-term health problems or disability: % of people whose day-to-day activities are limited by their health or disability	2011	162,647	19.2%	19.0%	17.6%	11.2%		25.6%
Prevalence of physical disability: Estimated % of population aged 16-64	2012	63,035	11.7%*	11.1%	11.1%	8.3%		12.6%
Adults with low education: % of adults that have no qualifications or level one qualifications	2011	270,881	38.8%	40.2%	35.8%	15.8%		49.8%
Unpaid carers: % of population who provide substantial unpaid care	2011	22,413	2.64%	2.68%	2.37%	1.23%		4.03%
Lone parents households: % of households that have lone parents with dependent children	2011	21,016	5.9%	7.5%	7.1%	4.4%		14.4%
Relationship breakup: % of adults whose current marital status is separated or divorced	2011	79,079	11.3%	11.3%	11.6%	7.7%		16.3%
Household overcrowding: % of households with occupancy rating for bedrooms of -1 or less	2011	9,150	2.6%	4.6%	4.8%	1.3%		25.4%
Rented accommodation: % of all households living in rented accommodation	2011	92,241	26.0%	33.0%	34.5%	18.2%		72.7%
Use of outdoor space for exercise/health: estimated % of population	Mar 2014 - Feb 2015	-	18.2%	16.9%	17.9%	7.2%		70.3%
English Language skills: % of people who cannot speak English / speak it well	2011	4,151	0.51%	1.99%	1.65%	0.13%		8.72%
Population turnover (internal migration): Rate per 1,000 resident population	2014	57,702	67.1	77.0	90.7	48.3		206.0
Migrant GP registrations: Rate per 1,000 resident population	2014	3,019	3.5	9.0	11.7	0.2		48.7

Source: Common Mental Health Disorders Profile Tool, Public Health England http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

3 How many people have mental health conditions in Staffordshire?

Poor mental health is common across the life course:

- **Around 9% of children aged five to 16 in Staffordshire suffer from a mental health disorder equating to 10,400 children. Around 1,600 children have special education needs recorded as social, emotional and mental health.**
- **Around one in four will experience a mental health problem during their life time whilst at least one in six people are thought to experience a mental health problem during the year.**
- **Around 12% of adults aged 18-64 are estimated to have a common mental health disorder (depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post‑traumatic stress disorder and social anxiety disorder) equating to around 82,700 adults in Staffordshire.**
- **More people in Staffordshire are on depression registers than the national average. Dementia and depression are common mental health conditions among older people.**

3.1 Children

Prevalence estimates from a national study suggests around 9.2% of children suffer from a mental health disorder in Staffordshire equating to 10,400 children (Table 2**)**. Around 5.5% are thought to suffer with conduct disorders, 3.5% with emotional disorders and 1.5% with hyperkinetic disorders.

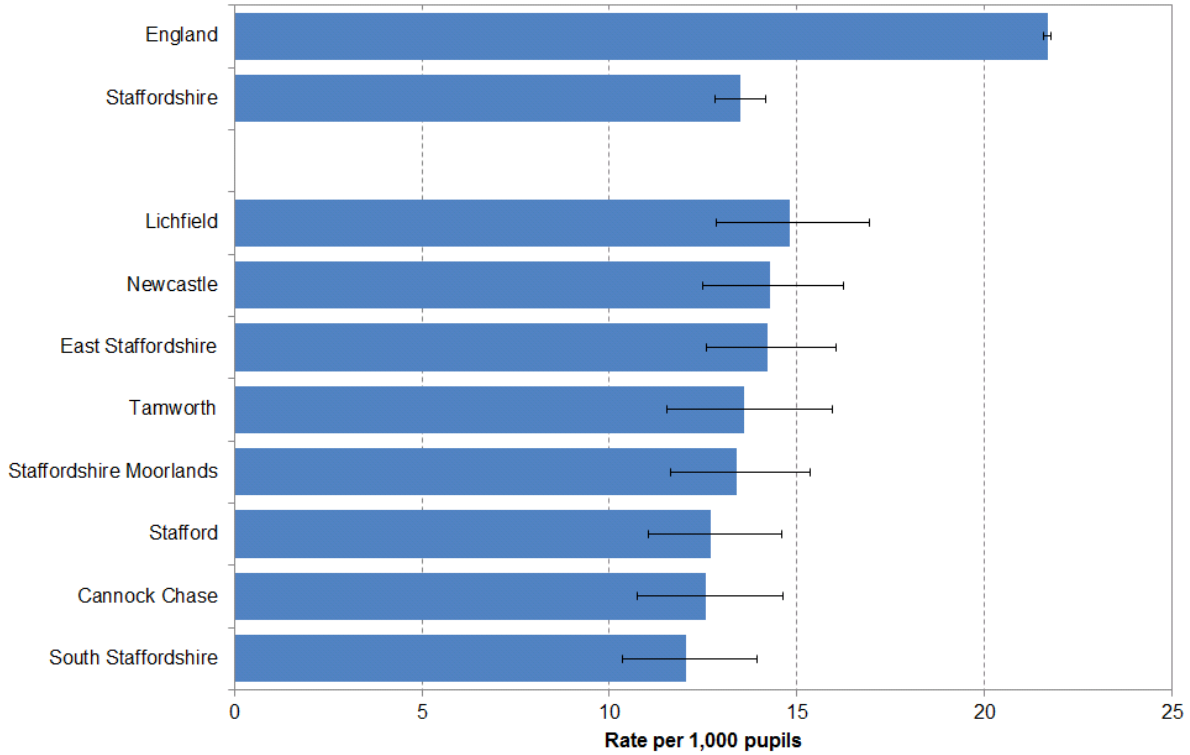
According to the January 2015 school census there were 1,600 Staffordshire pupils having special educational needs recorded as social, emotional and mental health. This equates to 14 per 1,000 pupils and is lower than the national rate of 22 per 1,000 children (Figure 2).

Table 2: Estimated mental health prevalence in children aged five to 16, 2014

	Any mental health disorder	Conduct disorders	Emotional disorders (anxiety disorders and depression)	Hyperkinetic disorders
Cannock Chase	1,310 (9.7%)	800 (6.0%)	500 (3.7%)	220 (1.6%)
East Staffordshire	1,530 (9.4%)	930 (5.7%)	590 (3.7%)	250 (1.5%)
Lichfield	1,150 (8.6%)	680 (5.1%)	450 (3.3%)	190 (1.4%)
Newcastle-under-Lyme	1,520 (9.5%)	920 (5.8%)	590 (3.7%)	250 (1.6%)
South Staffordshire	1,170 (8.6%)	690 (5.1%)	460 (3.4%)	190 (1.4%)
Stafford	1,460 (8.6%)	860 (5.1%)	570 (3.4%)	240 (1.4%)
Staffordshire Moorlands	1,120 (9.1%)	680 (5.5%)	430 (3.5%)	180 (1.5%)
Tamworth	1,100 (9.8%)	680 (6.0%)	420 (3.7%)	190 (1.7%)
Staffordshire	**10,380 (9.2%)**	**6,250 (5.5%)**	**4,020 (3.5%)**	**1,710 (1.5%)**
West Midlands	**79,600 (9.7%)**	**48,700 (5.9%)**	**30,890 (3.8%)**	**13,280 (1.6%)**
England	**694,990 (9.3%)**	**420,860 (5.6%)**	**269,580 (3.6%)**	**115,570 (1.5%)**

Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England, http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh

Figure 2: Pupils recorded with social, emotional and mental health needs, 2015



Source: School Census as at January 2015, Staffordshire County Council and Department for Education

3.2 Adults

One in four is widely cited in the UK as the number of people who suffer from a mental health problem and derives from a variety of sources, one of which is the estimate of mental ill-health in the community being between 26% and 31% of the population suffering some sort of mental disorder in a year. Based on national data, estimated numbers of adults with mental ill-health for Staffordshire are shown in Table 3.

Results from the 2014 Health Survey for England found that 26% of people in England had at least one mental illness diagnosed by a doctor, psychiatrist or other professional and that 18% reported at least one mental illness that was not diagnosed, leaving 56% with no mental illness.

Table 3: Estimates of adults aged 16 and over with mental ill-health and estimates of levels of care in Staffordshire, 2014

	Mental ill-health in the community	Attends primary care	GP identified disorder	GP refers to mental health services	Psychiatric in-patients
National estimates	**26%-31%**	**23%**	**10%**	**2%-3%**	**1%**
Cannock Chase	21,000 - 25,000	18,500	8,100	1,600 - 2,400	400
East Staffordshire	24,300 - 29,000	21,500	9,300	1,900 - 2,800	500
Lichfield	22,000 - 26,200	19,500	8,500	1,700 - 2,500	400
Newcastle-under-Lyme	27,400 - 32,600	24,200	10,500	2,100 - 3,200	500
South Staffordshire	24,300 - 28,900	21,500	9,300	1,900 - 2,800	500
Stafford	28,600 - 34,100	25,300	11,000	2,200 - 3,300	600
Staffordshire Moorlands	21,300 - 25,400	18,800	8,200	1,600 - 2,500	400
Tamworth	16,100 - 19,200	14,300	6,200	1,200 - 1,900	300
Staffordshire	**184,900 - 220,500**	**163,600**	**71,100**	**14,200 - 21,300**	**3,600**

Source: Based on figures from Goldberg, D. & Huxley, P, 1992, Common mental health disorders - a bio social model, Routledge and 2014 mid-year population estimates, Office for National Statistics, Crown copyright

Common mental health disorders include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post‑traumatic stress disorder and social anxiety disorder. The prevalence of a common mental health disorder in adults aged 18-64 is almost 12% equating to around 82,700 adults (Table 4).

Around 46,000 people (7.2% of the 16-74 population) are estimated to suffer from mixed anxiety and depressive disorders in Staffordshire. Approximately 19,000 (3%) suffer from generalised anxiety disorder and 9,000 (1.4%) from a depressive episode. In terms of perinatal mental health estimates suggest around 1,000 women support during pregnancy or postnatal period.

Table 4: Estimates of mental health for adults, 2014

	Staffordshire		Estimated England prevalence
	Estimated number	Estimated prevalence	
Any common mental health disorder: population aged 18-64	82,750	12.0%	12.5%
Mixed anxiety and depressive disorder: population aged 16-74	45,700	7.2%	8.9%
Generalised anxiety disorder: population aged 16-74	19,000	3.0%	4.5%
Depressive episode: population aged 16-74	8,900	1.4%	2.5%
All phobias: population aged 16-74	7,600	1.2%	1.8%
Obsessive compulsive disorder: population aged 16-74	4,500	0.7%	1.1%
Panic disorder: population aged 16-74	800	0.1%	0.7%
Eating disorders: population aged 16+	46,900	6.6%	6.7%
Post traumatic stress disorder: population aged 16+	21,600	3.0%	3.0%
Perinatal mental health	1,000	12.0%	12.0%

Source: Common Mental Health Disorders Profile Tool, Public Health England http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders and Projecting Adult Needs and Service Information (PANSI)

Each year the GP patient survey asks patients about mental health conditions. Results from the 2014/15 survey suggested that around one in 20 respondents reported a long term mental health problem and 12% reported feeling moderately or extremely anxious or depressed which is similar to the England average (Table 5).

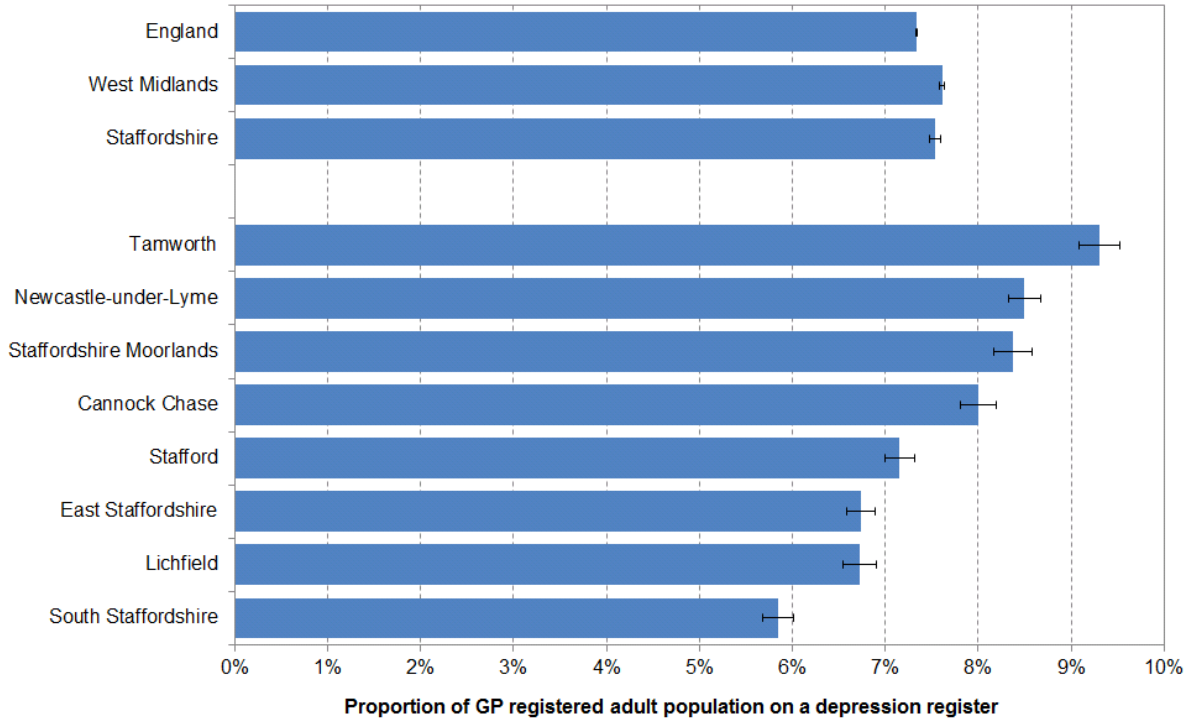
Table 5: Estimates of mental health illness from the GP Patient Survey, people aged 18 and over, 2014/15

	Respondents who feel moderately or extremely anxious or depressed	Respondents who report having a long-term mental health problem
Cannock Chase	13.8%	5.1%
East Staffordshire	11.9%	5.3%
North Staffordshire	13.5%	5.1%
South East Staffordshire and Seisdon Peninsula	11.1%	4.5%
Stafford and Surrounds	11.8%	4.1%
Staffordshire CCGs	**12.4%**	**4.8%**
England	**12.4%**	**5.1%**

Source: Common Mental Health Disorders Profile Tool, Public Health England http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

Primary care may be the only contact for some patients with mental health issues. The Quality and Outcomes Framework (QOF) register enable practices to offer prevention advice, care and treatment to a vulnerable group of patients. GP disease registers show that about 51,300 people are on a depression register in Staffordshire which is 8% of adults aged 18 and over and higher than England average (Figure 3).

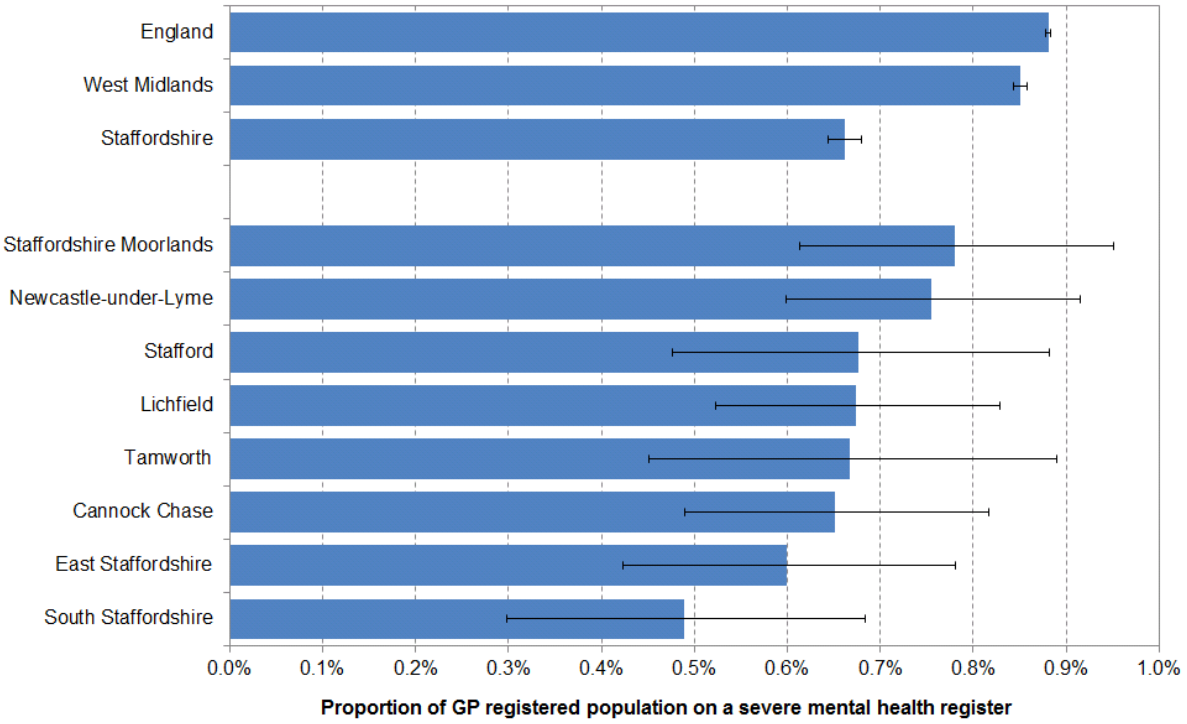
Figure 3: Recorded prevalence of depression in adults aged 18 and over, 2014/15



Source: Quality and Outcomes Framework (QOF) for April 2014 - March 2015, GPES and CQRS database - 2014/15 data extracted 10th July 2015, Copyright © 2015, Health and Social Care Information Centre. All rights reserved

GP disease registers show that about 5,600 people are on a register for a severe mental health condition (defined as schizophrenia, bipolar disorder or other psychoses) in Staffordshire which is 0.7% of the population and lower than England (Figure 4).

Figure 4: GP recorded prevalence of severe mental health conditions, 2014/15



Source: Quality and Outcomes Framework (QOF) for April 2014 - March 2015, GPES and CQRS database - 2014/15 data extracted 10th July 2015, Copyright © 2015, Health and Social Care Information Centre. All rights reserved

4 Excess mortality for people with a mental illness

Mental illness has a huge effect on life expectancy. Severe mental illnesses have a greater impact in reducing years of life than many cancers, diabetes or smoking. People with severe mental illness have life expectancies closer to those seen in low or middle-income countries than those seen in the UK.

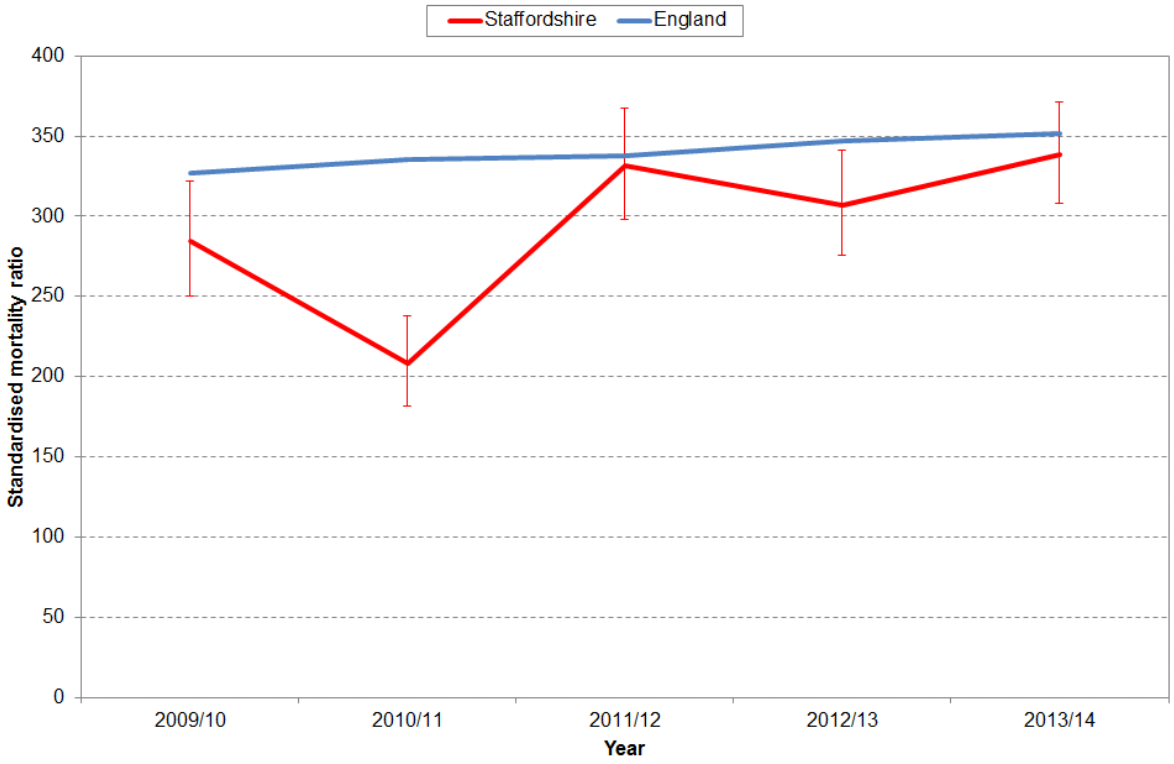
Estimates of the extent that severe mental illness has on life expectancy vary. Conservative estimates suggest that average reduction in life expectancy in people with bipolar disorder is between nine and 20 years, while it is 10 to 20 years for schizophrenia, between nine and 24 years for drug and alcohol abuse, and around seven to 11 years for recurrent depression. In comparison the loss of years among heavy smokers is eight to 10 years. Mental Health Research UK points to people with mental illness dying on average 20 years younger and mental illness accounting for nearly as much morbidity as all physical illnesses put together.

While suicide rates are undoubtedly raised in people with mental illnesses, contributing to between one-fifth and one-third of all deaths, the relative risk of mortality is still considerably raised when deaths by suicide are omitted. Further, there is considerable evidence that the incidence and prevalence of major physical diseases is higher in individuals with mental illness.

Staffordshire residents with a serious mental health illness are three times more likely to die before the age of 75 than the general population. They are over five times more likely to die from liver disease and over three times more likely to die from respiratory disease than the general population.

In Staffordshire during 2013/14 there were 434 deaths amongst people under 75 with a serious mental illness compared with an expected number of 134 deaths, giving a standardised mortality ratio (SMR) of 338. This means people with a severe mental illness are over three times more likely to die prematurely than the general population. The SMR for Staffordshire is similar to the national rate and has generally been the same over the last five years (Figure 5).

Figure 5: Excess mortality rates for adults under 75 with mental illness



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk), Copyright © 2016, Health and Social Care Information Centre. All rights reserved

In terms of the absolute numbers of death, similar to the general population, people with serious mental illness are likely to die early as a result of cancer or cardiovascular disease. People with serious mental illness in Staffordshire are over five times more likely to die from liver disease and over three times more likely to die from respiratory disease than the general population (Table 6).

Table 6: Excess mortality rates for adults under 75 with mental illness by condition in Staffordshire, 2010/11 to 2013/14

	Observed number of deaths	Expected number of deaths	Standardised mortality ratio (SMR)
Cancer	279	194	144
Cardiovascular disease	242	106	229
Liver disease	134	26	517
Respiratory disease	145	43	335

Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk), Copyright © 2016, Health and Social Care Information Centre. All rights reserved

The reasons for these reductions in life expectancy are complex and cannot be explained by a single risk factor or cause of death. Research suggests that around 60% of this excess mortality is avoidable. Table 7 lists some of the reasons for excess mortality in people with mental illness, some of which are explored further in this report.

Table 7: Causes of excess mortality in people with mental illness

- Health behaviours e.g. smoking, diet, exercise, alcohol and drugs
- Altered help seeking e.g. delayed presentation, reduced treatment adherence, poor uptake of health screening, impaired mental capacity leading to treatment refusal
- Diagnostic overshadowing' e.g. failure by health professionals to recognise physical health problems in people with mental disorders.
- Discriminatory policies
- Latrogenic factors e.g. obesity caused by antipsychotic medication.
- Social conditions e.g. homelessness, unemployment, poverty
- Suicide and violent victimisation
- Direct physical impacts of mental disorders e.g. changes to immune function

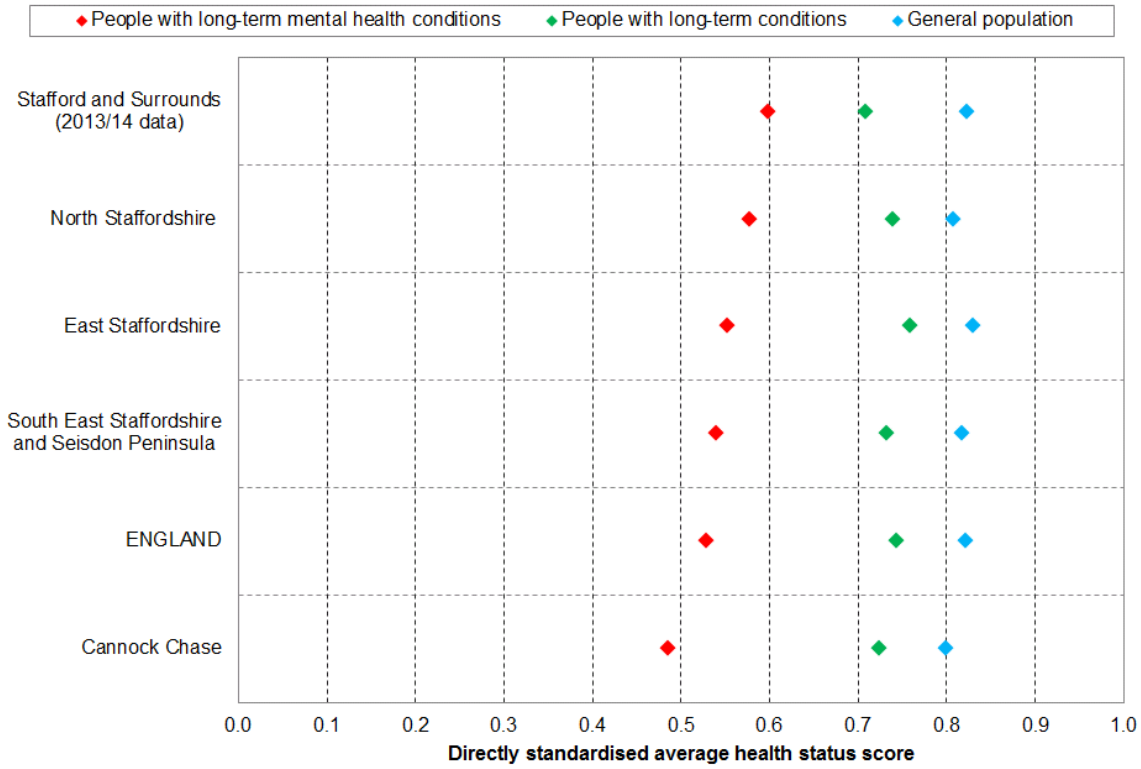
Source: Davies SC, Annual Report of the Chief Medical Officer 2013: Public Mental Health Priorities - Investing in the Evidence. Department of Health, 2014

5 Health-related quality of life

Figure 6 shows the average health status (EQ-5D™) score for individuals reporting that they have a long-term mental health condition, long term condition and all respondents to the GP survey (2014/15). This shows that across all Staffordshire CCGs patients with a long-term mental health condition report a worse health status than not just all respondents but also those with long term conditions. The largest gap is in Cannock Chase.

Staffordshire patients with a long-term mental health condition have much poorer health-related quality of life than people with long-term conditions and the general population.

Figure 6: Health-related quality of life, 2014/15



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk), Copyright © 2016, Health and Social Care Information Centre. All rights reserved

6 Life opportunities for people with mental health

Employment is a wider determinant of health and social inequalities. As well as the obvious links to low income and worklessness, detachment from the labour market can lead to a number of social and psychological disadvantages. People who are unemployed tend to have higher levels of premature mortality and poorer general health than those who work.

People with mental illness are less likely to be in work, leading to poorer health and wellbeing outcomes. Improving employment outcomes for adults with mental health problems reduces their risk of social exclusion and discrimination. Supporting someone to become and remain employed is also key to the recovery process. Employment outcomes are a predictor of quality of life, and are indicative of whether care and support is personalised.

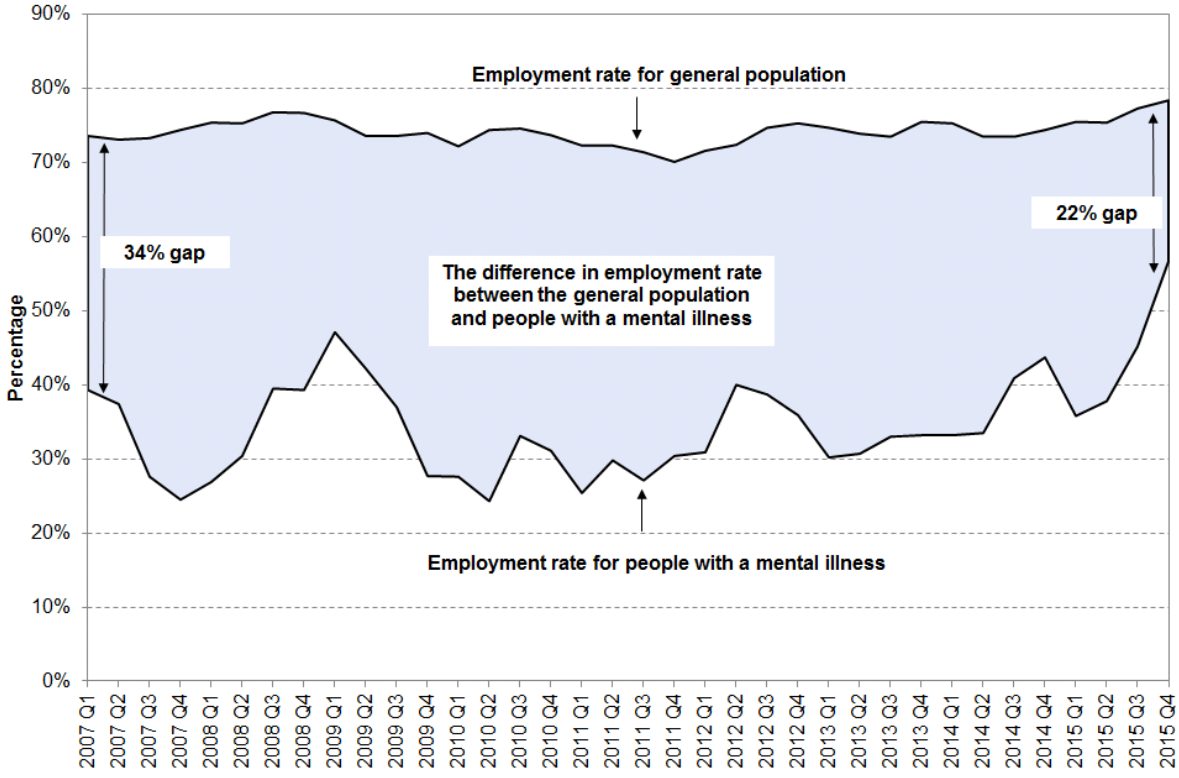
Staffordshire residents with a mental health illness are more likely to be employed compared with the national average. However there still remains a significant gap between employment rates for people with a mental health illness and the general population.

There are two key indicators of employment amongst people with a mental health illness, both showing that employment rates are better than the England average:

- Data from the Labour Force Survey suggests that the employment rate amongst people with self-reported mental illness between October and December 2015 was 57% which is higher than the national average (40%). Employment rates for people with a mental illness have been rising: from 39% at the start of 2007 to 45% at the end of 2015 (Figure 7). The difference in the employment rate between the general population and people with a mental illness reduced to 22% which is lower than the national average of 35% and a reduction of 12 percentage points from 2007.

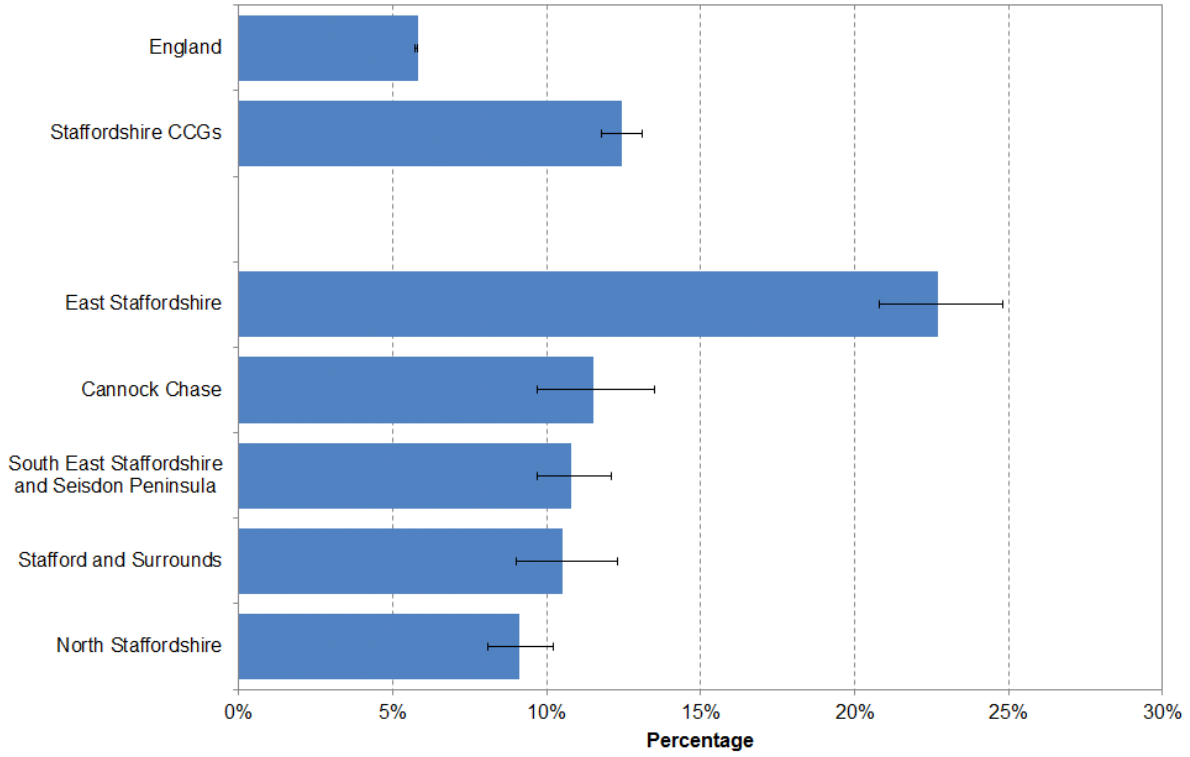
- The proportion of people in contact with secondary mental health services in employment was 12% (October 2014 to September 2015), which is higher than the national average of 6% but much lower than the Labour Force Survey (Figure 8).

Figure 7: Employment of people with mental illness



Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk), Copyright © 2016, Health and Social Care Information Centre. All rights reserved

Figure 8: Percentage of adults in contact with secondary mental health services in employment, October 2014 to September 2015



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Around two-thirds of Staffordshire adults in contact with secondary mental health services live independently which is better than the national average.

Living in stable and appropriate accommodation is also key to wellbeing, improves quality of life and is key to the recovery process for people with alcohol or substance addiction. Poor housing can have a negative impact on wellbeing and having a mental health illness can limit the housing choices due to stigma and discrimination. Good housing also improves the quality of life for secondary mental health users. It also prevents the need to admit people into hospital or more costly residential care. The proportion of adults in contact with secondary mental health services living independently was 66% in 2014/15 which is higher than the national average.

The proportion of Staffordshire residents with a mental health condition living independently in settled accommodation has fallen from last year; however due to changes in information systems there are known to be data issues with Staffordshire's data.

7 Lifestyle behaviours

There is vast evidence that people with mental illness lead less healthy lives, with higher rates of smoking, obesity, lower exercise levels, poor diet and high alcohol and drug consumption.

People with mental health are more likely to have weight fluctuations due to their dietary habits or a side effect of their medication resulting in either obesity or malnutrition, for example rates of obesity can be up to 60% in people with schizophrenia or bipolar disorder, with medications used to treat these conditions being associated with weight gain.

Not only is the prevalence of smoking higher in people with mental disorder but research has suggested that addiction to tobacco among smokers with severe mental illness is also stronger than in smokers in the general population. Evidence indicates that many patients want help to stop but often do not receive it, perhaps because of stigmatised attitudes by health professionals.

The co-existence of alcohol problems and mental ill-health is also very common, and often referred to as "dual diagnosis". The prevalence of alcohol dependence among people with psychiatric disorders is thought to be almost twice as high as in the general population whilst people with schizophrenia are three times likely to be alcohol dependant as the general population. Evidence also suggests that many people drink alcohol to help deal with anxiety and depressive thoughts.

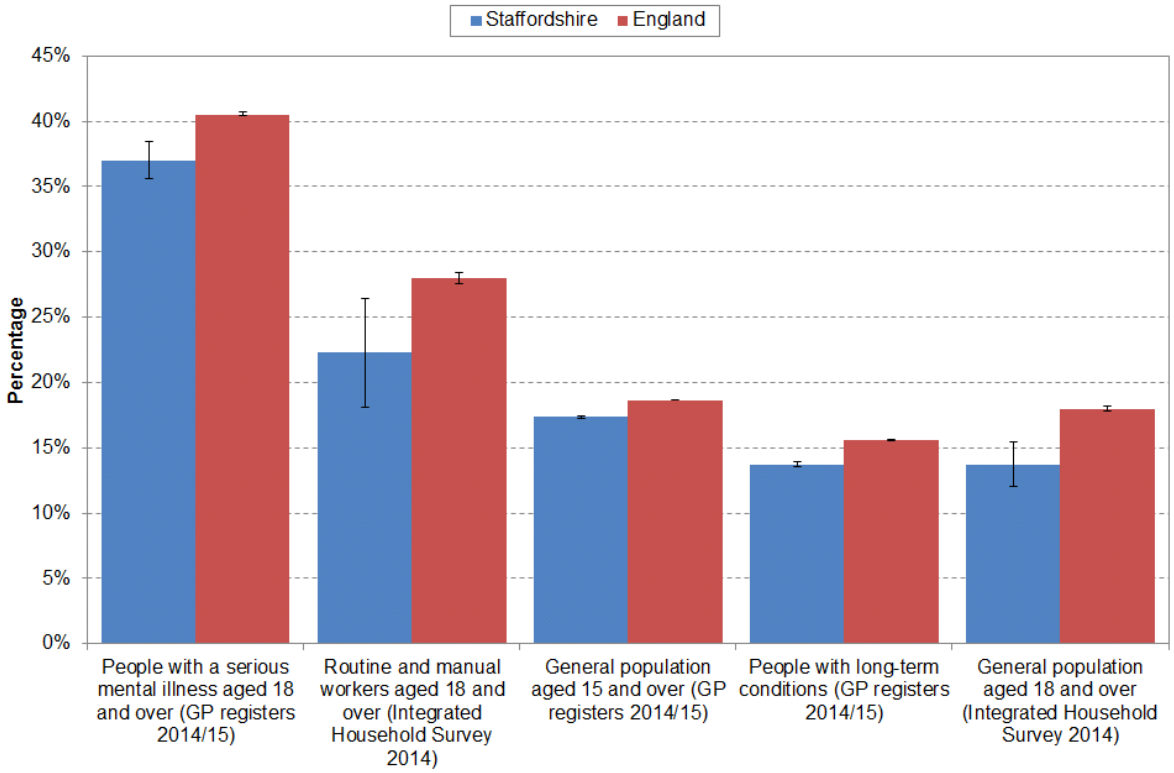
There is ample evidence on how health and care practitioners in both primary and secondary settings can support people with a mental health illness with behaviour change.

Around two-fifths of Staffordshire residents with a serious mental illness smoke. This is more than double the prevalence seen in the general population and compares with only 14% of people with long-term condition.

There is a gap in local prevalence data for other lifestyle behaviours.

Figure 9 illustrates that 37% of those registered with a serious mental illness in Staffordshire smoke which is more than double the number of people on GP registers who are known to smoke (17%). It is also much higher than people with a recorded long-term condition (14%).

Figure 9: Comparison of smoking prevalence rates, 2014/15



Note: Long-term conditions includes any or any combination of: coronary heart disease, peripheral arterial disease, stroke or transient ischaemic attack, hypertension, diabetes, chronic obstructive pulmonary disease, chronic kidney disease, asthma, schizophrenia, bipolar affective disorder or other psychoses

Source: HSCIC Indicator Portal (www.indicators.ic.nhs.uk), Copyright © 2016, Health and Social Care Information Centre. All rights reserved and Public Health Outcome Framework, Public Health England, http://www.phoutcomes.info/

Data on local alcohol consumption is not available. However data from the 2014 Health Survey for England show the proportion of people drinking at increased or higher risk between those diagnosed with a mental illness and those who had not were similar (Table 8).

Table 8: Weekly alcohol consumption in England, 2014

	Men		Women	
	At least one mental illness diagnosed	No mental illness ever diagnosed	At least one mental illness diagnosed	No mental illness ever diagnosed
Non-drinker	16%	15%	19%	21%
Up to 21 units (lower risk)	64%	64%	64%	64%
More than 21, up to 50 units (increasing risk)	16%	16%	13%	12%
More than 50 units (higher risk)	4%	5%	4%	4%

Note: No mental illness ever diagnosed includes those who reported never having experienced a condition and those who reported having experienced at least one condition but not having one diagnosed

Source: 2014 Health Survey for England, Copyright © 2015. The Health and Social Care Information Centre. All rights reserved

8 Long-term physical health conditions

Many people with long-term physical health conditions also have mental health problems. The journey a patient with a long-term condition takes is often one of loss, threat and uncertainty, which are established risk factors for anxiety and depression. Mental health co-morbidity can lead to a person's ability to manage their own condition being reduced.

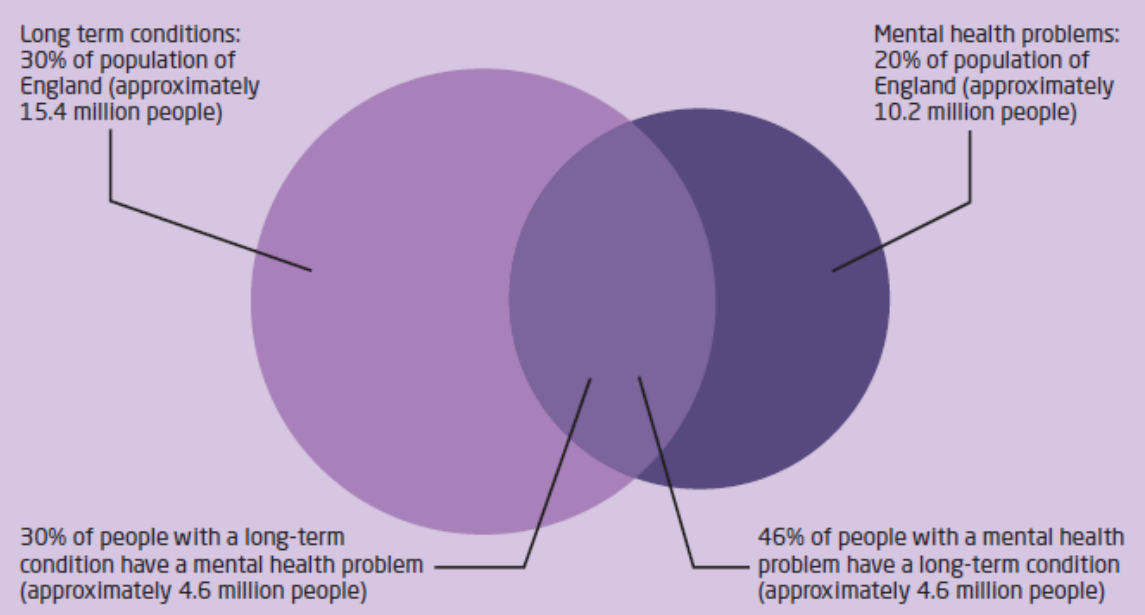
The mechanisms underlying the relationship between mental and physical health are complex, and evidence suggests that a combination of biological, psychosocial, environmental and behavioural factors may all be involved with an important point being that that the causal relationship is likely to be two-way. Evidence found that depression increases the risk of heart diseases by between 50% and 100% and a growing evidence base suggests that chronic stress has a direct impact on the cardiovascular, nervous and immune systems, leading to increased susceptibility to a range of diseases.

Research evidence consistently demonstrates that people with long-term conditions are two to three times more likely to experience mental health problems than the general population. There is particularly strong evidence for a close association with cardiovascular diseases, diabetes, chronic obstructive pulmonary disease and musculoskeletal disorders:

- Depression is two to three times more common in a range of cardiovascular diseases
- People living with diabetes are two to three times more likely to have depression than the general population
- Mental health problems are around three times more prevalent among people with chronic obstructive pulmonary disease.

Furthermore, co-morbid mental health problems are most common among those with multiple long-term conditions and those from deprived areas. Overall, evidence suggests that at least 30% of all people with a long-term condition also have a mental health problem and 46% of people with a mental health problem also have a long-term condition (Figure 10).

Figure 10: The overlap between long-term conditions and mental health



Source: Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M and Galea A, 2012. Long-term conditions and mental health: the cost of co-morbidities. London. The King's Fund

As well as serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively, costs to the health care system are also significant. By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12% and 18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing equating to between £8 billion and £13 billion in England each year and £127 million and £206 million in Staffordshire

Further work needs to be done to gather local intelligence on the prevalence of long-term conditions and mental health co-morbidity. Data collection should also include clinical outcomes where possible.

9 Health and care services

This section gives an overview of the inequalities people with mental ill-health experience in terms of health and care services particularly for physical health conditions. In addition being in contact with services does not necessarily mean that people will have their physical health needs assessed or supported.

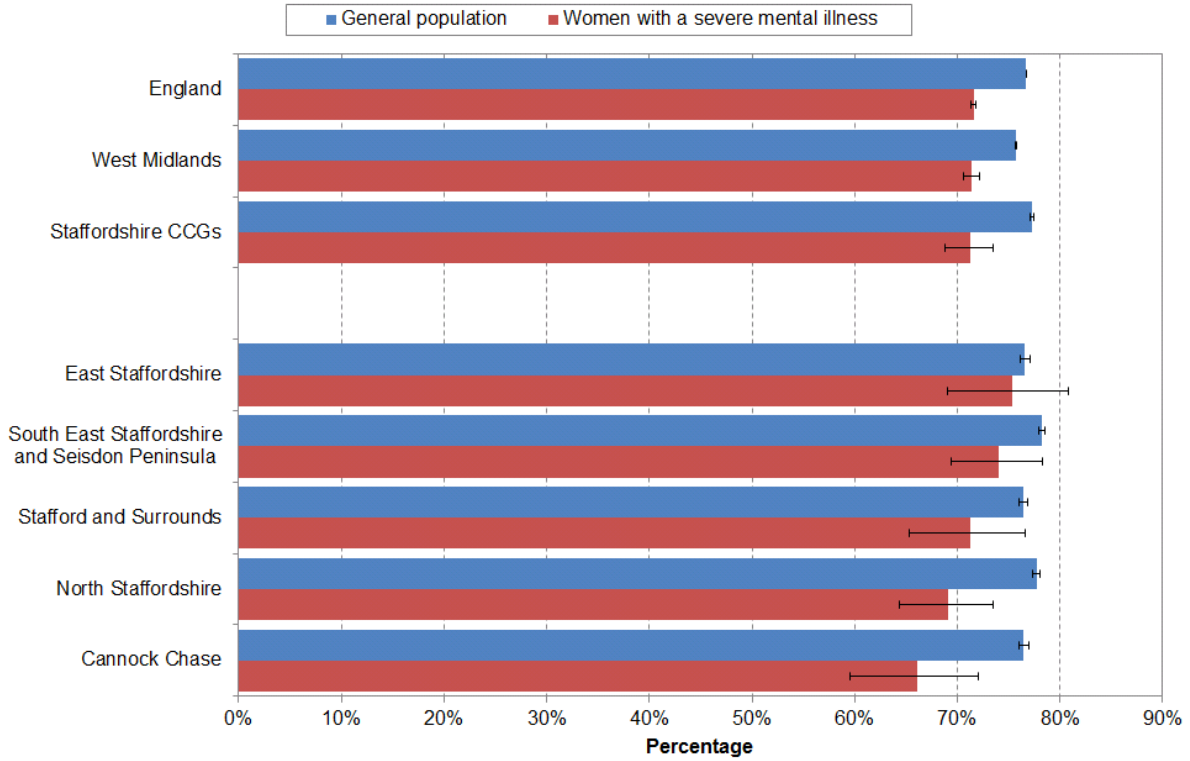
9.1 Primary care

It is estimated that 80-90% of all those with mental ill-health present for treatment in primary care. People with mental illness may be less likely to take up preventive interventions such as vaccinations or cancer screening or may present late with a physical disease.

Women in Staffordshire with a severe mental health illness are less likely to have a cervical smear compared to the general population.

- Only 71% of women with a severe mental illness aged 25-64 had a record of cervical screening in the last five years compared with 77% of women in the general population (Figure 11).

Figure 11: Cervical screening rates, 2014/15



Source: Quality and Outcomes Framework (QOF) for April 2014 - March 2015, GPES and CQRS database - 2014/15 data extracted 10th July 2015, Copyright © 2015, Health and Social Care Information Centre. All rights reserved

Around two-thirds of people with a severe mental illness in Staffordshire do not have a record of completed physical health checks which could prevent late diagnosis of physical health conditions.

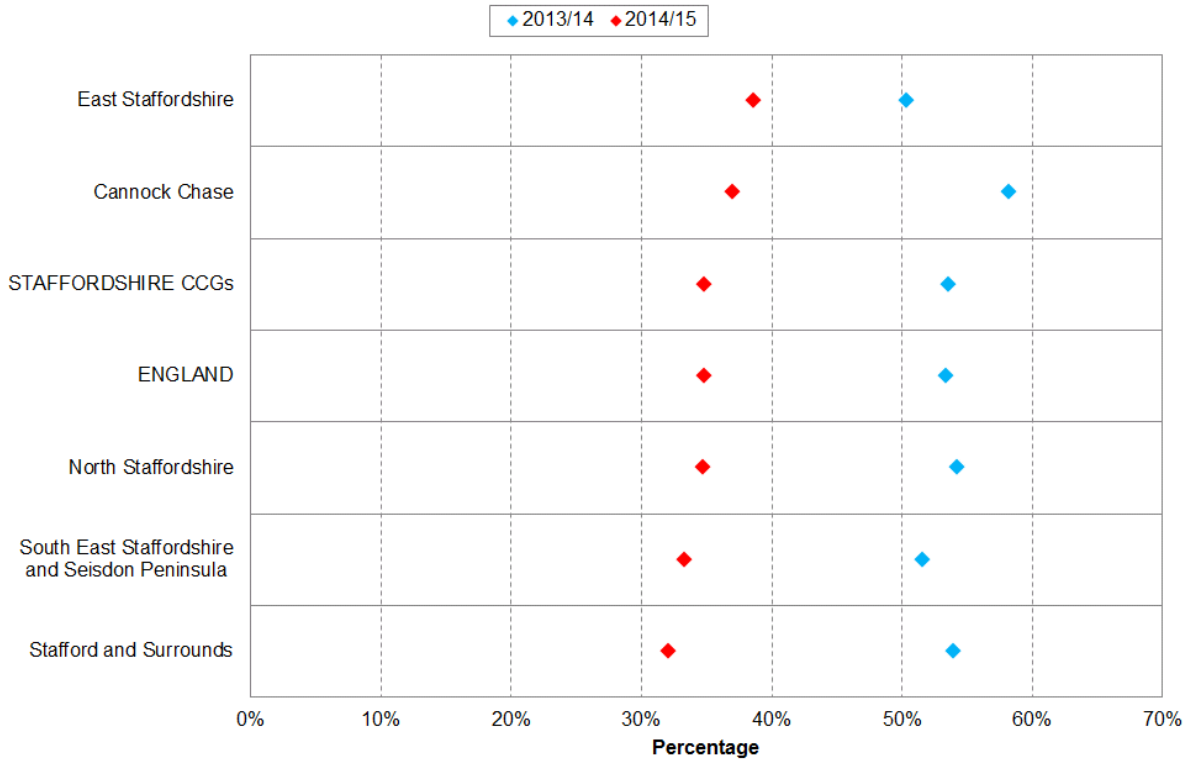
One of the key CCG outcome indicators in terms of preventing premature mortality is the proportion of people with a serious mental health illness who have had a number of physical health checks depending on their age:

- body mass index (BMI)
- blood pressure
- ratio of total cholesterol : high-density lipoprotein (hdl) cholesterol or "good cholesterol." (people aged 40 and over with a cardiovascular disease)
- blood glucose or HbA1c (glycated haemoglobin) (people aged 40 and over)
- alcohol consumption
- smoking status

During 2014/15 only 35% of patients in Staffordshire received all physical health checks meaning almost two-thirds of patients with a serious mental illness did not have a record of completed age-specific physical health checks. In addition the proportion of people with a serious mental illness who received all health checks in Staffordshire has reduced significantly from 54% in 2013/14 to 35% in 2014/15.

All six physical checks were included in the QOF for the period 2013/14. QOF indicators for recording cholesterol, blood glucose, and BMI were retired with the 2014/15 QOF release. Between these two periods the overall activity reported has reduced considerably. It is not clear whether this reduction is due to the actual checks not being performed or not being recorded.

Figure 12: Physical health checks for people with a severe mental illness



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What is not known is whether this is due to discrimination within primary care or failure of people with a serious mental health illness to take up their offer of preventative care. However, either way this can lead to late presentation of physical health conditions.

9.2 Access to psychological therapies

Accessing the right treatment at the right time can mean recovering well from a mental health problem. The Improving Access to Psychological Therapies (IAPT) program is a large-scale initiative that aims to increase the availability of recommended psychological treatments for depression and anxiety disorders.

For psychological therapy, for example, a MIND service user survey showed that over 12% of people wait longer than a year to start treatment, while 54% wait longer than three months. Comparing this to the general population, during 2014 89% of admitted and 96% of non-admitted patients started their treatment within 18 weeks of referral.

A third of Staffordshire patients have to wait longer than six weeks for psychological therapies and 13% longer than 18 weeks, both below the national average.

Until recently mental health services had an exemption from the 18-week maximum waiting time for services. However from April 2015, the NHS introduced access and waiting time standards for mental health services with the IAPT target being "*treatment within six weeks for 75% of people referred to the Improving Access to Psychological Therapies programme and 95% of people being treated within 18 weeks*".

- During 2014/15, the percentage of referrals entering treatment within six weeks in Staffordshire was 63%, lower than the national average of 79%, meaning a third of patients had to wait longer than six weeks. The percentage of referrals entering treatment within 18 weeks was higher at 87% but still lower than both the national target of 95% and the England average of 96%.

- The government target for recovery for 2014/15 was that 50% of referrals to IAPT services should move to recovery by the end of their course of treatment. During 2014/15 Cannock Chase CCG reported the highest recovery rates in the Country (65% compared with 43% across Staffordshire and also 43% nationally) whilst East Staffordshire CCG reported one of the worst in the Country at 19%. North Staffordshire and South East Staffordshire and Seisdon Peninsula CCGs also have lower than average recovery rates during 2014/15.

New targets for other mental health pathways are also being introduced, for example data collection for waiting times for early intervention in psychosis was introduced from January 2016.

9.3 Secondary mental health services

Some people with more serious or complex psychiatric disorders need additional support that cannot be provided by primary care services and are often referred to secondary mental health for more specialist care. This can include community mental health teams, hospital care or support from other mental health service providers.

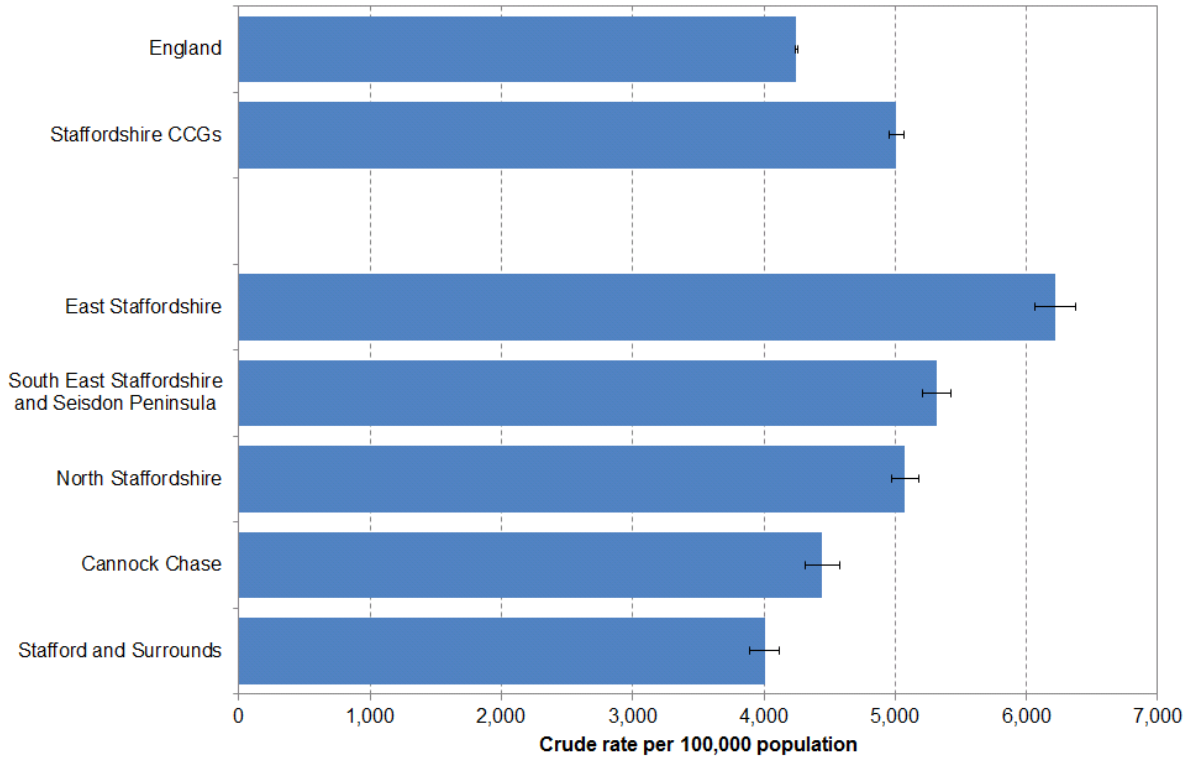
More adults in Staffordshire access secondary mental health and learning disability services than the national average.

- During 2014/15 there were about 34,100 Staffordshire adults who received NHS-funded adult secondary mental health and learning disability services at some point during the year. This equates to around one in 20 adults and is higher than the national average.

- National data suggests that more women and older people are in contact with secondary services. With the exception of Stafford and Surrounds CCGs, all Staffordshire CCGs have higher rates of adults contacting secondary mental health and learning disability services compared to the England average (Figure 13).

- The majority of patients use either or a combination of community or outpatient care. However around 4% of Staffordshire adults in contact with mental health and learning disability services spent time in hospital during 2014/15 which is lower than the England average of almost 6%.

Figure 13: Number of adults in contact with mental health and learning disability services by CCG, 2014/15



Source: Mental Health Bulletin: Annual Statistics 2014/15, Copyright © 2015, Health and Social Care Information Centre, Community and Mental Health Team. All rights reserved

Overall the two Staffordshire mental health providers score well in terms of satisfaction and overall experience particularly in terms of care in relation to their mental health. However both providers score less favourably in terms of supporting patients with other areas of life such as physical health, finances, employment and accommodation.

The 2015 Community Mental Health Survey scores patients answers from one (poor) to 10 (good). These results show that overall experience scores of 7.3 for North Staffordshire Combined Healthcare NHS Trust (NSCHT) and 7.0 for South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) are similar to the national score of 7.9. Scores ranged from 8.6 (NSCHT) and 8.7 (SSSFT) for organising care to 5.2 (NSCHT) and 5.3 (SSSFT) for other areas of life (Table 9). Other areas of life covers key areas contributing to health and wellbeing such as advice and support on physical health needs, finances, employment and accommodation.

Table 9: Patient experience of community mental health services, 2015

	North Staffordshire Combined Healthcare NHS Trust	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Organising care	8.6	8.7
Reviewing care	7.8	7.6
Health and social care workers	7.8	7.5
Overall views of care and services	7.7	7.7
Treatments	7.8	7.5
Planning care	7.2	7.3
Overall experience	7.3	7.0
Changes in who people see	6.3	6.4
Crisis care	6.3	6.3
Other areas of life	5.2	5.3

Key: Statistically better than average; statistically worse than average

Source: Care Quality Commission 2015

9.4 Acute hospital care

People with mental health problems are also prevalent in acute settings such as Accident and Emergency (A&E) departments, out-patient clinics and in-patient wards. Research indicates that acute hospital staff often lacks the necessary training, knowledge and skills related to the recognition and management of common mental health problems. This means that mental health and wellbeing of patients are not addressed at the same time leading to poorer outcomes for acute physical illnesses for these individuals.

Unfortunately data is not currently available to link data for people with mental health conditions who use acute care services. This section therefore looks at in-patient care and identifies people with a mental health condition as those who are aged 16 and over who have been admitted to hospital with a mental health diagnosis code within their electronic record.[1] This therefore is likely to under-report the numbers of in-patients with a mental health condition where it has not been recognised or recorded.

- **Around 90 Staffordshire residents with a recorded diagnosis of a mental health condition are admitted to hospital every day – over 50 of these are unplanned admissions. This makes up 16% of all hospital admissions (10% elective; 26% emergency).**

- **People with a mental health diagnosis were more likely to have an emergency admission rather than a planned admission. Emergency rates for people with a mental health condition or a severe mental illness are generally higher than the general population average. They are also more likely to be admitted at weekends.**

- **People with mental health conditions who are admitted as an emergency are more likely to be men, older than their counterparts and from deprived areas.**

- **Only 3% of patients with a recognised mental health condition are admitted for their mental health condition with the remaining being admitted for a physical illness. Common reasons for unplanned admissions in this cohort were: injuries and poisonings (17%), respiratory disease (17%) and ill-defined (16%). Almost three in 10 people who are admitted for an ambulatory care sensitive (ACS) condition also have mental health comorbidities. Urinary tract infections are the single most common reason for a person with mental health being unexpectedly admitted to hospital.**

- **Once admitted to hospital, people with a mental health condition have longer spells in hospital compared with the general population. The average cost of an admission is on average around £420 more than the general population. People with a mental health condition make up around a third of all emergency bed days and 28% of all costs in Staffordshire**

- **In terms of outcomes, readmission rates to hospital for people with a mental health condition are slightly higher than in the general population and only 82% of people in this cohort return to their "usual place of residence" after an emergency admission compared with 87% of patients in the general population.**

[1] The mental health cohort is defined as any admission where there was a recorded diagnosis in any position for a mental and behavioural disorder (ICD-10 codes F00 to F99). People with a severe mental illness are defined as having a diagnosis in any position of ICD 10 F20-F39.

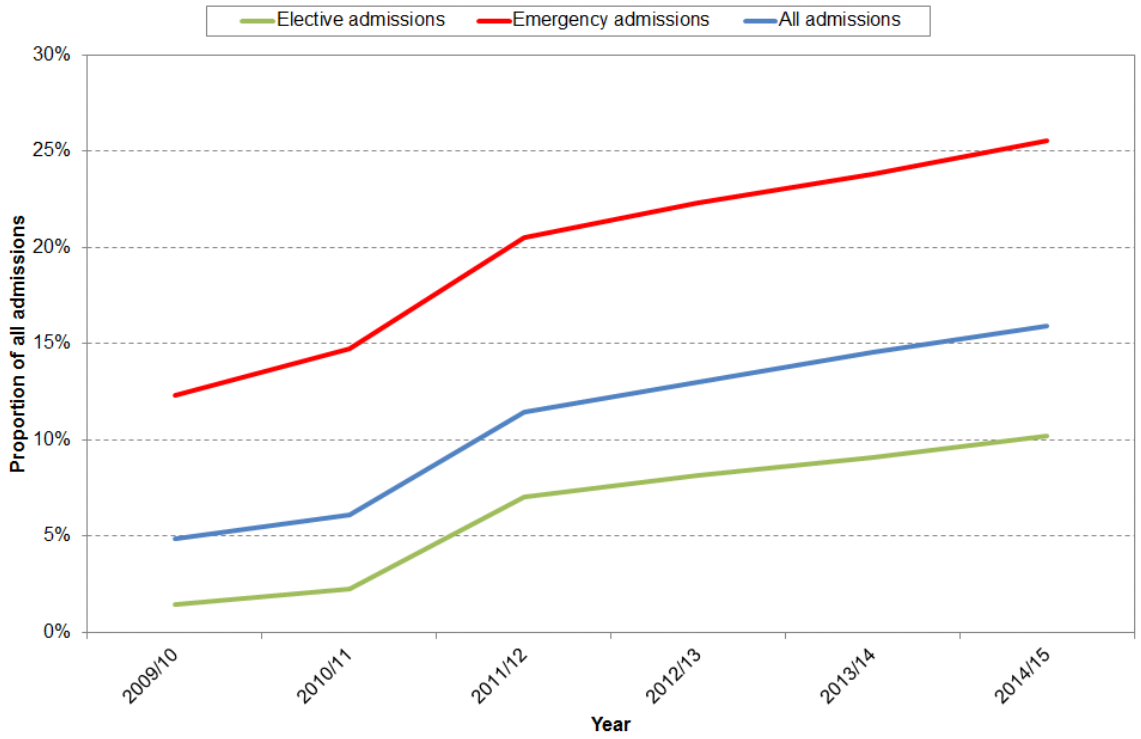
9.4.1 Trends in hospital admissions

National research indicates that the likely prevalence of people in acute settings is around one in four. During 2014/15 there were over 31,800 admissions to Staffordshire patients aged 16 and over where there was a diagnosis of a mental health condition. This makes up around 16% of all admissions (10% of elective and 26% of emergency admissions). Around 4% of all admissions (2% of elective and 6% of emergency admissions) had a recorded diagnosis of a severe mental illness (e.g. schizophrenia, bipolar disorder or psychosis).

The absolute numbers of people aged 16 and over who have a recognised mental health condition in Staffordshire increased by three fold between 2009/10 and 2014/15. This represents an 11 percentage point increase in people aged 16 and over being admitted to hospital with a mental health condition which is likely to reflect the increased awareness and recording of people presenting with an acute illness who have a mental health condition as a comorbidity within acute care settings (Figure 14).

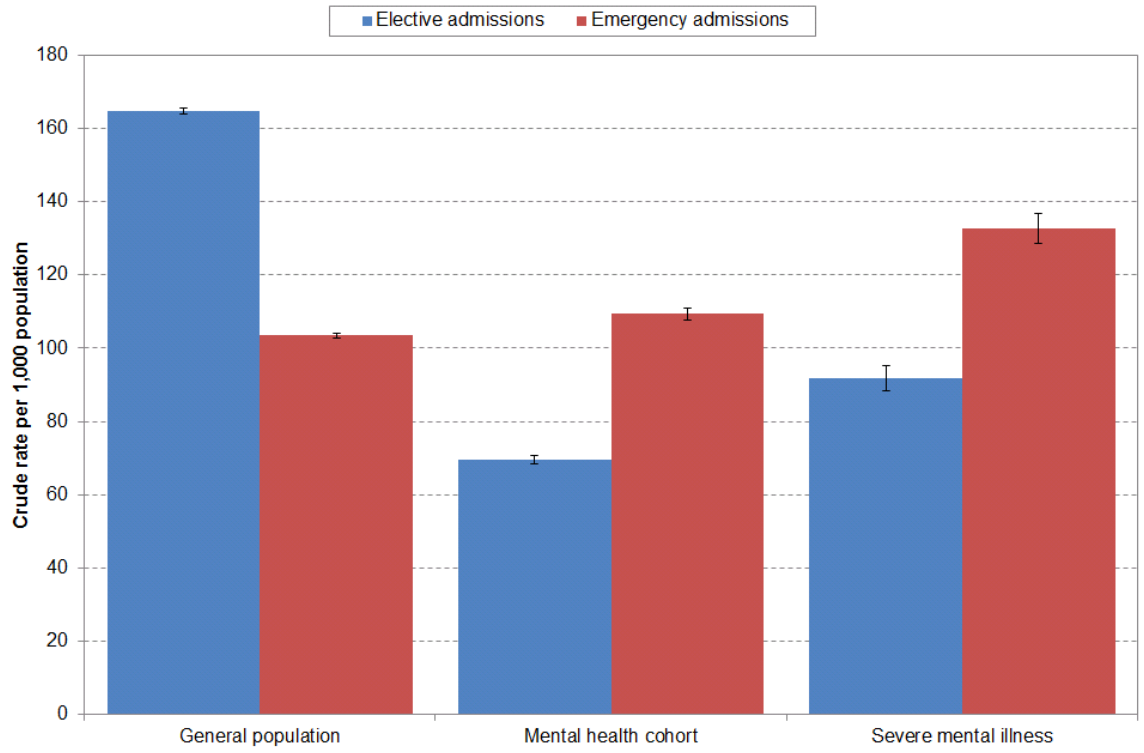
People with a mental health illness tend to use emergency care more than the general population; conversely rates of elective (planned) care are lower among people with a mental health condition (Figure 15). It is not known whether this is because people with mental health problems are less likely to access appropriate primary, community or out-patient care which could lead to increases in elective care or if physical health problems can be identified earlier and reduce the burden on unplanned care.

Figure 14: Prevalence of Staffordshire admissions for patients aged 16 and over that have a diagnosis of a mental health condition



Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit

Figure 15: Hospital admission rates for Staffordshire patients aged 16 and over, 2014/15

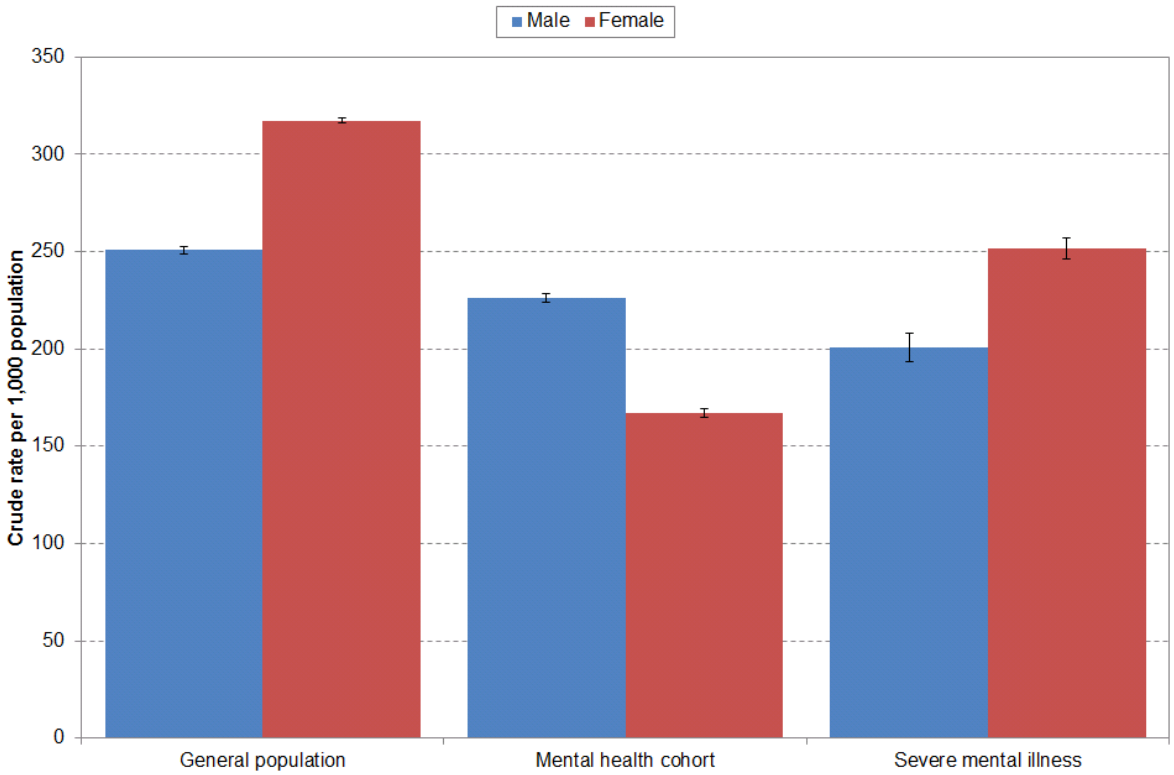


Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit, Health Survey for England 2014, Copyright 2016, The Information Centre for health and social care, All rights reserved and Numbers of patients registered at a GP practice, Health and Social Care Information Centre. All rights reserved

9.4.2 Characteristics of people being admitted to hospital

Unlike the general population, men with a mental health condition were more likely to be admitted to hospital compared with women, particularly among older age groups. However the pattern for people with severe mental illness is similar to the general population with higher rates amongst women (Figure 16). These differences in gender are observed across both elective and emergency care.

Figure 16: Hospital admission rates for Staffordshire patients aged 16 and over by gender, 2014/15



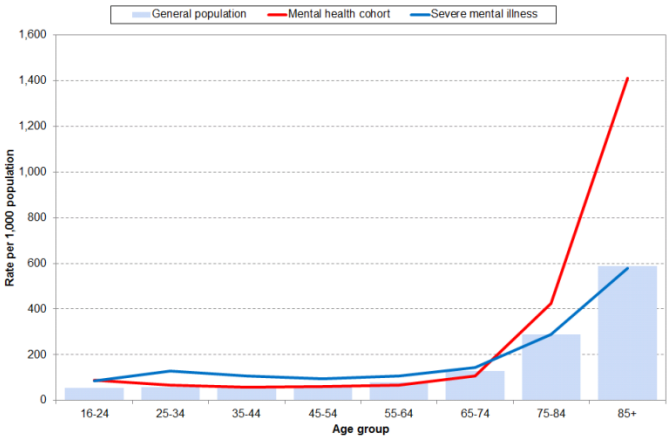
Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit, Health Survey for England 2014, Copyright 2016, The Information Centre for health and social care, All rights reserved and Numbers of patients registered at a GP practice, Health and Social Care Information Centre. All rights reserved

The age profile of people attending hospital shows that older people are more likely to be admitted as an emergency (Figure 17). The higher than average rates for unplanned admissions in the very old age groups is mostly in people with a dementia diagnosis. People with mental health condition across all age groups were less likely to receive planned care.

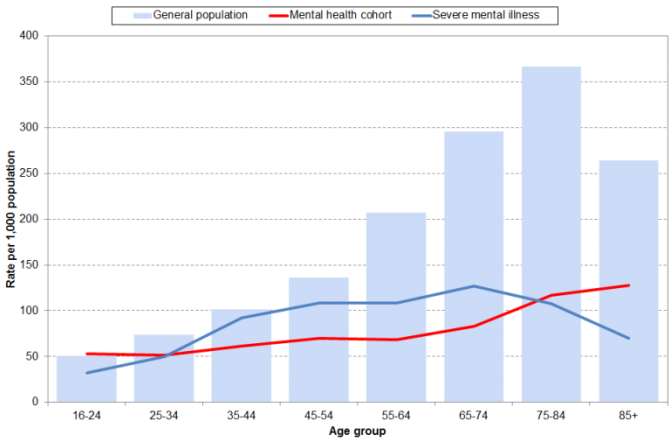
The ratio of admissions to the population shows that the mental health cohort is more likely to come from deprived areas. The ratio is even higher when looking at unplanned admissions where the number of admissions from the most deprived deciles is between 40%-60% more than the expected numbers (Figure 18).

Figure 17: Age-profile for in-patient admissions in Staffordshire, 2014/15

Emergency admissions

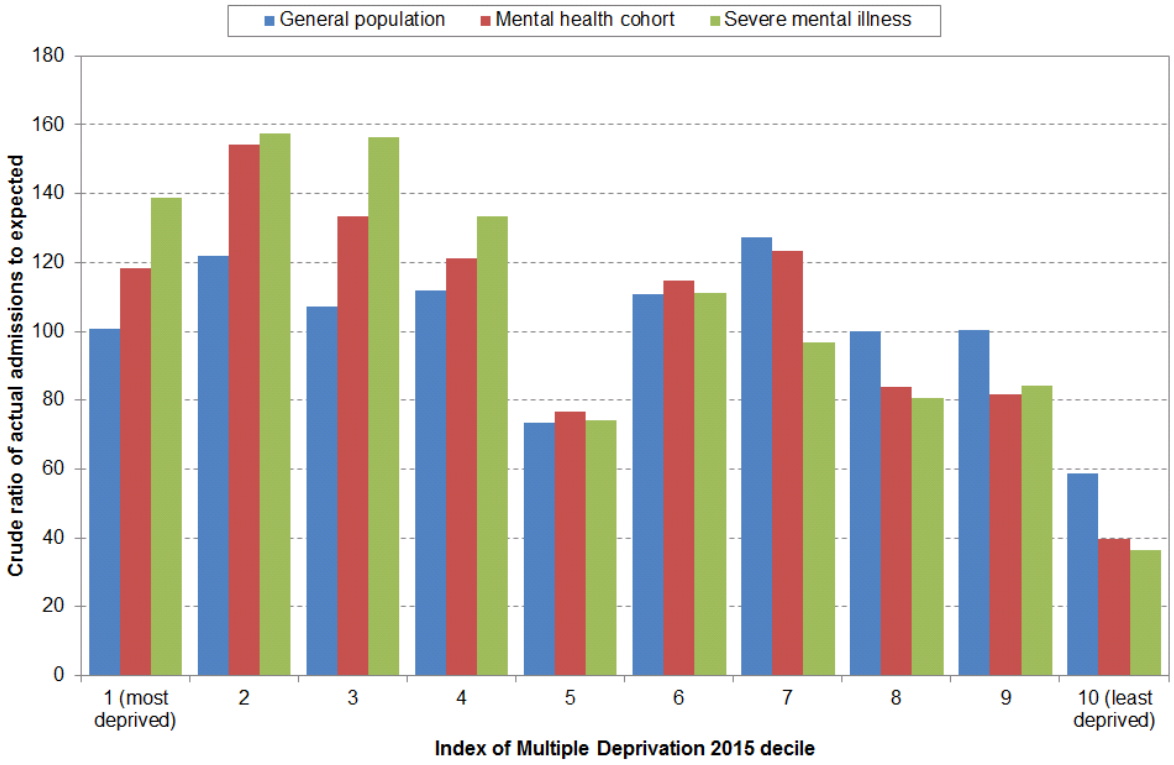


Elective admissions



Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit, Health Survey for England 2014, Copyright 2016, The Information Centre for health and social care, All rights reserved and Numbers of patients registered at a GP practice, Health and Social Care Information Centre. All rights reserved

Figure 18: Unplanned hospital in-patient admissions for Staffordshire patients aged 16 and over by deprivation, 2014/15

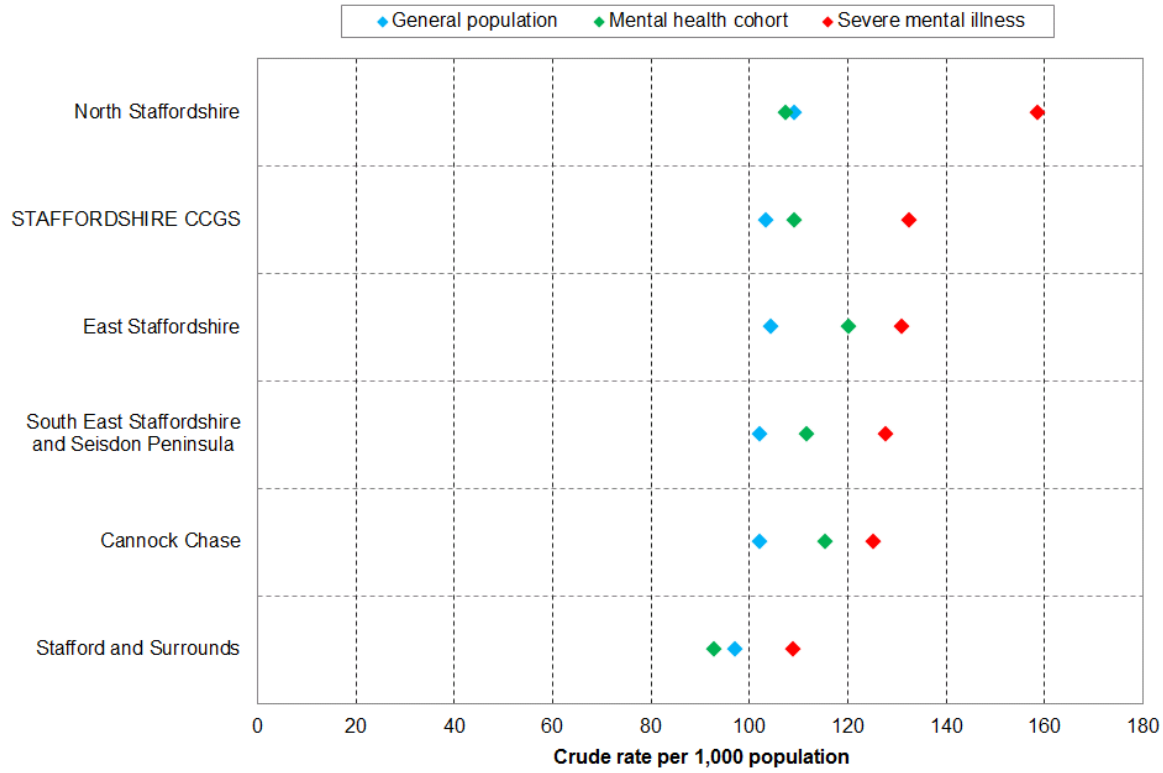


Note: A ratio above 100 means that more than expected people in the cohort are admitted, ratios below 100 means less than expected are admitted

Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit, Mid-year population estimates, Office for National Statistics, Crown copyright and Indices of Deprivation 2015, Communities and Local Government, Crown Copyright 2015

Emergency admissions in the mental health cohort and severe mental illness cohorts are generally higher than the general population across most CCGs. North Staffordshire patients in particular are more likely to be admitted to hospital with a severe mental illness compared with other CCGs (Figure 19).

Figure 19: Unplanned hospital in-patient admissions for people aged 16 and over by CCG, 2014/15



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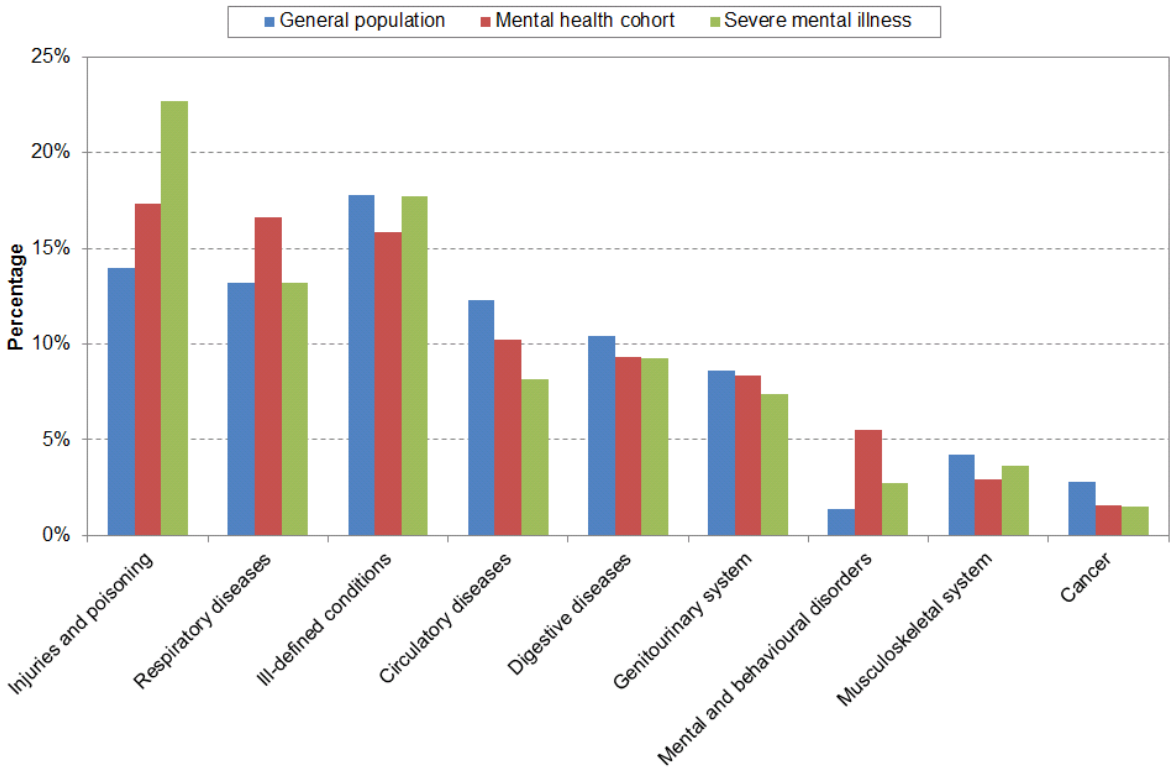
9.4.3 Why do people get admitted to hospital?

Although around 16% of admissions to hospital were for people with a diagnosed mental health condition, only around 3% of these admissions were admitted for their mental health condition with the remaining being admitted for a physical illness with a comorbidity of a mental health illness.

The most common primary diagnoses for admissions are digestive diseases (12%), ill-defined conditions (12%), injuries and poisonings (12%) and respiratory disease (11%). Common reasons for unplanned admissions are similar: injuries and poisonings (17%), respiratory disease (17%) and ill-defined (16%) (Figure 20).

Figure 20: Common reasons for unplanned hospital admissions for Staffordshire patients aged 16 and over, 2014/15



Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit

Table 10 shows that urinary tract infection (UTI) was the single most common reason for a person with mental health being unexpectedly admitted to hospital which is similar to the general population. People with a mental health condition make up 32% of all UTI unplanned admissions but a higher proportion of total costs and bed days in Staffordshire (40% and 43% respectively).

Table 10: Common reasons for unplanned hospital admissions for Staffordshire patients aged 16 and over by primary diagnosis, 2014/15

	Mental health cohort			General population			Mental health cohort as a proportion of total		
	Number	Cost	Bed days	Number	Cost	Bed days	Number	Cost	Bed days
Urinary tract infection, site not specified	984	£3,156,168	11,890	3,038	£7,939,879	27,410	32%	40%	43%
Lobar pneumonia, unspecified	579	£1,776,302	6,292	1,806	£5,206,034	18,258	32%	34%	34%
Unspecified acute lower respiratory infection	525	£1,175,992	4,456	1,690	£3,297,388	11,377	31%	36%	39%
Pneumonia, unspecified	485	£1,443,097	4,602	1,569	£4,418,070	14,935	31%	33%	31%
Chronic obstructive pulmonary disease with acute lower respiratory infection	447	£1,006,304	2,735	1,097	£2,423,866	6,713	41%	42%	41%
Chest pain, unspecified	359	£251,874	328	1,594	£1,124,791	1,407	23%	22%	23%
Fracture of neck of femur	300	£1,774,310	4,935	766	£4,287,862	11,728	39%	41%	42%
Poisoning: 4-Aminophenol derivatives	274	£152,106	383	500	£240,027	612	55%	63%	63%
Other and unspecified abdominal pain	264	£272,256	613	1,222	£1,141,133	1,935	22%	24%	32%
Syncope and collapse	240	£266,502	712	996	£1,004,347	2,462	24%	27%	29%
Mental and behavioural disorders due to use of alcohol : Withdrawal state	230	£241,263	1,050	230	£241,263	1,050	100%	100%	100%
Acute myocardial infarction, unspecified	211	£750,359	1,393	844	£3,066,353	5,996	25%	24%	23%
Chronic obstructive pulmonary disease with acute exacerbation, unspecified	210	£419,574	1,104	512	£1,037,142	2,663	41%	40%	41%
Tendency to fall, not elsewhere classified	200	£621,828	2,402	546	£1,482,279	5,301	37%	42%	45%
Pain localized to other parts of lower abdomen	196	£191,616	375	1,038	£988,899	1,498	19%	19%	25%
Top 15 diagnoses	**5,504**	**£13,499,550**	**43,270**	**17,448**	**£37,899,332**	**113,345**	**32%**	**36%**	**38%**
All unplanned admissions	**18,548**	**£41,830,992**	**130,374**	**72,605**	**£148,442,583**	**413,088**	**26%**	**28%**	**32%**

Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit

In terms of mental health as a comorbidity the most common reasons were substance related disorders, mood disorders and dementia (Table 11).

Table 11: Common mental health conditions associated with hospital admissions for Staffordshire patients aged 16 and over, 2014/15

	Elective	Emergency	All admissions
Substance-related disorders	57%	37%	46%
Mood disorders	23%	20%	21%
Organic disorders including dementia	4%	29%	19%
Neurotic and anxiety disorders	13%	9%	10%
Schizophrenia / psychotic disorders	1%	2%	2%
Other disorders	2%	4%	3%
All admissions	**11,789**	**18,548**	**31,849**

Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit

9.4.4 What is the burden of mental ill-health on acute care?

- Ambulatory care sensitive (ACS) conditions are those where effective management of conditions in community settings, for example in primary care, clinics or outpatients, can help prevent a need for hospital admission. High rates of ACS conditions are often early signs of poor quality of health care across the system. ACS conditions account for around one in five of all emergency admissions. Almost three in 10 people who are admitted for ACS condition have mental health comorbidities.

- The average length of stay for people with a mental illness is 4.9 days compared with 2.8 days for the general population. People with a severe mental illness also have a longer length of stay (4.1 days).

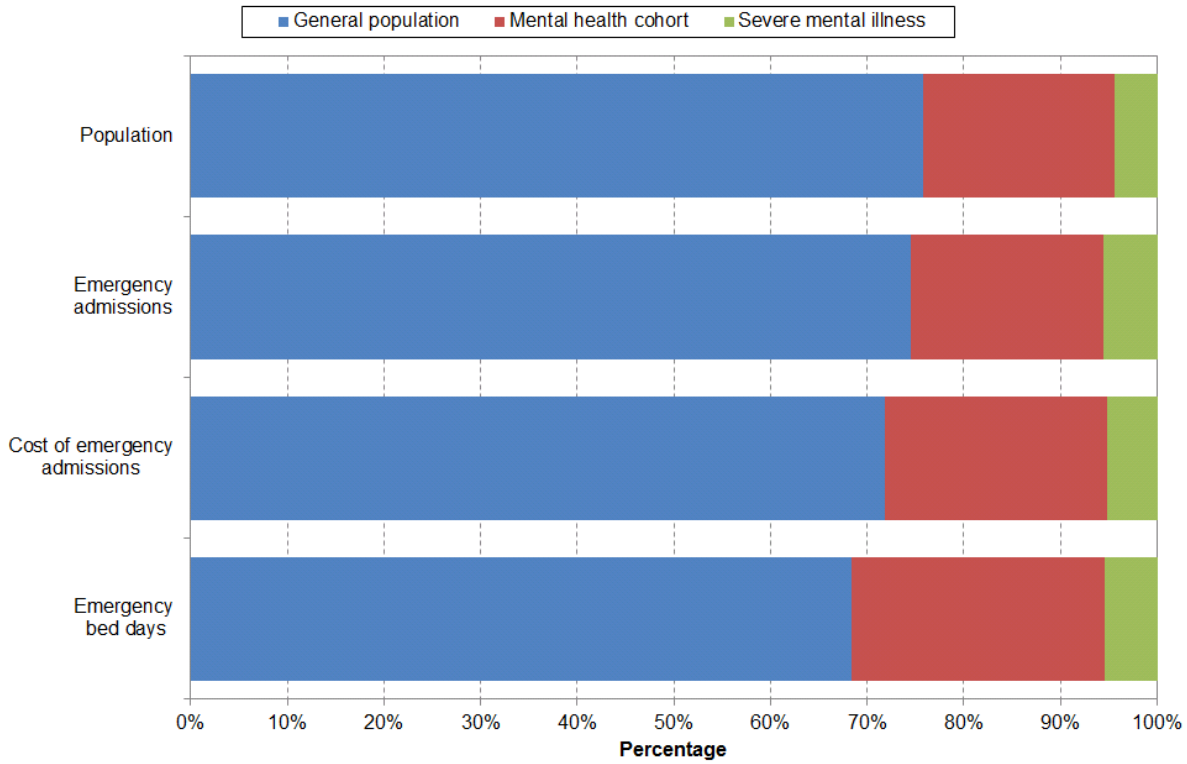
- The average cost of an admission for a patient with a mental health condition is around £420 more than the general population but ranges to around £700 for older people with a mental health condition. People with a mental health condition make up around a third of all emergency bed days and 28% of all costs in Staffordshire (Figure 21).

- A higher proportion of people with a mental health condition are admitted at weekends (18% compared with 13%).

- Around 19% are readmitted within 30 days of an emergency admission. Readmission rates for the mental health cohort are slightly higher (20%) with the severe mental illness cohort being 22%.

- Around 87% of patients who have an unplanned admission return to their “usual place of residence” compared with only 82% within the mental health cohort. The gap between people returning to their usual place of residence declines with age (69% for general population, 62% mental health cohort).

Figure 21: Population and emergency admissions for Staffordshire patients aged 16 and over, 2014/15



Source: Hospital In-patient Data Extract, Midlands and Lancashire Commissioning Support Unit, Health Survey for England 2014, Copyright 2016, The Information Centre for health and social care, All rights reserved and Numbers of patients registered at a GP practice, Health and Social Care Information Centre. All rights reserved

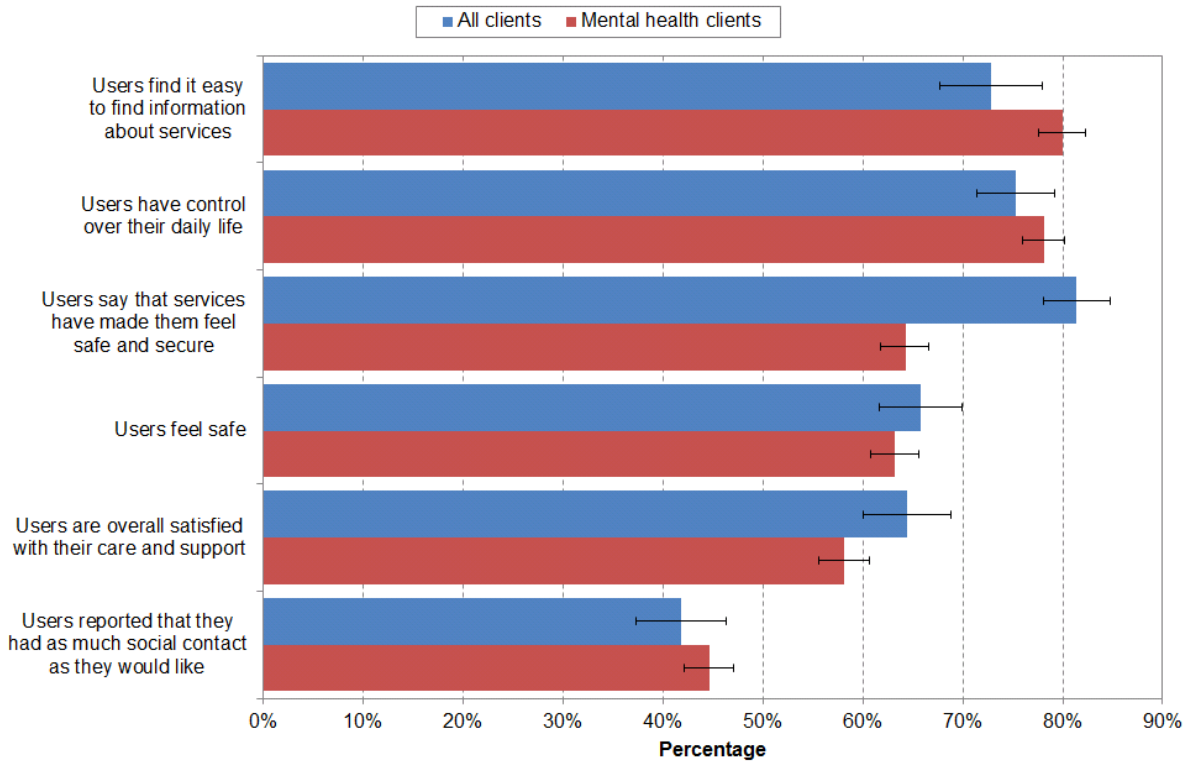
9.5 Social care

Around 1,265 adults with a primary need of mental health accessed Staffordshire County Council funded social care during 2014/15. Of these around half (670 adults) also had a dementia diagnosis. There were also around over 7,000 packages or services received by this cohort meaning that on average each client has around five to six care packages or services during the year.

Using adult social care outcomes framework (ASCOF) indicators it is possible to compare mental health and general service care users. The good news is that the majority of indicators are similar between the two cohorts (Figure 22). However less mental health clients felt that services made them feel safe and secure compared with the average.

Less mental health clients using adult social care felt that services made them feel safe and secure compared with the average for all social care users.

Figure 22: Comparison of selected adult social care outcomes between mental health clients and the general population, 2014/15



Source: Measures from the Adult Social Care Outcomes Framework (ASCOF), Copyright © 2015, Health and Social Care Information Centre. All Rights Reserved and Operational Intelligence and Performance Team, Staffordshire County Council

10 Stigma and discrimination

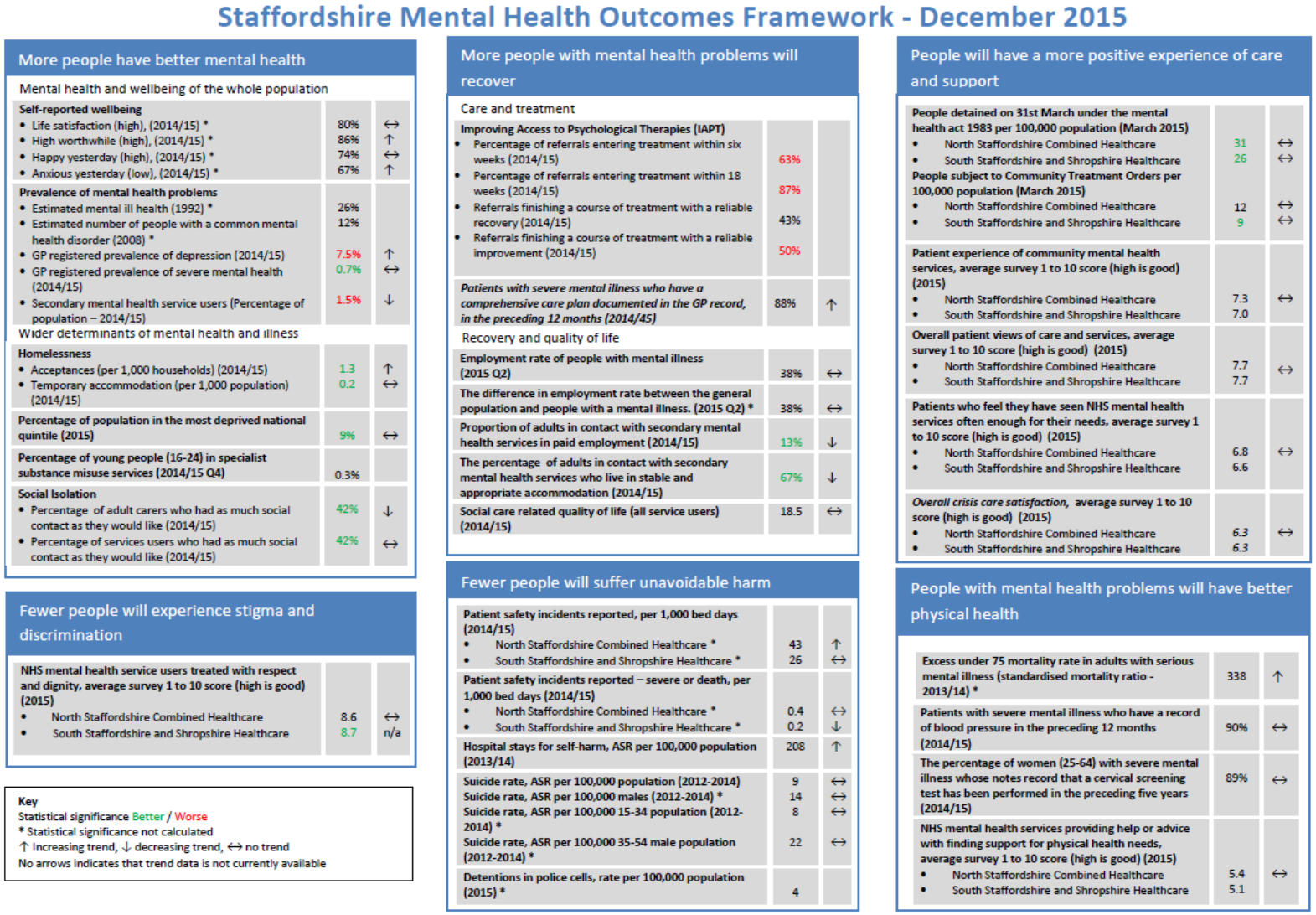
The theme of stigma and discrimination cuts across all areas. Stigma and discrimination against people with mental illness have a substantial public health impact in England which can be an important factor in maintaining inequalities, including poor access to mental and physical healthcare, reduced life expectancy, exclusion from higher education and employment, increased risk of contact with the criminal justice system, victimisation, poverty and homelessness.

Whilst there have been improvement in stigma and discrimination, especially in public perceptions of mental health, stigma and discrimination can be major barriers to full participation in healthcare, education and citizenship.

Stigma and discrimination and the effect it has are difficult to quantify and report. However users of the two Staffordshire mental health providers reported scores of 8.6 and 8.7 out of 10 for feeling that they were treated with respect and dignity (Appendix 1).

Unfortunately there is little insight into stigma and discrimination issues against people with mental ill-health in Staffordshire.

Appendix 1: Staffordshire mental health outcomes framework, December 2015



Staffordshire Mental Health Outcomes Framework - December 2015

More people have better mental health

Mental health and wellbeing of the whole population

Self-reported wellbeing		
• Life satisfaction (high), (2014/15) *	80%	↔
• High worthwhile (high), (2014/15) *	86%	↑
• Happy yesterday (high), (2014/15) *	74%	↔
• Anxious yesterday (low), (2014/15) *	67%	↑
Prevalence of mental health problems		
• Estimated mental ill health (1992) *	26%	
• Estimated number of people with a common mental health disorder (2008) *	12%	
• GP registered prevalence of depression (2014/15)	7.5%	↑
• GP registered prevalence of severe mental health (2014/15)	0.7%	↔
• Secondary mental health service users (Percentage of population – 2014/15)	1.5%	↓

Wider determinants of mental health and illness

Homelessness		
• Acceptances (per 1,000 households) (2014/15)	1.3	↑
• Temporary accommodation (per 1,000 population) (2014/15)	0.2	↔
Percentage of population in the most deprived national quintile (2015)	9%	↔
Percentage of young people (16-24) in specialist substance misuse services (2014/15 Q4)	0.3%	
Social Isolation		
• Percentage of adult carers who had as much social contact as they would like (2014/15)	42%	↓
• Percentage of services users who had as much social contact as they would like (2014/15)	42%	↔

Fewer people will experience stigma and discrimination

NHS mental health service users treated with respect and dignity, average survey 1 to 10 score (high is good) (2015)		
• North Staffordshire Combined Healthcare	8.6	↔
• South Staffordshire and Shropshire Healthcare	8.7	n/a

Key
Statistical significance Better / Worse
* Statistical significance not calculated
↑ Increasing trend, ↓ decreasing trend, ↔ no trend
No arrows indicates that trend data is not currently available

More people with mental health problems will recover

Care and treatment

Improving Access to Psychological Therapies (IAPT)		
• Percentage of referrals entering treatment within six weeks (2014/15)	63%	
• Percentage of referrals entering treatment within 18 weeks (2014/15)	87%	
• Referrals finishing a course of treatment with a reliable recovery (2014/15)	43%	
• Referrals finishing a course of treatment with a reliable improvement (2014/15)	50%	
Patients with severe mental illness who have a comprehensive care plan documented in the GP record, in the preceding 12 months (2014/45)	88%	↑

Recovery and quality of life

Employment rate of people with mental illness (2015 Q2)	38%	↔
The difference in employment rate between the general population and people with a mental illness. (2015 Q2) *	38%	↔
Proportion of adults in contact with secondary mental health services in paid employment (2014/15)	13%	↓
The percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation (2014/15)	67%	↓
Social care related quality of life (all service users) (2014/15)	18.5	↔

Fewer people will suffer unavoidable harm

Patient safety incidents reported, per 1,000 bed days (2014/15)		
• North Staffordshire Combined Healthcare *	43	↑
• South Staffordshire and Shropshire Healthcare *	26	↔
Patient safety incidents reported – severe or death, per 1,000 bed days (2014/15)		
• North Staffordshire Combined Healthcare *	0.4	↔
• South Staffordshire and Shropshire Healthcare *	0.2	↓
Hospital stays for self-harm, ASR per 100,000 population (2013/14)	208	↑
Suicide rate, ASR per 100,000 population (2012-2014)	9	↔
Suicide rate, ASR per 100,000 males (2012-2014) *	14	↔
Suicide rate, ASR per 100,000 15-34 population (2012-2014) *	8	↔
Suicide rate, ASR per 100,000 35-54 male population (2012-2014) *	22	↔
Detentions in police cells, rate per 100,000 population (2015) *	4	

People will have a more positive experience of care and support

People detained on 31st March under the mental health act 1983 per 100,000 population (March 2015)		
• North Staffordshire Combined Healthcare	31	↔
• South Staffordshire and Shropshire Healthcare	26	↔
People subject to Community Treatment Orders per 100,000 population (March 2015)		
• North Staffordshire Combined Healthcare	12	↔
• South Staffordshire and Shropshire Healthcare	9	↔
Patient experience of community mental health services, average survey 1 to 10 score (high is good) (2015)		
• North Staffordshire Combined Healthcare	7.3	↔
• South Staffordshire and Shropshire Healthcare	7.0	
Overall patient views of care and services, average survey 1 to 10 score (high is good) (2015)		
• North Staffordshire Combined Healthcare	7.7	↔
• South Staffordshire and Shropshire Healthcare	7.7	
Patients who feel they have seen NHS mental health services often enough for their needs, average survey 1 to 10 score (high is good) (2015)		
• North Staffordshire Combined Healthcare	6.8	↔
• South Staffordshire and Shropshire Healthcare	6.6	
***Overall crisis care satisfaction,* average survey 1 to 10 score (high is good) (2015)**		
• North Staffordshire Combined Healthcare	*6.3*	↔
• South Staffordshire and Shropshire Healthcare	*6.3*	

People with mental health problems will have better physical health

Excess under 75 mortality rate in adults with serious mental illness (standardised mortality ratio - 2013/14) *	338	↑
Patients with severe mental illness who have a record of blood pressure in the preceding 12 months (2014/15)	90%	↔
The percentage of women (25-64) with severe mental illness whose notes record that a cervical screening test has been performed in the preceding five years (2014/15)	89%	↔
NHS mental health services providing help or advice with finding support for physical health needs, average survey 1 to 10 score (high is good) (2015)		
• North Staffordshire Combined Healthcare	5.4	↔
• South Staffordshire and Shropshire Healthcare	5.1	