LEICESTERSHIRE JOINT STRATEGIC NEEDS ASSESSMENT 2024

MENTAL HEALTH - ADULTS

April 2024

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Foreword

This document presents a three-year update of the Joint Strategic Needs Assessment (JSNA) for mental health and mental wellbeing among adults in Leicestershire. It reviews the population health needs in relation to mental health, its socio-economic determinants, impact on health outcomes, outlines the relevant policy and guidance, existing services and the range of services that are currently provided. It also estimates the unmet needs and presents recommendations based on the findings.

In general, the purpose of a JSNA is to:

- Improve the health and wellbeing of the local community and reduce inequalities for all ages.
- Determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- Provide a source of relevant reference to the Local Authority, Integrated Care Board (ICBs) and NHS England for the commissioning of any future services.

The Local Authority and ICBs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, ICBs and NHS England's plans for commissioning services to be informed by up-to-date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, ICBs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with ICBs and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, a relevant working group was created. The outputs of the JSNA may include:

- Subject-specific chapters of an assessment of current and future health and social care needs
- An online infographic summary of each chapter
- An online data dashboard that is updated regularly to allow users to self-serve high level data requests.

Please note, the majority of indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included.

Executive Summary

Poor mental health and wellbeing has a significant impact on people's lives. Mental health services have been facing many challenges highlighted in the past years at a national level, such as poor access to timely support and intervention, long waiting times, lack of resources, shortage of mental health professionals or problems with public perceptions. The need for improvement addressed in several key strategic documents nationally and locally. Examples include the Long Term Plan (2019), Suicide Prevention Strategy (2023) or A Mentally Healthier Nation (2023). Local strategies such as the LCC Strategic Plan for 2022-26, Leicestershire Health and Wellbeing Strategy (2022-2032) and a series of Community Health and Wellbeing Plans all prioritise mental health. In addition, the LLR Suicide Prevention Strategy, and the Joint LLR Living Well with Dementia Strategy provide local guidance for these specific issues.

Health Needs Assessment

Several key themes were identified through this needs assessment:

- The local population is on generally older than the national average with a higher growth experienced in older age groups. The demographic trends alone point toward a significant rise in the numbers of people with several chronic conditions (both mental and physical) in the near future, with additional 20 thousand people suffering from three or more conditions by the year 2032. Despite the overall lower levels of socio-economic deprivation across Leicestershire, there are pockets of rural deprivation with problems of loneliness and social isolation, as well as poor access to services, housing and transport.
- Several population groups were identified as having higher risk for mental health problems in Leicestershire, including people with disabilities and carers, LGBTQ+ communities, women in peri-natal period, prison populations, traveller and migrant populations, armed forces veterans, and students. These also include people sleeping rough in Leicestershire – although remaining under 30, their number has almost doubled in 2023 when compared to previous years. It is estimated that around 2.400 people in Leicestershire could suffer from severe multiple disadvantage (SMD), this group is characterised by overlapping vulnerabilities, usually homelessness, substance use, crime and a particularly high risk of mental health problems.
- Risk factors identified as important locally include wider determinants of health such as: lack of employment and the recent 'cost of living' crisis, educational attainment, rurality and loneliness, negative role of social media, or disrupted social ties. An analysis of recent crime trends in Leicestershire also suggests a rising incidence of violence against person, and, to a lesser degree, rural crime and domestic incidents.
- The levels of poor mental wellbeing and mental ill-health are high, with an estimate for nearly 99 thousand people with any common health disorder (CMD), depression and dementia accounting for nearly 78,000 other CMDs including anxiety, panic disorders, phobias and other

mental health conditions. In 2022/23 nearly 89,000 people were registered with their GPs with a diagnosis of depression and nearly 6,000 with dementia. Estimates suggest that only 63% suffering from dementia are registered, suggesting that a large proportion are not receiving treatment. This coverage rate was below the national Quality and Outcomes Framework (QOF) target of 68.5% in 2023 with districts of Harborough and North West Leicestershire placed significantly lower at 57.7% and 55.7%, respectively. People with a CMD in Leicestershire had lower than national average rates of contact with community, out-patient or hospital services.

- There is some evidence that people may have difficulties in accessing services. The local access to NHS Talking Therapies is just around 13 thousand referrals per year (less than 70% of the planned target), although there could be a number of reasons for this apparently low demand. In-treatment waiting times are also worse than the national average. In terms of the annual spend in 2022/23 LLR as a whole was just 80% of the target, significantly below the national average. In Leicestershire, the rates of referral to memory services were lower than the national average (17/1,000 vs national 19/1,000); and with some variation - lowest in NWL (13.3/1,000) and highest in Oadby and Wigston (21.1/1,000).
- There are likely to be around 15,000 of people with severe mental illness (SMI) in Leicestershire (a minimum estimated 12,500), while just around 6,000 are registered on GP registers. The rate of registration in 2022/23 was 7.9/1,000 in East Leicestershire and Rutland and 8.4/1,000 in West Leicestershire, significantly below the 10/1,000 rate nationally. The gap in registration is further highlighted by the point that over 7.5 thousand of adults with SMI accessed community mental health services in 2022/23; the rate of access to these services being higher than national average.
- People with severe mental illness have relatively poor health outcomes locally. The rates of premature mortality in this group seem to be relatively high, particularly premature cancer mortality. Of note in this context are very low coverage rates for breast cancer screening - less than a third of eligible women with SMI are screened, compared to 70% of those in the general population. Only a half of people with severe mental illness receive full physical health checks (50% in West Leicestershire and 45% in East Leicestershire and Rutland), against the current 60% performance target.
- The suicide mortality rate for 2020-22 was statistically similar to the national average while being significantly lower in previous years; the admission rates for self-harm compare favourably with national figures. There are around 55-60 suicides in Leicestershire every year and an estimated 40 thousand people self-harming and/or attempting suicide.
- The demand for mental health services is growing and predicted to grow into the future. Nearly 33 thousand of adults registered with Leicestershire practices accessed secondary NHS mental health services in 2022/23, with the rate increasing year on year at a faster rate than nationally. Women were 40% more likely to be in contact with services than men, although they were also

30% less likely to be admitted as inpatients. Overall, about 2.5% of Leicestershire adults in contact were admitted as inpatients.

- Poor mental health has a significant impact on the lives of those affected and their families. The employment gap between those in contact with mental health services and general population seems to be wider in Leicestershire than is the national average (78% vs 69% in 2021/22). Also, a relatively low proportion of people in contact with secondary mental health services lived in stable and appropriate accommodation in 2021/22 (11% vs 26% nationally).
- The impact of the COVID-19 pandemic, the on-going cost of living crisis or issues affecting housing and transport have all been highlighted as important factors in mental health needs at neighbourhood level.
- Mental health interventions can bring significant return on investment - evidence indicates that there is a positive return of around £5.30 on every £1 spent on mental health interventions in the workplace, and £15 of cost saved for every £1 invested in the early intervention in psychosis (EIP) programme.

Services

The report gives a summary of services provided by the NHS, voluntary, community and social enterprises (VCSE), local authority and other organisations. Most of the local mental health services for adults are commissioned and operate across Leicester, Leicestershire and Rutland (LLR).

Identified Needs, Gaps and Areas of Improvement

These have can be summarised as follows:

- Older population growth is faster in Leicestershire which will have impact on future levels of morbidity and multimorbidity.
- There are issues of loneliness, social isolation and access to services linked to rurality.
- There is an apparent recent increase in local crime rates which may impact mental wellbeing at different levels.
- An increasing number of women are accessing community perinatal mental health services.
- There is an estimated 2,400 cohort of people with severe multiple disadvantage (SMD) in Leicestershire who could have especially high mental health needs.
- Of note is the perceived lack of flexible mental health outreach for people who sleep rough.
- Perception that the current 'cost of living' crisis and housing and transport issues are impacting on more people and leading to higher demand for services, particularly in some neighbourhoods.
- Potential gap in provision of services; disparity between estimated prevalence and demand for

services such as Talking Therapies. Less than a half of people estimated to have a severe mental illness are registered with GPs or accessing community mental health services.

- The rates of premature cancer mortality among people with SMI are higher than average, of note are very low coverage rates for breast cancer screening and low uptake of physical health checks for people with SMI.
- Care for people with personality disorder (PD) are perceived to be fragmented with gaps in service provision, as are those for people self-harming, affecting the interface between emergency care and primary care.
- The rates of access to secondary NHS mental health services are increasing, albeit remaining lower than the national average.
- The employment gap between those in contact with mental health services and general population is wider than expected, while the proportion of those in contact in stable and appropriate accommodation is lower than expected.
- Potentially less than a third of children with a mental health condition have an appropriate intervention at a sufficiently early age.

Recommendations

The recommendations include:

- To undertake further modelling of the impact of current demographic trends on future mental health needs and demand for health care to enhance planning of future services.
- Issues of social isolation, access to services and hidden pockets of deprivation in rural areas should be recognised and addressed at a neighbourhood level, through improved joint working. This should include needs of at risk groups such as unpaid carers, prisoners, travellers, vulnerable migrants, and armed forces veterans should also be assessed at a neighbourhood level.
- To enhance local data collection on mental health inequalities, prevention and services, including mapping of services and patient pathways, particularly for vulnerable groups such as pregnant women, veterans or students.
- To seek opportunities for prevention and early detection of mental health conditions, particularly for those in high risk groups. Continue raising awareness of the risk factors of dementia and prevention measures for these.
- Work should be undertaken to target individuals with Severe and Multiple Disadvantage (SMD) with access to support and services, particularly at a neighbourhood level.
- Explore opportunities for developing flexible mental health outreach for people who sleep

rough.

- To develop a prevention programme as part of Prevention Concordat to promote mental health and wellbeing to wider population. To include wellbeing support and access to services, and interventions to mitigate, where possible social factors (wider determinants of health) which are contributing to poorer mental wellbeing.
- To explore opportunities to further understand and address, as appropriate, premature cancer mortality among people with severe mental illness (SMI) which may be linked to low breast screening coverage.
- To improve the uptake of breast screening for women with SMI and to monitor and improve uptake of physical health checks, particularly among those with SMI.
- To explore opportunities to improve awareness of and access to effective treatments for personality disorders (PD).
- To enhance the continuity of care for people who are self-harming, including emergency services, primary and social care and other local services.
- Continue to support and develop interventions to enable people in contact with mental health services to engage in employment and have access to stable and appropriate accommodation.
- Improve access to mental health services particularly in communities where there may be a stigma attached to living with a mental health problem.
- Improve the transition from children's services such as CAMHS into adult services, with a focus on prevention. The ICB is leading on this piece of work and the system plays a key part in shifting the focus from separate children and adult services into considering children's mental health as part of the preventative offer across the whole life course.

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AMHPs	Approved Mental Health Professionals
APMS	Adult Psychiatric Morbidity Survey
ASB	Antisocial Behaviour
ASD	Autism Spectrum Disorders
ASPD	Anti-Social Personality Disorder
BHPS	British Household Survey Panel
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
CIPFA	Chartered Institute of Public Finance and Accountancy
CKS	Clinical Knowledge Summary
CMD	Common Mental Disorders
CPN	Community Psychiatric Nurse
DLUHC	Department of Levelling Up Hosing and Communities
EIP	Early Intervention for Psychosis
ELSA	English Longitudinal Study of Ageing
EL&R	East Leicestershire and Rutland sub-ICB (formerly CCG) area
ESA	Employment Support Allowance
GAD	Generalised Anxiety Disorder
HSCIC	Health and Social Care Information Centre (NHS Digital)
ICB	Integrated Care Board
IMHA	Independent Mental Health Advocacy
LCL	Lower Confidence Limit
LLR	Leicester, Leicestershire, and Rutland
OCD	Obsessive-Compulsive Disorder
ONS	Office for National Statistics
NHSMHD	NHS Mental Health Dashboard
NICE	National Institute for Care Excellence
NOS	Not Otherwise Specified

NPS	New Psychoactive Substances
ONS	Office for National Statistics
PFA	Police Force Area
PTSD	Post-Traumatic Stress Disorder
QOF	Quality and Outcomes Framework
RCRP	Right Care Right Person
SMI	Severe Mental Illness
STP	Sustainability and Transformation Partnership
UCL	Upper Confidence Limit
VAP	Violence Against the Person
VCSE	Voluntary, Community and Social Enterprises
WL	West Leicestershire sub-ICB (formerly CCG) area
YOI	Youth Offender Institution

1. Introduction

A quarter of people across the UK experience a mental health problem each year, and 1 in 6 experience a common mental health issue, such as depression or anxiety, in any given week[1]. The prevalence of common mental diseases, such as anxiety and depression, could be as high as 20% among adults, with 1 in 8 children having a diagnosable mental health disorder. Despite the high prevalence, it is estimated that at least a third of people with a mental health problem do not seek help.

The level and the character of mental health need varies by condition, population factors, such as age, ethnicity or deprivation, putting some groups at a particularly high risk. It may also vary over time; research suggests that the COVID-19 pandemic has exacerbated mental health issues, particularly the rates of depression in the adult population, which are likely to have doubled during the pandemic.

Of the many challenges highlighted in the past years at a national level, the key issues include access to services, characterised in some areas by long waiting times and lack of resources, poor funding resulting in insufficient service provision and shortage of mental health professionals, problems with poor public perceptions, stigma and discrimination. Mental health problems disproportionately affect some groups, such as those living in poverty, homeless people, LGBTQ+ individuals, ethnic minorities, people with disabilities or their carers. Work-related stress and the resulting mental health problems remain a significant issue, despite some progress in increasing the awareness in this area. Need for better integration of services, including health, social and other support services, has been widely recognised, particularly for groups with coexisting problems of substance use ('dual diagnosis') or suffering from physical conditions. For such individuals integrated care is key for addressing all their health issues simultaneously.

This report summarises the available data on the mental health of the population of Leicestershire, in the national context where possible. Effort has been made to include the most up to date information, as of March 2024, however, in many areas comparative information is, by necessity, published with a significant delay, particularly when reporting annual statistics.

1.1. Policy and Guidance

The recent national policy and guidelines for mental health include:

1.1.1. NHS Long Term Plan (2019)

The National Health Service (NHS) Long Term Plan, published in January 2019, outlined key strategies and commitments regarding mental health services in England. It offered a comprehensive approach to improving mental health services in England, with an emphasis on

prevention, early intervention, integration, and innovation. It set out a number of goals to address the growing demand for mental health support and improve outcomes for individuals. Focusing on early intervention and prevention, increasing access to services, service integration, increasing funding and resources for children and young people, improving perinatal mental health services, developing mental health workforce, it highlighted the role of harnessing digital technology and reducing stigma surrounding mental health issues and ultimately reducing the number of suicides and addressing the underlying social and economic factors contributing to mental health problems.

1.1.2. Advancing Mental Health Equalities Strategy (2020)

The Advancing Mental Health Equalities Strategy by NHS England[2] outlined a comprehensive approach to address disparities and promote equity in mental health care through a number of aims such as addressing the underlying factors contributing to mental health inequalities, improving access to mental health services for marginalized and underserved communities, targeted interventions in schools, workplaces, and communities, tackling stigma and discrimination, or tailored support and interventions for specific population groups. The Strategy puts an emphasis on the importance of data on mental health inequalities, collaboration and partnership working, workforce diversity, and monitoring and evaluation.

1.1.3. National Disability Strategy (2021)

The National Disability Strategy in the UK[3] outlines a comprehensive plan to address the barriers and challenges faced by disabled people across various aspects of life, including independent living, employment, skills, education, transport and public spaces. It focuses on improving access to health and social care services for disabled people, mental health and rehabilitation support, and personal care.

1.1.4. National Partnership Agreement: Right Care, Right Person (2023)

Set out around the Right Care, Right Person approach, which aims to ensure that individuals in mental health crisis are seen by the right professional, the agreement between the Department of Health and Social Care (DHSC), Home Office, NHS England, National Police Chiefs' Council (NPCC), Association of Police and Crime Commissioners (APCC) and College of Policing [4].

The Right Care, Right Person (RCRP) framework was developed to help police to make decisions about when to respond to incidents.

1.1.5. Suicide Prevention Strategy (2023)

In September 2023, the Government published the Suicide prevention strategy for England: 2023 to 2028[5].

The strategy and corresponding action plan set out ambitions for the next five years a) to reduce the suicide rate, with initial reductions made within at least half this time, b) to improve support for

people who have self-harmed, and c) improve support for people who have been bereaved by suicide.

The strategy includes over 100 actions focused on improving data, providing targeted support to these priority groups, addressing common risk factors linked to suicide, promoting online safety, providing crisis support, reducing access to means of suicide, and providing bereavement support.

1.1.6. Major Conditions Strategy and A Mentally Healthier Nation (2023)

In April 2022, the Government launched a Mental health and wellbeing plan: discussion paper and call for evidence, intended to inform a new 10-year, cross-government mental health strategy. The discussion paper and consultation questions focused on promotion of mental wellbeing, prevention of mental health conditions, early intervention, quality and effectiveness of treatment, support for people with mental health conditions and support for people in crisis. The responses to the consultation for the 10-year strategy were to be used to inform the Major Conditions Strategy and to develop the new Suicide Prevention Strategy. In January 2023, the Government announced that it will publish a Major Conditions Strategy that will include mental health to ensure that mental health conditions are considered alongside physical health conditions.

In response, mental health charities, including the Mental Health Foundation, Mind and Rethink Mental Illness, with many other mental health charities and organisations published in January 2023 a document entitled Mentally Healthier Nation, setting out priorities for a ten-year, cross-government mental health strategy. The document includes policies on prevention, equality, and support that the group would like to see implemented following the next general election [6].

1.1.7. NHS Long Term Workforce Plan (2023)

The NHS Long Term Workforce Plan was published in June 2023 by the Department of Health and Social Care. The plan estimates a shortfall of over 15,800 full time-equivalent mental health nurses by 2036/37[7]. The plan sets out an ambition to increase training places for mental health nursing by 93% to over 11,000 places by 2031/32. This would start with an increase in mental health nursing places of 38% by 2028/29. The increase in places would include an expansion of the nursing apprenticeship scheme so that by 2028/29, 28% of mental health nurses are qualifying via this route.

However, it is expected that there will continue to be shortfalls in mental health staffing in the medium-term.

Prior to 2019, the following key policies were published:

1.1.8. Mental Health Act (1983)

The Mental Health Act (1983) in the UK is legislation that provides a legal framework for the care and treatment of individuals with mental disorders. It balances the need to protect the rights of individuals with mental disorders while ensuring they receive appropriate care and treatment when

necessary. It provides a legal framework for the detention, assessment, and treatment of individuals with mental health needs, with safeguards in place to protect their rights and interests.

The Act has undergone various reforms over the years, with the most recent amendments introduced by the Mental Health Act 2007 and ongoing discussions about further reforms to modernize and improve mental health legislation, including the 2018 Review of The Mental Health Act, an independent review of the Mental Health Act 1983, published in December 2018[8].

In June 2019, the then-Government accepted further recommendations to tackle the disproportionate number of people from Black, Asian and minority ethnic groups who are detained under the Act, and further steps to end the use of police stations as a place of safety.

1.1.9. 2018 Review of The Mental Health Act

In October 2017, the Government commissioned an independent review of the Mental Health Act 1983 (the Act); the report from the review was published in December 2018[9].

In June 2019, the then-Government accepted further recommendations to tackle the disproportionate number of people from Black, Asian and minority ethnic groups who are detained under the Act, and further steps to end the use of police stations as a place of safety.

1.1.10. The Five Year Forward View for Mental Health (2016)

The Five Year Forward View for Mental Health[10], a report from the independent Mental Health Taskforce to NHS England, was published in February 2016. The Taskforce made a series of recommendations, including achieving parity of esteem between mental and physical health, wider, cross-government action across areas such as employment, housing and social inclusion, Tackling inequalities. It also addressed inequalities in access to services among certain black and minority ethnic groups, whose first experience of mental health care often came when they were detained under the Mental Health Act, often with police involvement.

It made specific recommendations for supporting more new and expectant mothers through maternal mental health services each year, providing mental health care to more children and young people, increasing access to talking therapies, improving integrated care for people living with long-term physical health conditions, meeting the physical health needs of people with a severe mental illness and helping this group find and stay in employment. It also recommended making a community-based crisis response available across England and providing a mental health liaison service for people of all ages in every acute hospital. It also made a commitment to reducing suicides by 10%.

1.1.11. NICE Guidance

The National Institute for Care Excellence (NICE) issued the following guidance documents for mental health:

- *Social, Emotional and Mental Wellbeing in Primary and Secondary Education (NG223)* published in 2022 - covers ways to support social, emotional and mental wellbeing in children and young people in primary and secondary education, and people with special educational needs or disability in further education colleges[11].
- *Depression in Adults: Treatment and Management (NG222)* published in 2022 – deals with identifying, treating and managing depression in people aged 18 and over, provides advice on preventing relapse, and managing chronic depression, psychotic depression and depression with a coexisting diagnosis of personality disorder[12].
- *Mental Wellbeing at Work (NG212)* published in 2022 – provides best evidence on how to create the right conditions for mental wellbeing at work[13].
- *Antenatal and Postnatal Mental Health: clinical management and service guidance (CG192)* published in 2014, updated 2020 - covers recognising, assessing and treating mental health problems in perinatal period[14].
- *Generalised Anxiety Disorder and Panic Disorder in Adults: management (CG113)* published in 2011, updated 2020 - covers the care and treatment of people aged 18 and over with chronic anxiety or panic disorder (with or without agoraphobia or panic attacks), aiming to help people achieve complete relief of symptoms, better functioning and a lower likelihood of relapse[15].
- *Decision-Making and Mental Capacity (NG108)* published in 2018 - discusses decision-making in adults (aged 16 and over) who may lack capacity now or in the future, providing health and social care practitioners to support people to make their own decisions where they have the capacity to do so[16].
- *Eating Disorders: Recognition and Treatment (NG69)* published in 2017 – covers assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders[17].
- *Mental Health of Adults in Contact with the Criminal Justice System (NG66)* published in 2017 - covers assessing, diagnosing and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system[18].
- *Transition Between Inpatient Mental Health Settings and Community or Care Home Settings (NG53)* published in 2016 - covers the period before, during and after an admission to, and discharge from, a mental health hospital, aiming to improve experience of transition[19].
- *Workplace Health: Management Practices (NG13)* published in 2015 - covers how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of line managers. The 2016 update covered recommendations about older employees, aged over 50 in paid or unpaid work [20].
- *Older People: Independence and Mental Wellbeing (NG32)* published in 2015 - covers

interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older[21] .

- *Mental Wellbeing in Over 65s: Occupational Therapy and Physical Activity Interventions (PH16)* published in 2008 - covers promoting mental wellbeing in people aged over 65 focusing on practical support for everyday activities, based on occupational therapy principles and methods[22] .

NICE also publishes accessible **clinical knowledge summaries (CKS)** of the current evidence base and advice on best practice across clinical areas (full list at https://cks.nice.org.uk/), including mental health:

- Antenatal and postnatal depression (revised in April 2022)
- Attention deficit hyperactivity disorder (revised in August 2023)
- Autism in adults (revised in May 2020)
- Bipolar disorder (revised in January 2024)
- Dementia (revised in January 2024)
- Depression (revised in December 2023)
- Eating disorders (revised in July 2019)
- Generalized anxiety disorder (revised in February 2024)
- Mental health in students (October 2020)
- Obsessive-compulsive disorder (revised in February 2024)
- Post-traumatic stress disorder (revised in December 2023)
- Psychosis and schizophrenia (revised in September 2021)
- Self-harm (revised in November 2023)

1.1.12. NICE Quality Standards

- *Decision Making and Mental Capacity (QS194)* published in 2020[23] - aims to support the implementation of the aims and principles of the Mental Capacity Act 2005 and relevant Codes of Practice.
- *Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups (QS167)* published in 2018[24] – includes quality statements on support for people with mental health problems and physical health checks for people with serious mental illness.
- *Mental Health of Adults in Contact with the Criminal Justice System (QS163)* published in 2018[25] – sets out standards for recognising, assessing and managing mental health problems in adults who are in contact with the criminal justice system.
- *Transition Between Inpatient Mental Health Settings and Community or Care Home Settings (QS159)* published in 2017[26] – contains quality statements on access to independent advocacy

services, out-of-area admissions, communication on discharge and suicide risk.

- *Violent and Aggressive Behaviours in People with Mental Health Problems (QS154)* published in 2017[27] - covers short-term prevention and management of violent and physically threatening behaviour among adults, children and young people with a mental health problem.
- *Healthy Workplaces: Improving Employee Mental and Physical Health and Wellbeing (QS147)* published in 2017[28] - describes high-quality care in priority areas for improvement.
- *Learning Disability: Identifying and Managing Mental Health Problems (QS142)* published in 2017[29] - covers the prevention, assessment and management of mental health problems in people with learning disabilities in all settings.
- *Mental Wellbeing and Independence for Older People (QS137)* published in 2016[30] - describes high-quality care in priority areas for improvement, including statements on physical activity, social participation and risk of decline.
- *Antenatal and Postnatal Mental Health (QS115)* published in 2016[31] - covers the organisation of mental health services for women during and after pregnancy, describes high-quality care in priority areas for improvement.
- *Mental Wellbeing of Older People in Care Homes (QS50)* published in 2013[32] – sets out a number of quality statements on recognition of mental health conditions, sensory impairment, physical problems and on access to healthcare services in this group.
- *Service User Experience in Adult Mental Health Services (QS14)* published in 2011 and updated in 2019[33] - covers improving the experience of people using adult NHS mental health services.

1.2. Outline of Local Priorities

Many local strategies and policies address issues linked to mental health and wellbeing, while the following list is not exhaustive it aims to include the priority documents identified at the time of writing.

1.2.1. Leicestershire County Council

The Local Authority have a Strategic Plan for 2022-26[34] which sets out the long term vision for the next four years. Whilst there are five specific aspirational strategic outcomes, the below are relevant to mental health and mental wellbeing in adults:

- Great Communities: Leicestershire to have active and inclusive communities in which people support each other and participate in service design and delivery.
- Safe and Well: ensuring that people are safe and protected from harm, live in a healthy environment and have the opportunities and support they need to live active, independent and

fulfilling lives.

1.2.2. Health and Care Priorities

The vision for Leicestershire Health and care integration has a number of outcomes for the local population, which is to make best use of the available resources. The following outcomes reflect the health and wellbeing conditions that are to be achieved in Leicestershire over the next five years:

- The people of Leicestershire are enabled to take control of their own health and wellbeing.
- The gap between health outcomes for different people and places has reduced.
- Children and young people in Leicestershire are safe and living in families where they can achieve their full potential and have good health and wellbeing.
- People plan ahead to stay healthy, age well and older people feel they have a good quality of life.
- People give equal priority to their mental health and wellbeing and can access the right support throughout their life.

1.2.3. Public Health

The Public Health Department within Leicestershire County Council have a service mission and aim to protect and improve the health and quality of life of the residents of Leicestershire (Delivering Good Health and Prevention Services 2022-2027[35]). This will be achieved through a commitment to the Authorities core values and behaviours. The Public Health Strategy has a number of strategic priorities that are linked to mental health:

- Building a network of partners to develop asset-based, community-centred approaches to increasing well-being, including:
    - Development and implementation of the NHS Wave 4 Suicide Prevention project to reduce stigma around mental health and help to prevent suicides by empowering and enabling communities to become mental health-friendly places.
    - Support to the awareness-raising of Suicide Prevention and mental health within communities at a local level and to utilise natural community assets to support this theme.
- Working with communities and partners to maximise resources (including financial resources, skills and social and natural resources).
- Working with Local Authorities and partners to address the wider issues that affect health (e.g. housing), including working with local employers and business groups to promote workplace health and employment for people with long term conditions.
- To strengthen the delivery of health improvement programmes and partnership working using a life course approach, including embedding the start a conversation suicide prevention

campaign into business as usual workstreams ensuring its focus stays high on everyone's agenda.

- Influencing healthy policy and infrastructure developments throughout Leicestershire through health in all policies.
- Working with partners internally and externally to address the wider issues that affect wellbeing and health.
- Reducing health inequalities and embedding an equitable approach to everything we do
- Taking a multi-agency approach on issues such as mental health, domestic abuse, substance use, sexual health, and air quality, including support to social marketing campaigns to increase awareness of domestic abuse and reduce stigma for survivors of abuse, and implementing Trauma-Informed Practice across services.
- Commissioning high quality and safe services that are linked with key services in the community.
- Designing and delivering services in house that contribute to the department's prevention model, including an integrated prevention door through First Contact Plus that enables professionals to refer patients and for individuals to self-refer for support with everyday issues that affect their health and wellbeing.
- Ensuring that services are effective and efficient, balance universal and targeted provision and meet safeguarding principles.
- Maintain robust evidence-based commissioning of services that reflect the local needs of the population, linking the latest evidence and Joint Strategic Needs Assessment Chapters.
- Ensuring that the local voice of communities is embedded in our service redesign work.
- Undertaking research and analysis to monitor service performance and population health outcomes.

1.2.4. Leicestershire Health and Wellbeing Board (HWB)

The **Leicestershire Health and Wellbeing Strategy**[36] sets out the key priorities and actions of the Health and Wellbeing Board for 2022-2032. Improving mental health has been identified as a cross-cutting priority with the aim of delivering the "right care to meet the needs of individual patients at the right time" and "integrating with health and social care partners to care for people when they feel they have mental health needs".

The following outcomes are proposed to be markers of success:

- Increased proportions of Leicestershire experiencing good mental health and wellbeing.

- Qualitative feedback that good emotional health and wellbeing is actively promoted and supported across the county including for carers and that services are joined up and meeting patient's needs at the right time and place.
- Reduction in the proportion of people with mental health challenges that need intensive, and specialist offers.
- Maintain suicide rates that are lower than the national average.
- Increase dementia diagnosis rates to meet NHSE target of 67% and clear links made between healthy lifestyle and the risk of dementia.
- To increase the proportions of people with mental health challenges that:
  - Access and take up high quality advice, support and access to local amenities, including activities and groups to strengthen mental health and wellbeing.
  - Live as independently as possible.
  - Be supported around their individual recovery goals.
  - Access to education, employment, training and housing and are supported by their employer/institution.
  - Have easy and timely access to the right, local, coordinated service.
  - Have their physical health needs monitored and key health/lifestyle needs supported.
  - Have their carers' and families' caring and mental health needs identified and supported.

The Leicestershire HWB commitments include:

- Prioritise Mental Health on an equal basis to physical health in plans, investment and focus.
- Seek to co-produce a Prevention Concordat for Better Mental health for Leicestershire to align organisations to further support mental health and wellbeing and prevent poor mental health.
- Maintaining low rates of suicide and impact of suicide, supporting work of the LLR Suicide Strategy.
- Continue to support the system work on children and young people's emotional health and wellbeing.
- Listen and respond to the Leicestershire population in the 'Step up to Great Mental Health' consultation.
- Support key recommendations of the Dementia JSNA Chapter and LLR Dementia Strategy, including improving dementia diagnosis rates and ensuring clear links between healthy lifestyle and risk of dementia through MECC Plus and Health Checks.

1.2.5. Leicestershire Partnership NHS Trust (LPT)

LPT provides mental health, learning disability and community health services across Leicester, Leicestershire and Rutland. Their 'Step Up to Great' Strategy for 2021-24[37] outlines nine key areas which will help the trust deliver their vision of 'creating high quality compassionate care and wellbeing for all'. Key areas to adult mental health across the region are:

Transformation: Services

- Providing community healthcare services at home and locally to allow people to avoid hospital admissions and live at home for longer.
- Join up mental health services with physical health and social services to improve the health and wellbeing of local people.
- To have safe, patient-centred, high-quality care which is accessible when and where it is needed.
- Improve services for adults with a learning disability by providing more support to improve their health and wellbeing in the community and decrease the need for them to be admitted to hospital.
- Improve services for people with autism by reducing the health inequalities experienced, reducing waiting times for care, and supporting them to stay out of hospital as much as possible.

Transformation: Digital

- To have the technology and support for communities to access services digitally, with support and alternatives for those who cannot.

Access to services

- Improve uptake and delivery of health services to reduce health inequalities.

1.2.6. Leicester, Leicestershire and Rutland Audit and Prevention Group

The LLR Suicide Prevention Strategy 2020-23 has been produced via the LLR Suicide Audit Prevention group which has representation from a broad group of key stakeholders. The strategy is currently being 'refreshed' in line with the national suicide prevention strategy published in 2023. The current strategy identifies 9 key priority areas for delivery as follows:

Targeted support at high-risk groups:

- Focus on men aged 35-54

- Vulnerable groups including people from lower socioeconomic backgrounds, young care leavers, those in the criminal justice system, survivors of abuse, veterans, individuals with long-term conditions, minority groups (Black and Minority Ethnic Backgrounds, LGBTQ+ individuals, asylum seekers, refugees), and those with a history of alcohol or drug use.
- People bereaved by suicide are themselves at high risk; everyone affected by suicide will be offered bereavement support.

Protecting people with a history of self-harm:

- Work with primary and secondary care to ensure that best practice guidance is implemented in Emergency Care settings to protect people who self-harm
- Provide support and signposting for individuals who self-harm.

Prevent death by suicide in public places:

- Identify and prioritise locations for prevention efforts in collaboration with partners.

S*upport Primary Care to Prevent Suicide*

- Enable GPs to offer life-saving support, including training for GPs, advocate longer appointments and continuity of care for those needing ongoing support, emotional support for GPs themselves, establish effective care pathways between clinical and social support for people feeling suicidal, make it easier to refer and access further support.
- Work with health care commissioners to enable primary care to be more supportive of people at risk of suicide.

Partnerships with private and corporate sectors to tackle suicide:

- Link up local public mental health campaigns, employee assistance programmes and occupational health schemes.
- Liaise with local Chambers of Commerce, trade associations, sports clubs and universities to engage the business community in promoting a greater understanding of suicide prevention.
- Engage employers in promoting workplace mental health by working with local occupational health services to strengthen the support available for employees, enable implementation of NICE guidance and HSE Management Standards for Stress.

Provision of enhanced suicide awareness training:

- Offer training programs for professionals and community members.
- Focus on gatekeeper training, general awareness, and skills-based training.

Better use of media (including social media) to manage messages about suicide:

- Ensure local media follows Samaritans' guidance on responsible reporting of suicides locally.
- Provide local media with access to the designated suicide prevention lead and promote sources of suicide support.

Raise awareness with better data and better use of data:

- Systematic collection of Real Time Surveillance (RTS) data to improve understanding of local risk factors, led by Police and Public Health.
- Utilise RTS to identify high-risk groups, locations of concern, patterns and trends, provide evidence for targeted interventions and contribute to the monitoring and evaluation of outcomes.

Supporting individuals experiencing suicide ideation during Covid-19

1.2.7. Leicester, Leicestershire and Rutland Dementia Programme Board

The LLR Joint Living Well with Dementia Strategy 2024-28 outlines the local strategy to support people to live well with dementia including:

Leading, Integrating and Commissioning Well

- Use Public Health led Joint Strategic Needs Assessments to support the commissioning of dementia friendly services, consider joint commissioning opportunities and continue to jointly commission the Dementia Support Service.
- Support local and organisational focused delivery plans, within which system wide actions will be agreed and implemented.

Preventing well:

- Raise awareness of dementia and its symptoms
- Screen for and raise awareness of dementia risk factors and promote preventative healthy lifestyle behaviours.
- Promote involvement in research development and the value of early diagnosis.

Diagnosing Well:

- Reduce wait times for dementia diagnosis and refine assessment pathways.
- Improve patient access to the pre and post Dementia Support Service.

- Improve Dementia Diagnosis experience for people from South Asian communities and explore culturally appropriate diagnosis tools.

S*upporting Well:*

- Provide and raise awareness of person-centred support for individuals living with dementia and their carers, especially seldom heard groups (eg. prison population, ethnic minorities).
- Improve inpatient experience for people with dementia.
- Promote the development of dementia-friendly accommodation.
- Enhance pathways for people with complex needs.
- Promote and develop good risk reduction methods that keep people safe and promote independence - including Care Technologies and practice in relation to the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards including Positive Behaviour Support and Positive Risk-taking practice.

Living Well:

- Promote the development of information and advice about living well with dementia that is accurate, timely, accessible, and joined up across LLR.
- Promote and develop the LLR Dementia Friendly Community and access to the Dementia Support Services and other living well support, especially in areas which are less well served.
- Develop routine engagement processes with people living with dementia and carers to inform our work, including people with lived experience being involved in strategy development.
- Promote and develop practice that supports people living with dementia plan and live well including crisis contingency planning, advanced care planning, and promote the benefits of Lasting Powers of Attorney.

Dying Well:

- Promote and develop good practice in relation to people with dementia including strengthening the link with End-of-Life pathways and RESPECT Procedures.

1.2.8. Community Health and Wellbeing Plans

Community Health and Wellbeing Plans are strategic frameworks designed by local authorities and health organisations to address and improve the health and wellbeing of local populations. They are developed in collaboration with a range of stakeholders, including public health, local government, voluntary, community and social enterprises, and healthcare providers.

They are developed in response to the DHSC 2021 Integration and Innovation White Paper[38] inherent to the establishment of Integrated Care Systems (ICS) in 2022. The ICS for Leicester, Leicestershire and Rutland (LLR) was established in July 2022. Partnership working has been established across the system (LLR collectively), place (Leicester, Leicestershire, and Rutland separately) and neighbourhood (at locality level). While the Leicestershire Joint Health and Wellbeing Strategy (see paragraph 1.2.4) sets out the strategic vision and priorities for health and wellbeing at place level, across the County of Leicestershire, it is recognised that some needs are better identified and tackled at a neighbourhood level. Therefore, Community Health and Wellbeing Plans are also being developed to identify local needs and actions that, alongside the County and system (LLR) wide work, will help to improve people's overall health and wellbeing, to achieve local integration, prevention and improvement.

2. Who is at Risk

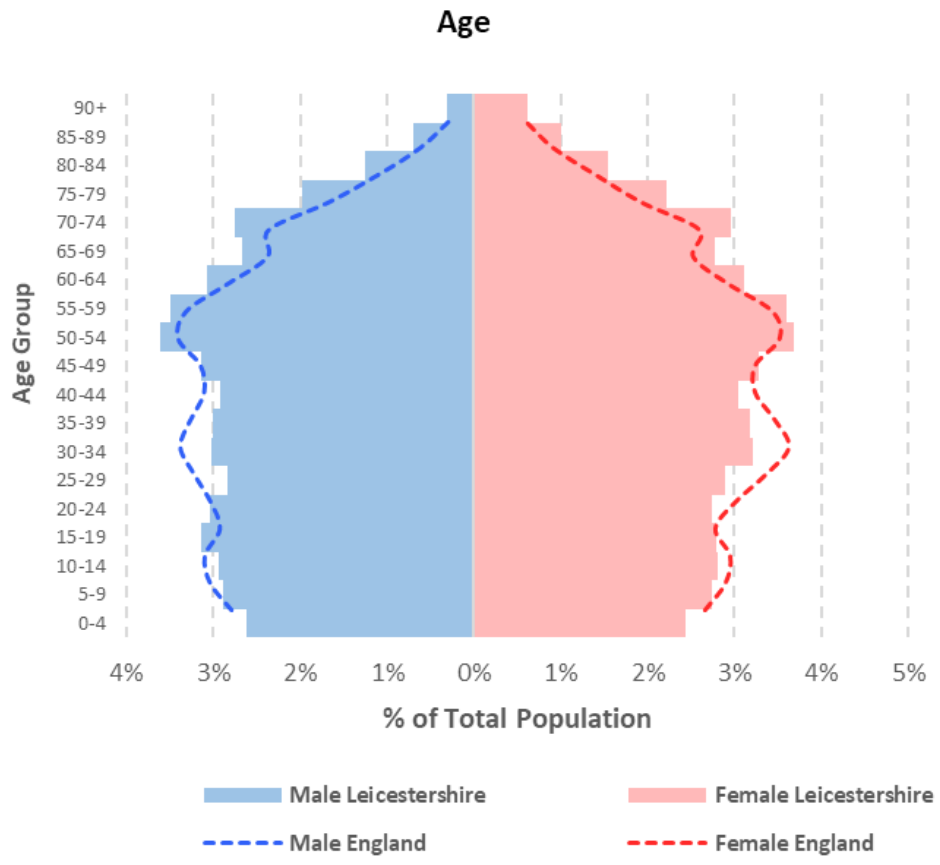
This section presents the current insights into the population of Leicestershire, highlighting groups which maybe at higher risk of mental health issues and evidence on why this is the case. Some important population factors rather than groups are also described.

Where relevant, details for individual districts are provided in **the Appendix**.

2.1. Population of Leicestershire

The latest Census estimated the resident population of Leicestershire to be approximately 712,400 within a total of 296,400 households in 2021. Compared to the national average, there were relatively fewer adults aged 20-45, with proportionately higher numbers of adults above that age (Figure 1).

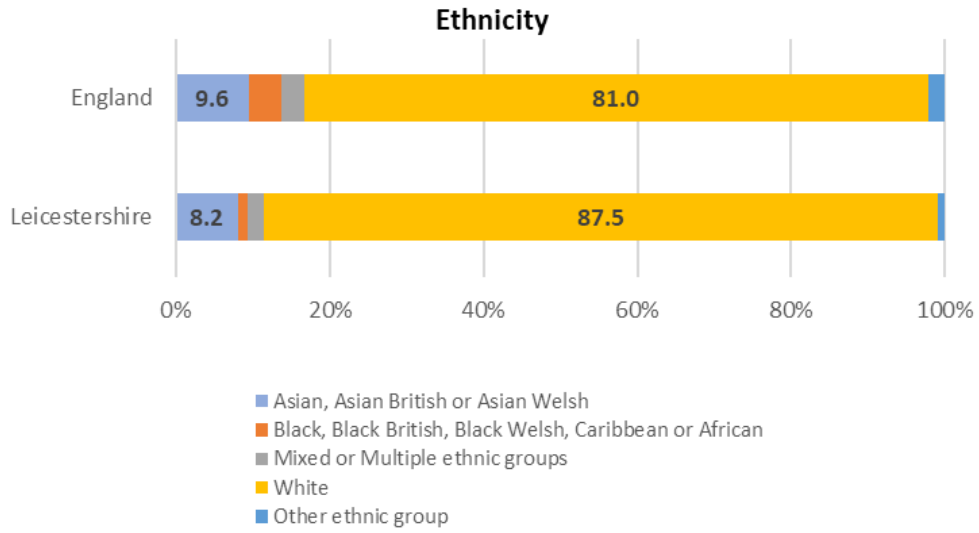
Figure 1. Leicestershire population - Census 2021



(Source: ONS)

Leicestershire population was in the majority of white ethnicity (87.5% vs 81% nationally), with the Asian population accounting for 8.2% (lower than national average of 9.6%) (Figure 2).

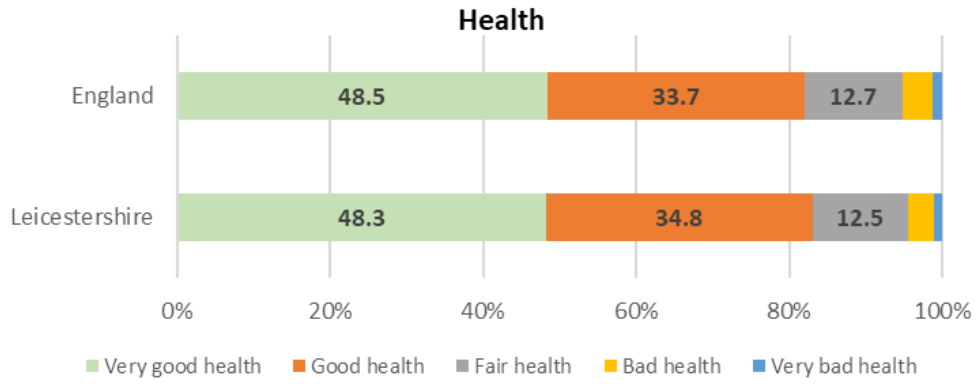
Figure 2. Ethnic profile of population of Leicestershire in 2021



(Source: ONS)

The broad health profile from Census 2021 does not indicate major departures from national average, although these rates have not been standardised for age, which would be important given the somewhat different age structure of Leicestershire's population (Figure 3).

Figure 3. Health profile of Leicestershire population in 2021

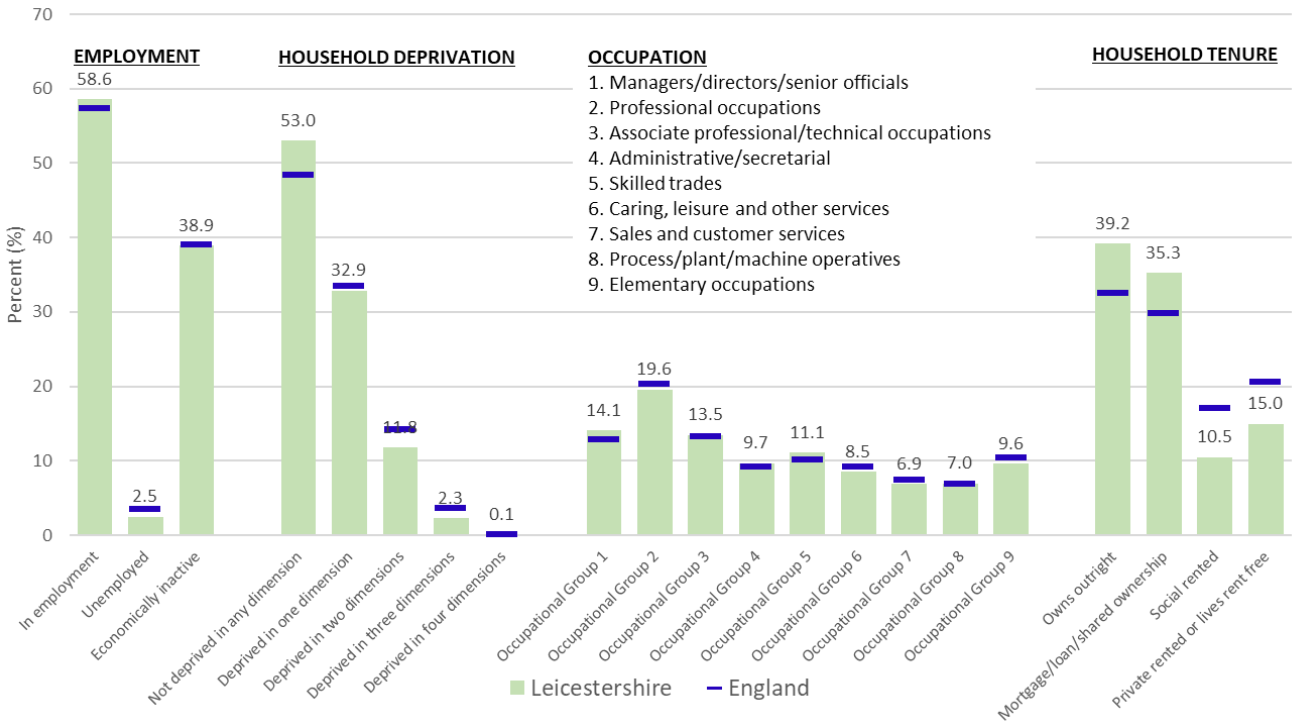


(Source: ONS)

A broad socio-economic profile of Leicestershire population, based on Census 2021, shows a higher proportion of households as not deprived in any dimension (53% vs 48% nationally), and less of those deprived in two or more dimensions. Also, a higher proportion of Leicestershire population owned their homes outright or through mortgage or loan, with lower than national average rates of

social or private renting (household tenure). Other indicators show a broadly similar patterns to the national average (Figure 4).

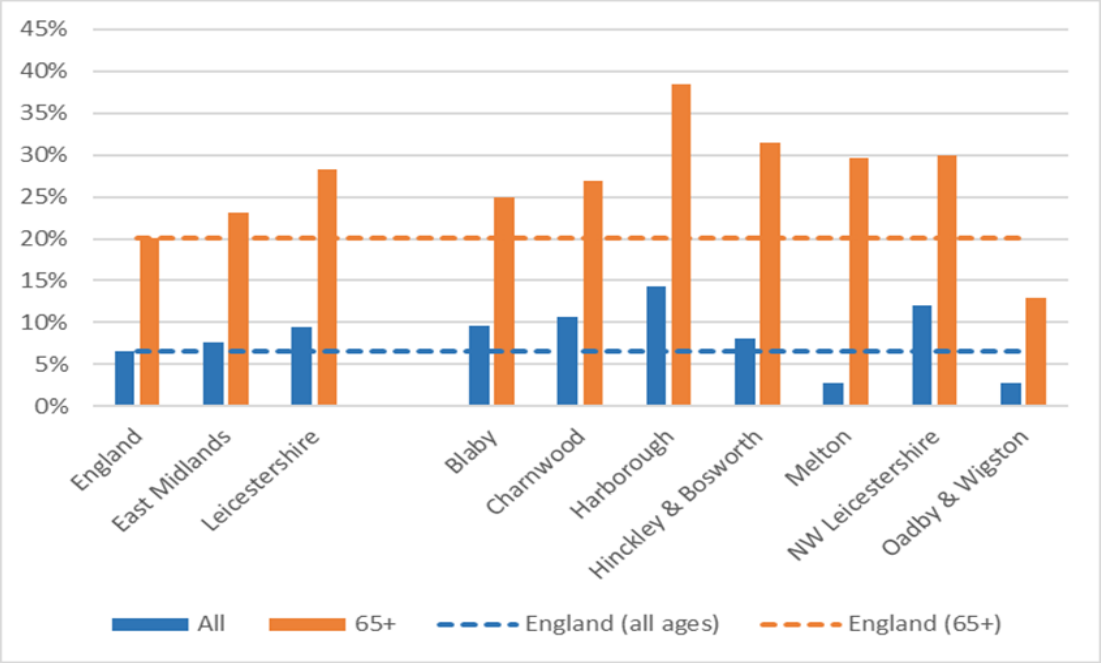
Figure 4. Summary of socio-economic indicators form Census 2021



(Source: ONS)

Recent and projected changes in population age structure is important to note as increasing numbers of the population in older age groups can have a significant impact on the burden of morbidity, including mental health. In Leicestershire, 21% of the population is aged 65 or over, compared to 18.5% across England. The population of Leicestershire grew at a faster rate than England or the East Midlands since 2011 with the highest growth rate among those aged 65 and over (28% overall; 39% in Harborough) (Figure 5).

Figure 5. Population growth (%) between 2011 and 2021

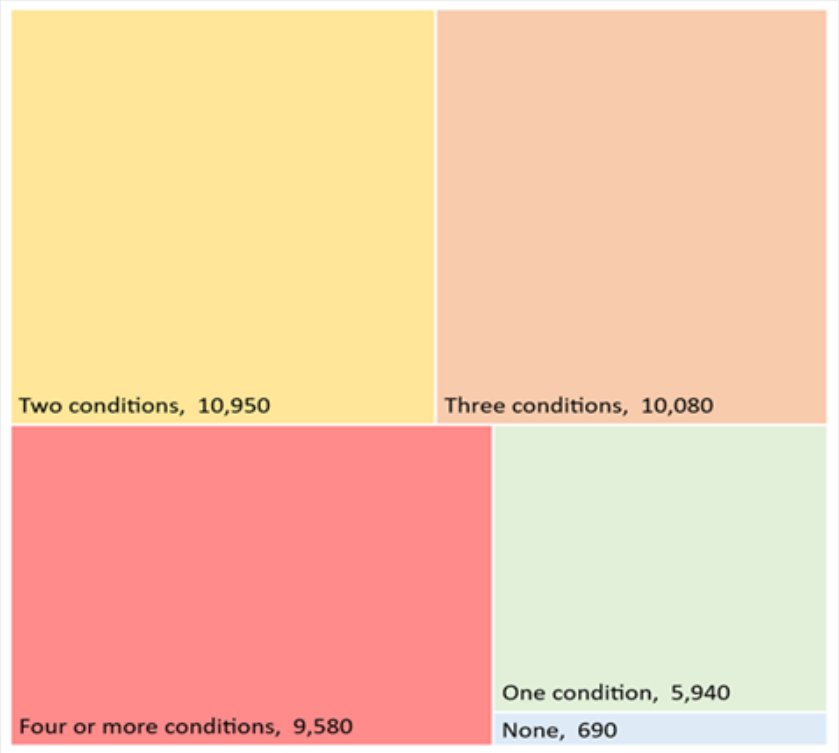


(Source: ONS)

The population of Leicestershire is projected to increase by over 10% in the next decade, by more than 70,000 people (to at least 803 thousand); this includes a nearly 37 thousand increase in older people (65 and over) by 2032; the number of people aged 80 and above is projected to rise by almost a half by 2032.

The population projections and current morbidity trends point toward a significant rise in the numbers of people with several chronic conditions (both mental and physical) in the near future[39]. This is important for planning purposes, both for health service and community care. An important factor is the increasing role of multi-morbidity – Leicestershire expected to experience a rise of over 30 thousand in the older population with at least two chronic conditions, and over 9.5 thousand with four or more, within a decade (Figure 6).

Figure 6. 2022-2032 Forecast for multimorbidity in Leicestershire (numbers of residents)



It is important to note that assumptions underlying the population projections are based on current and past demographic behaviours (births, deaths and migration) and trends; with a wide level of uncertainty, they are not forecasts. International migration was at unprecedented levels in the recent years and is a prime factor for that uncertainty[40] .

Further details of on demographic and economic picture of Leicestershire population is available in the Leicestershire JSNA 2022-25 Demography chapter.

2.2. Protected Characteristics

In the context of equality and discrimination law, 'populations with protected characteristics' refers to groups of individuals who are legally protected from discrimination and harassment based on specific characteristics or attributes. Equality Act 2010[41], which provides the legal framework for addressing discrimination and promoting equality in various areas of society identifies nine protected characteristics – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

The Equality Act 2010 places legal obligations on individuals, employers, service providers, educational institutions, and other organizations to promote equality and prevent discrimination based on these protected characteristics. It also establishes legal mechanisms for addressing complaints of discrimination, harassment, and victimization. By protecting individuals with these characteristics, the law aims to create a more inclusive and equitable society where everyone has

the opportunity to participate fully and without discrimination in all aspects of public life.

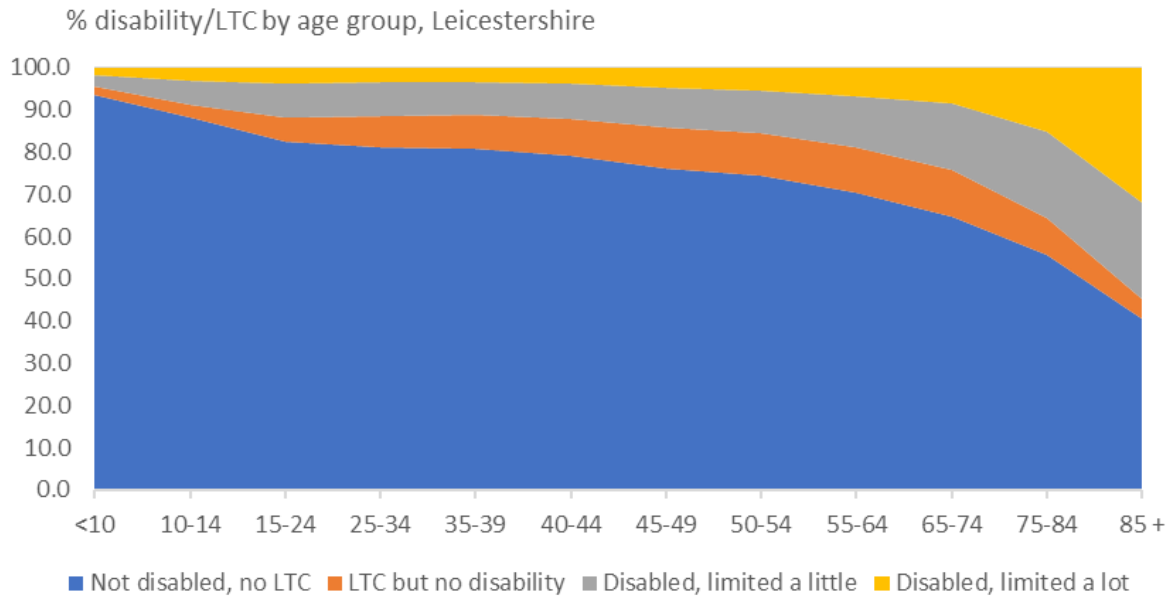
2.2.1. Disability and chronic ill-health

In Census 2021, 16.2% of Leicestershire population (N=113,470) declared they were disabled under the Equality Act, with 6% (N=43,222) saying that they were limited a lot in their daily activities. As comparison, for England these proportions were 16.9% and 7%. In addition, 7.8% (N=54,258) of Leicestershire population, although not disabled had a long-term physical or mental health condition, which is higher than the national average of 6.9%. These proportions are highly dependent on age, with rates of disability and chronic disease rising steeply in older population. More than half of the over 85s are disabled in Leicestershire (Figure 7).

There is a degree of local variation – rates of disability are higher than national average in Hinckley and Bosworth and North West Leicestershire. However, the rates of long-term disease without disability are generally high across local districts (higher than the average for England, except for Oadby and Wigston) (Figure 8).

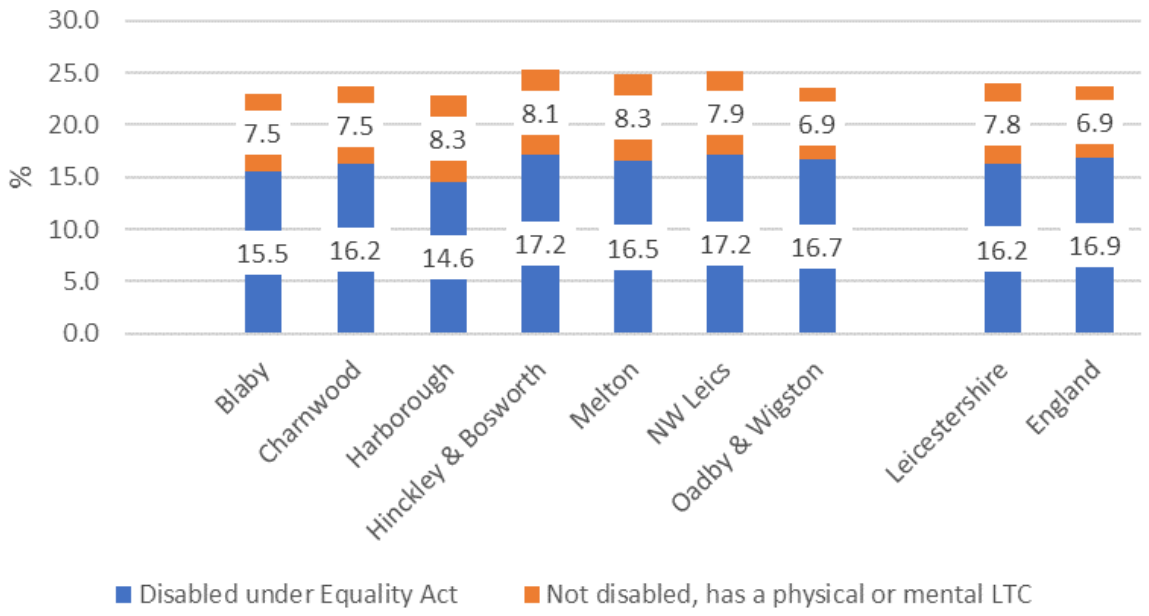
As these are crude rates, a variety of factors are involved, such as demographics, mainly age, and deprivation.

Figure 7. Disability and long-term conditions (LTC) - Census 2021



(Source: ONS)

Figure 8. Proportion of population with a disability or a long-term condition (LTC) across Leicestershire districts - Census 2021 (Source: ONS)



(Source: ONS)

2.2.2. Ethnicity, national identity, and religion

There is evidence for higher prevalence of mental health issues in some minority ethnic groups, for example rates of schizophrenia could be 5-6 time higher in the black populations and 2.5 times higher in the Asian groups. Ethnic minority groups can experience barriers in access to mental health care and could remain undiagnosed.

Overall, the proportion of ethnic minority population is lower in Leicestershire when compared to the national average (12.5% vs 19%). The highest proportion is that of Asian descent (8.2%) followed by mixed groups (2.2%). The proportion of the black minority is much lower in Leicestershire when compared to England (1.1% vs 4.2%). The picture varies across Leicestershire districts with lowest ethnic minority proportion in Melton (3.1%) and highest in Oadby and Wigston (36.6%) (Table 1).

Table 1. Ethnicity of Leicestershire population, Census 2021

	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple ethnic groups	White	Other
Blaby	8.3	1.5	2.7	86.2	1.3
Charnwood	12.4	1.5	2.5	82.3	1.2
Harborough	5.4	0.7	2.1	91.0	0.8
Hinckley and Bosworth	2.8	0.6	1.8	94.3	0.6
Melton	1.2	0.4	1.3	96.9	0.3
North West Leicestershire	1.5	0.6	1.5	95.9	0.5
Oadby and Wigston	27.9	2.2	3.2	63.4	3.3
Leicestershire	**8.2**	**1.1**	**2.2**	**87.5**	**1.0**
England	**9.6**	**4.2**	**3.0**	**81.0**	**2.2**

(Source: ONS)

In addition to ethnicity, religion and national identity can also play a part in mental health wellbeing. Research indicates that there is a positive correlation between religion and mental health possibly through positive cognitive appraisals, increased social support, healthier lifestyles and meditative practices. However, negative impacts (e.g., guilt or dependency) are also possible and such research is often criticised for biased recruitment of subjects and lack of reliable comparators from non-religious groups.

While Christian denominations are the most predominant religion in Leicestershire as well as nationally (46%), over 40% of Census 2021 respondents in Leicestershire declared themselves as having no religion, which is somewhat higher than the national average of 36.7%. While Hindu and Sikh religions are represented more commonly in Leicestershire than nationally, the proportion of people declaring themselves as Muslim are lower (2.3% vs 6.7%) (Table 2).

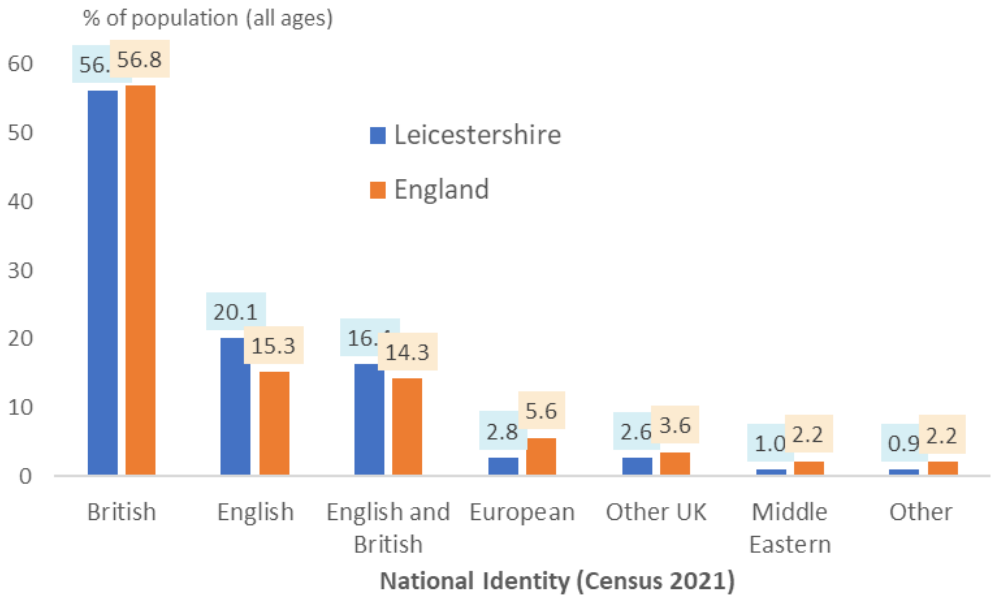
Leicestershire has relatively high numbers of people identifying as British, English or both (92%) when compared to England as a whole (86%). Another 3% are people with other UK identities, while any other groups constitute just 5% of population, compared to 10% nationally (Figure 9).

Table 2. Census 2021 - religion

	Leicestershire (%)	England (%)
Christian	45.7	46.3
No religion	40.3	36.7
Hindu	3.7	1.8
Muslim	2.3	6.7
Sikh	1.7	1.0
Other	0.8	1.6
Not stated	5.5	6.0

(Source: ONS)

Figure 9. National identity of Leicestershire population



(Source: ONS)

2.2.3. Sexual orientation and gender reassignment

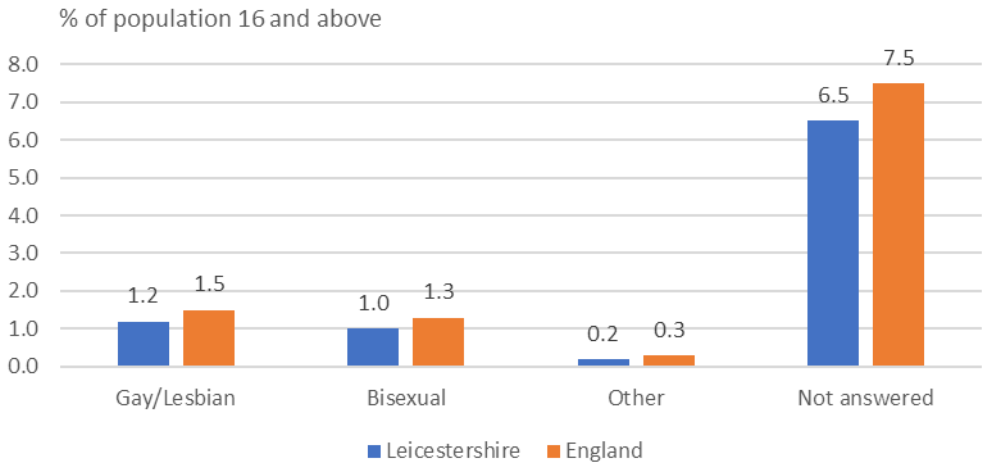
Research shows higher risk of depression, anxiety, self-harm and suicide in LGBT+ population. Gay men have been shown to have a four-times higher risk of attempted suicide, with women more prone to suicidal thoughts and self-harm when compared to the general population. The relative proportion of LGB is rising in the UK - the Annual Population Survey (2022), estimated 3.1% of the UK adult population as lesbian, gay or bisexual (LGB) in 2020, almost double the figure from 2014 (1.6%), with a similar pattern estimated for the East Midlands.

In Census 2021 a slightly lower proportion of adult Leicestershire population declared themselves

to be gay/lesbian or bisexual when compared to the national average; of note is a better response rate (only 6.5% not answered, compared to 7.5% in England) (Figure 10).

There was a total of around 7 thousand gay/lesbian and 6 thousand bisexual Leicestershire residents and 2.4% of adults declaring sexual orientation other than heterosexual (3.1% nationally) (Table 3).

Figure 10. LGBTQ population - Census 20



(Source: ONS)

Table 3. Sexual orientation - Census 2021

	Gay/Lesbian		Bisexual		Other		No answer
	Number	%	Number	%	Number	%	%
Blaby	1,055	1.3	690	0.8	150	0.2	6.1
Charnwood	1,970	1.3	2,070	1.4	440	0.3	7.2
Harborough	925	1.1	620	0.8	140	0.2	6.0
Hinckley & Bosworth	1,105	1.2	865	0.9	195	0.2	5.9
Melton	480	1.1	405	0.9	75	0.2	6.2
North West Leicestershire	1,070	1.2	865	1.0	200	0.2	6.1
Oadby & Wigston	420	0.9	425	0.9	120	0.3	7.8
Leicestershire Total	7,030	1.2	5,940	1.0	1,320	0.2	6.5

(Source: ONS)

In Census 2021 a total of 735* Leicestershire adults declared their gender was different to their sex

* All numbers in this section were rounded to nearest 5

at birth (0.15% of adult population, compared to the 0.25% national average). This number includes 375 trans women and 360 trans men.

Other categories include 280 non-binary adults and 144 in other gender identity groups.

2.2.4. Pregnancy and maternity

Pregnancy and the postpartum period can be times of significant emotional and psychological changes for women, and common mental health problems can arise during this period. Transient mood changes that occur in the days following childbirth are common and typically resolve within a few weeks. More serious and common mental health problems may include:

- Perinatal depression, term specifically referring to depression that occurs during pregnancy or in the first year after childbirth with symptoms such as persistent sadness, low energy, changes in appetite and sleep patterns, feelings of worthlessness or guilt, and difficulty bonding with the baby.
- Perinatal anxiety disorders, such as generalized anxiety disorder (GAD) and panic disorder, which can occur in that period, involving excessive worry, restlessness, irritability, trembling or palpitations.

Personal history of mental illness, experiencing stressful life events, lack of social support, lifetime history of abuse, marital conflicts, childcare stress, chronic physical illness, preeclampsia, gestational diabetes mellitus, being exposed to second-hand smoke and sleep disturbance are among the major contributing factors to perinatal depression[42].

Other less common mental health problems include post-traumatic stress disorder (PTSD) which can follow a traumatic childbirth experience, such as a complicated delivery or medical emergency, perinatal obsessive-compulsive disorder (OCD), with obsessions often related to the baby's safety or cleanliness, leading to compulsive behaviours like excessive checking or cleaning, relatively rare but severe postpartum psychosis, characterized by hallucinations, delusions, confusion, and rapid mood swings. There is evidence that women who are forced migrants are at a particular risk of PTSD [43].

Importantly, any pre-existing severe mental illness tends to relapse in the postpartum period. Early recognition, support, and appropriate treatment are essential for managing these mental health problems during pregnancy and maternity as problems may go unrecognised and untreated due to stigma. Healthcare providers play a crucial role in assessment, diagnosis, and treatment planning, but support from family and friends, as well as community resources, are equally important in addressing mental health challenges and promoting maternal well-being.

Estimates suggest that 12% of pregnant women experience depression and 13% anxiety, rising, respectively, to 15% and 20% postpartum. Often both. 1-2 per 1,000 women may develop psychosis postpartum. Mental health of mothers in perinatal period affects foetal well-being, obstetric

outcomes and the development of the child, and there are risks to using psychotropic medication[44].

Estimates presented in this section have serious potential caveats and were derived in 2019 from 2017 data by applying national estimates to local birth data; also data are only available down to UA level.

The number of women with post-partum psychosis or chronic SMI are estimated at less than 20 for Leicestershire, with under 190 cases of severe depression or PTSD in perinatal period. However, there could be around 800 women with mid-moderate depression and anxiety and twice as many with adjustment disorders and distress in perinatal period (Table 4).

Table 4. Estimated prevalence of mental health disorders in post-partum period in Leicestershire

	Number/Range	Lower CI	Upper CI
Postpartum psychosis	11	5	19
Chronic SMI	11	5	19
Severe depressive illness	159	136	186
Mid-moderate depression and anxiety	531-797	487	854
PTSD	159	136	186
Adjustment disorders and distress	797-1,593	742	1,674

(Source: OHID 2024)

Perinatal Mental Health Services

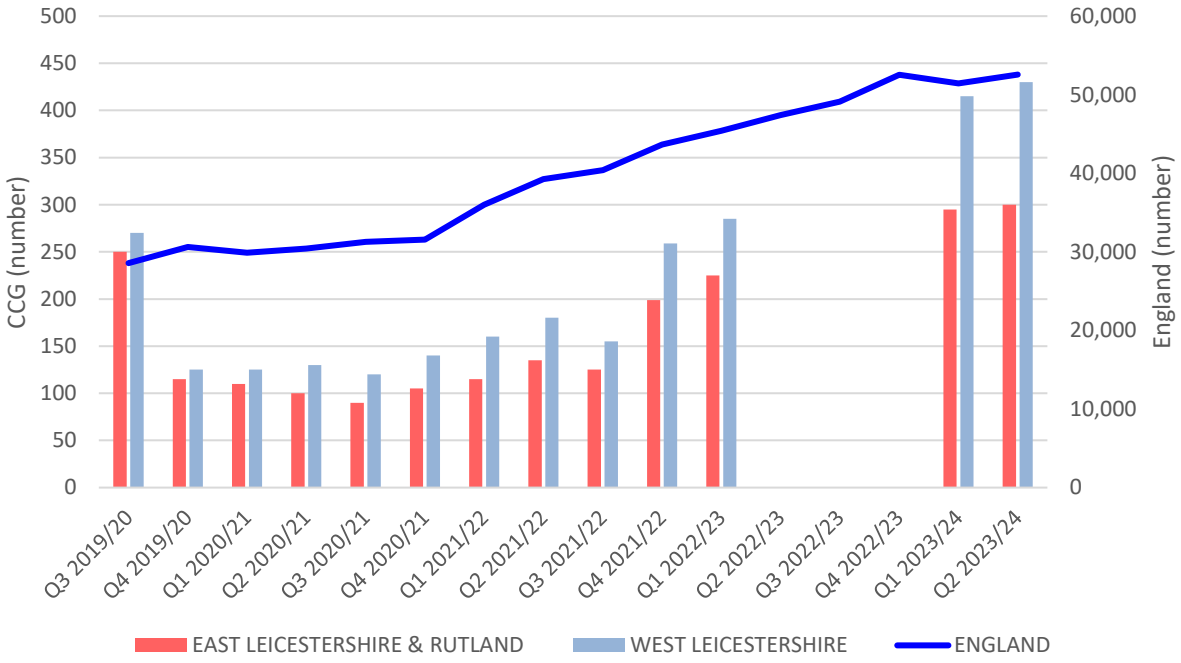
The trends in the numbers of women accessing community perinatal mental health services have been increasing in both old CCG areas, with 730 women across Leicestershire and Rutland recorded in quarter 2 of 2023/24 financial year, 300 in East Leicestershire and Rutland and 430 in West Leicestershire. The observed growth was similar to that observed nationally (Figure 11). CCG areas are the lowest level reporting for these services.

In 2022/23 the spend on this service across Leicester, Leicestershire and Rutland was over £2.55 million, with over £2.7 million planned for 2023/24 across LLR[†].

The national data for 2022/23 show that the rates for contact with specialist perinatal mental health community services correlated to social deprivation with 4.4/1,000 women in contact in the most deprived quintile of population, compared to 2.9/1,000. This would indicate a 50% increased risk, although these are crude rates and need to be treated with caution. Women from minority ethnic groups accessing these services appear to have somewhat older age profile (Figure 12).

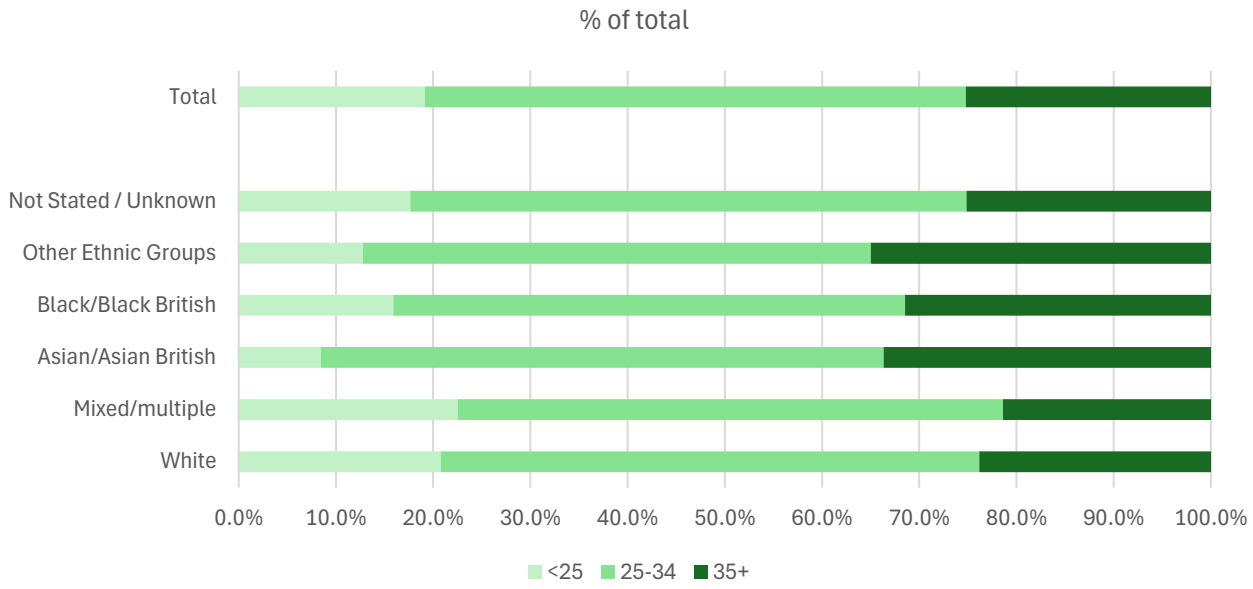
[†] *NHS England NHSMH Dashboard Q2 2023/24 (February 2024 – no financial data for sub-STP areas provided)*

Figure 11. Women accessing specialist community perinatal mental health services (trend – rolling 12 months)



Source: NHS Mental Health Dashboard (February 2024)

Figure 12. Age profile of women accessing specialist perinatal mental health services by broad ethic group in England 2022/23



Source: NHS Mental Health Bulletin (February 2024)

2.2.5. Marriage and partnership

The interaction between being in a relationship (whether marriage or civil partnership) and mental wellbeing is complex, with people in poor quality relationships having worse mental health outcomes than those who are single, while good relationships are strongly linked to higher level of mental wellbeing.

The positive side includes higher level of social and emotional support, reduction in feelings of loneliness, social integration with a partner's family and their social network, lower stress levels and better mental well-being. The sense of companionship and a sense of purpose and responsibility can enhance the overall well-being. Relationships can provide economic stability and reduce the stress associated with financial challenges.

However, marital or partnership conflict or communication issues, can lead to increased stress, anxiety, and depression. Being in an unsatisfying or unhappy marriage or partnership can negatively impact mental health, particularly the unresolved conflicts, past traumas, or unaddressed issues within the relationship can contribute to mental health challenges.

Other issues impacting mental health may involve overdependence on a partner, isolation from wider social networks and loss of autonomy.

All these are highly individualized, and quality and dynamics of the relationship play a significant role in determining whether the impact is positive or negative.

In 2021, nearly 48.8% of adults in Leicestershire were either married or in a civil partnership, higher than the national average of 44.7%. All districts had a proportion higher than national, with lowest rate in Charnwood (44.8%) and highest in Harborough (53%). There were over 81.7 thousand people in Leicestershire (11.7% of population) living alone in 2021, a slight increase from 11.4% in 2011 Census but below the national average of 12.7%. Nearly half of those living alone (39.1 thousand) were over the age of 65 (Table 5).

As these are crude rates, a variety of factors are involved, such as demographics, mainly age, and deprivation.

Table 5. Marriage and partnership - Census 2021

	Never married/CP [1]		Married/CP [2]		Separated [3]		Divorced [4]		Widowed [5]	
	Number	%	Number	%	Number	%	Number	%	Number	%
Blaby	27,296	32.6	41,743	49.9	1,680	2.0	7,440	8.9	5,507	6.6
Charnwood	59,880	39.1	68,613	44.8	3,005	2.0	12,650	8.3	8,956	5.8
Harborough	23,779	29.6	42,622	53.0	1,555	1.9	7,334	9.1	5,138	6.4
Hinckley and Bosworth	29,533	31.4	46,636	49.7	2,040	2.2	9,514	10.1	6,195	6.6
Melton	12,767	29.7	21,975	51.2	927	2.2	4,285	10.0	2,990	7.0
North West Leicestershire	28,861	33.5	41,450	48.1	1,926	2.2	8,598	10.0	5,333	6.2
Oadby and Wigston	15,680	33.2	23,404	49.6	935	2.0	3,656	7.7	3,535	7.5
Leicestershire	197,796	33.7	286,441	48.8	12,065	2.1	53,477	9.1	37,655	6.4
England	-	37.9	-	44.7	-	2.2	-	9.1	-	6.1

[1] Never married and never registered a civil partnership.
[2] Married or in a registered civil partnership.
[3] Separated, but still legally married or still legally in a civil partnership
[4] Divorced or civil partnership dissolved.
[5] Widowed or surviving civil partnership partner.
(Source: ONS)

2.3. Education, Learning and Development

The level of education can have a significant impact on mental health, and this relationship is complex and multifaceted. Educational attainment is often associated with various social, economic, and psychological factors that can influence an individual's mental well-being. Higher levels of education are generally associated with greater access to financial resources through employment opportunities, healthcare, and social support. Education can open doors to a wider range of employment opportunities and higher-paying jobs. Having stable employment and financial security can reduce stress and anxiety related to economic stability, which is a significant factor in mental health. Education can enhance cognitive skills, problem-solving abilities, and coping strategies as well as improve health literacy, enabling individuals to better understand and manage their physical and mental health.

Individuals with higher educational attainments are more likely to have better social networks, including friendships and professional relationships. These social connections can provide emotional support and reduce feelings of loneliness and isolation, which are important for mental well-being. Education can also promote greater awareness and reduce stigma surrounding mental health issues. Individuals with higher levels of education may be more open to seeking help and discussing mental health concerns. Education is associated with healthier lifestyle choices, including regular exercise, a balanced diet, and reduced rates of tobacco and alcohol use. These factors can have a positive

impact on mental health.

Education is considered one of the social determinants of health, including mental health.

2.4. Childhood

Specific issues affecting children and young people are covered CYP MH JSNA (https://www.lsr-online.org/children-and-young-people-mental1)

2.5. Social Media

Social media can also have various effects on mental health, both positive and negative, ones that can vary widely from person to person and depends on individual usage patterns and experiences. The positive effects may include enabling social connections, information and awareness regarding mental health issues or reduction of stigma, providing a platform for self-expression and creativity, and group support groups on social media platforms where individuals with shared experiences can connect, share advice, and provide mutual support[45].

However, there are several potential negative effects, such as online harassment and cyberbullying, negative social comparison, or addiction-like behaviours which interfere with daily life activities.

The resulting problems may include feelings of inadequacy, low self-esteem, procrastination, reduced productivity, all the way to severe psychological consequences, including anxiety, depression, and feelings of isolation.

Concerns about privacy, data security, and the potential for information to be misused on social media platforms can lead to anxiety and mistrust. Seeing updates and activities of others can lead to a fear of missing out (FOMO) on experiences, which can induce stress and anxiety.

Social media algorithms can create echo chambers where individuals are exposed to information and opinions that align with their existing beliefs, potentially leading to polarization and reinforcing biased views[46].

2.6. Lifestyle

Lifestyle plays a crucial role in mental health, and the choices individuals make in their daily lives can significantly impact their psychological well-being. While positive lifestyle choices can promote good mental health, unhealthy behaviours can contribute to mental health challenges. Positive behaviours include regular physical activity, healthy diet, adequate sleep, stress management, maintaining healthy social relationships and a strong support network, and engaging in meaningful activities that provide a sense of purpose can boost self-esteem, promote happiness, and reduce the risk of depression.

Conversely, unhealthy lifestyle choices that have been shown to effect poor mental health include

sedentary lifestyles (lack of physical activity and prolonged periods of sedentary behaviour have been associated with an increased risk of depression and anxiety), poor diet, high in processed foods, chronic sleep deprivation or poor sleep quality can impair cognitive function, mood regulation, and overall mental well-being, prolonged exposure to chronic stress without effective coping mechanisms can lead to the development of anxiety and depression. Lack of social connections and feelings of loneliness can have a detrimental impact on mental health and increase the risk of depression and anxiety, substance use, including excessive alcohol consumption and drug addiction, can worsen existing mental health issues and increase the risk of developing new ones. Engaging in negative coping strategies, such as avoidance, self-medicating with substances, or engaging in risky behaviours, can exacerbate mental health problems[47].

It is important to recognize that mental health is influenced by a combination of genetic, environmental, and lifestyle factors. While lifestyle choices can significantly impact mental well-being, mental health disorders are complex, and individuals may require professional help and support to address their mental health needs.

2.7. Employment

Employment provides not only financial security but also a sense of purpose, social connections, and opportunities for personal growth, while involuntary unemployment is likely to have significant negative impact on individual's mental health.

Various aspects of the work environment can influence mental well-being positively or negatively. Employment generally provides a source of income, which can reduce financial stress, and often a sense of purpose and meaning in life. It can enable the development of social connections, enhancing emotional support and reducing feelings of isolation. It can provide routine and structure to daily activities, leading to a sense of stability and predictability. Employment can also offer opportunities for skill development and personal growth, contributing to a positive self-concept and mental well-being.

However, the negative impacts may include work-related stress, which can lead to mental health issues such as anxiety, depression, and burnout. Workplace bullying, harassment, discrimination, or toxic work environments can have a detrimental impact on mental health and well-being. Imbalanced work-life schedule or excessive overtime can both contribute to exhaustion, stress, and mental health problems. Job insecurity, such as temporary employment or frequent layoffs, can lead to anxiety and uncertainty about the future. Lack of autonomy or control of one's job can be stressful and negatively affect mental health. Jobs that are unfulfilling or do not align with an individual's interests and values can lead to dissatisfaction and unhappiness. Irregular or rotating shift work can disrupt sleep patterns and contribute to sleep disorders, which can negatively impact mental health.

The impact of employment on mental health varies from person to person and is influenced by

individual factors, job characteristics, and work environments. Employers can play a significant role in promoting mental well-being by creating supportive work environments, offering employee assistance programs, and addressing issues related to workplace stress and mental health stigma.

Further discussion of employment is provided **in section 4.2** on impact of wider economic factors on mental health in Leicestershire.

2.8. Cost of Living

The rising cost of living has had significant impact on mental health, affecting various demographic groups. Economic challenges lead to financial stress, which is closely linked to anxiety and depression. A report by the Money and Mental Health Policy Institute highlighted that 59% of adults in the UK say that the cost of living has had negative impact on their mental health leading to anxiety, depression or feelings of hopelessness[48] .

The cost of living crisis has well documented, wide-ranging impacts, including increased social isolation, workplace stress, often coupled with job insecurity, leading to anxiety and depression. There can be significant impact on families; children in low-income families are more likely to suffer from mental health problems[49] . Higher food prices can lead to poorer nutritional choices, which research suggests may have a further detrimental impact on mental health. Nutrient deficiencies, resulting from cost-cutting on groceries, can exacerbate mental health issues[50] . Economic downturns often lead to reduced access to mental health services, through cuts to funding and changes in help-seeking behaviours. The ongoing uncertainty about economic conditions and future financial stability can lead to chronic stress, impacting overall mental health. Particularly long-term exposure to such stress can lead to severe mental health problems, including anxiety disorders and depression.

2.9. Rurality

Living in a rural environment can have a significant impact on mental health. Whether these effects are predominantly positive or negative can vary depending on individual factors, such as access to resources, and the specific challenges and opportunities that rural living presents.

Potentially positive effects include strong communities with supportive social networks, access to natural settings and outdoor activities, resulting in reduced stress, improved mood, and enhanced well-being, lower levels and more relaxed pace of life compared to urban areas.

However, there are also significant risks to mental health resulting from limited access to healthcare facilities, including mental health services. This can result in delayed or inadequate mental health care. Smaller communities can sometimes lead to concerns about privacy and stigma surrounding mental health issues. At an individual level, the experience of social isolation can a be a significant contributory factor to feelings of loneliness and depression, especially among older adults.

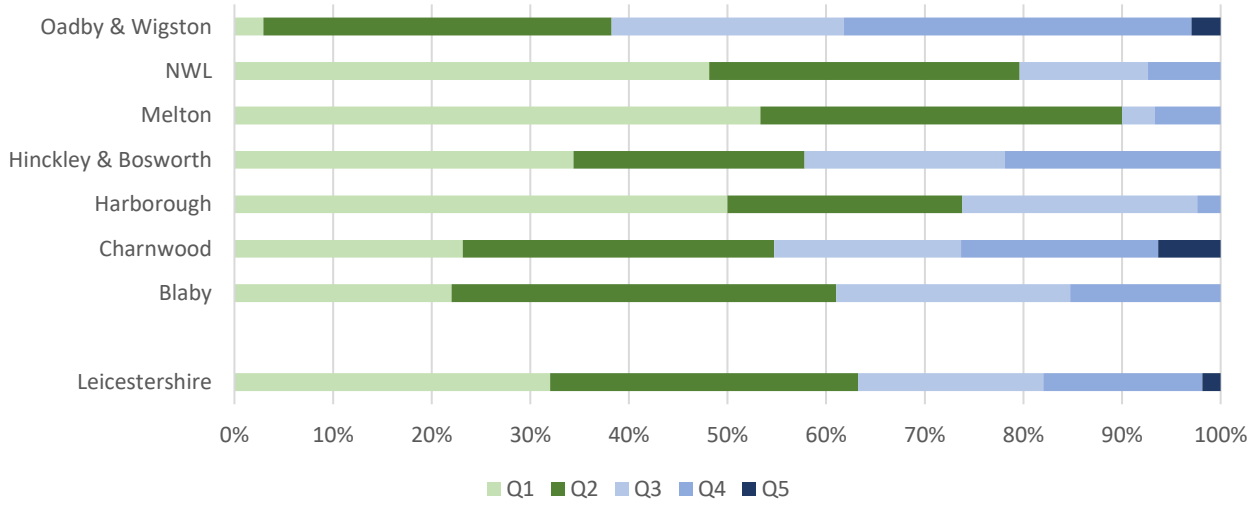
For the younger adults, rural areas may have fewer job opportunities, lower wages, and limited career options, impacting negatively on mental health, compounded by poor public transport and long travel distances to essential services. Rural areas may have limited access to high-speed internet and digital technologies. This can affect individuals' ability to access online mental health resources and telehealth services.

It's important to note that the impact of rurality on mental health is not uniform and can vary widely based on individual circumstances and the specific rural community in question. Addressing the mental health needs of rural communities requires a comprehensive, multidisciplinary approach that considers the unique challenges and strengths of rural living.

As currently available urban-rural classification is based on Census 2011, population density from Census 2021 is presented here as a more recent proxy. Nearly a third of Leicestershire LSOAs (32%) are in the national lowest national quintile by population density (less than 2,610 residents per square kilometre), although this varies between just 3% in Oadby and Wigston and more than a half (53%) in Melton. On the other hand, only 2% of Leicestershire LSOAs are in the highest quintile (over 6,526 per km^2) with just two districts having such highly populated areas - 6% of LSOAs in Charnwood and 3% in Oadby and Wigston (Figure 13).

According to the Census 2011 rural-urban classification, Blaby, Oadby and Wigston, and Charnwood are described as predominantly urban ('urban with city and town'), Hinckley and Bosworth, and North West Leicestershire are predominantly rural ('largely rural') while Harborough and Melton are described as 'mainly rural'[51].

Figure 13. Leicestershire and district LSOAs by national quintiles of population density



Source: ONS 2021

2.10. Loneliness

Loneliness is a complex emotional state that arises when individuals perceive a gap between their desired and actual social connections. It can affect people of all ages and backgrounds, and is closely associated with symptoms of depression, anxiety, and low self-esteem. Individuals who are lonely may be more prone to developing clinical depression, generalized anxiety disorder and social anxiety.

Chronic loneliness can contribute to elevated stress levels. The stress response, when activated over extended periods, can negatively impact physical and mental health, potentially leading to conditions such as cardiovascular disease and immune system dysfunction. It has also been linked to cognitive decline and impairments in attention, memory, and problem-solving.

Some individuals may turn to alcohol or drugs as a way to cope with the emotional pain of loneliness, leading to substance use disorders and addiction.

Loneliness is a known risk factor for the development or exacerbation of various mental health disorders, including mood disorders (depression and bipolar disorder), anxiety disorders, and even psychotic disorders. Persistent loneliness can be a significant risk factor for suicidal thoughts and behaviours.

Loneliness is not only detrimental to mental health but also has physical health consequences. It has been associated with inflammation, compromised immune function, cardiovascular problems, and a higher risk of chronic diseases. It can disrupt sleep patterns, leading to difficulties falling asleep or staying asleep, with further consequences on individual's mental health. Addressing loneliness and nurturing social connections is essential for maintaining good mental health and overall well-being.

Based on the responses the Active Lives Adult Survey (Sport England)[52], in 2021/22 6% of adults in Leicestershire (aged 16 and over) are likely to be lonely 'often or always' (equivalent to approximately 35,300 adults in Leicestershire), and 18.1% 'some of the time'. These rates were not significantly different to the national figures of 6.8% and 18.1%, respectively.

2.11. Other Groups at Risk

This section discusses the sub-groups of population which can be missed in the general statistics but can be at a much higher risk of mental ill-health with specific vulnerabilities and combinations of common or group-specific risk factors. A substantial proportion of people in prison, for example, experience depression, anxiety, self-harm or attempt suicide. Victims of crime have higher risk of developing mental health problems. Other groups include the homeless, migrants, adult social care users, military personnel and their families.

2.11.1. Prison population

The experience of being in prison, along with the factors leading up to incarceration, can affect

individuals in various ways, both psychologically and emotionally. Individuals with pre-existing mental health conditions may find it challenging to access the necessary treatment and support within prison.

Prisoners have an increased risk of mental health conditions including depression, due to harsh and restrictive environment of prisons, loss of freedom and separation, and anxiety as result of stress of incarceration concerns about safety, violence, and the uncertainty of the future. This includes acute anxiety or panic attacks. Other common problems include post-traumatic stress disorder (PTSD) and substance use; both drug and alcohol use are prevalent in prison populations and incarceration may initiate or exacerbate pre-existing substance use[53].

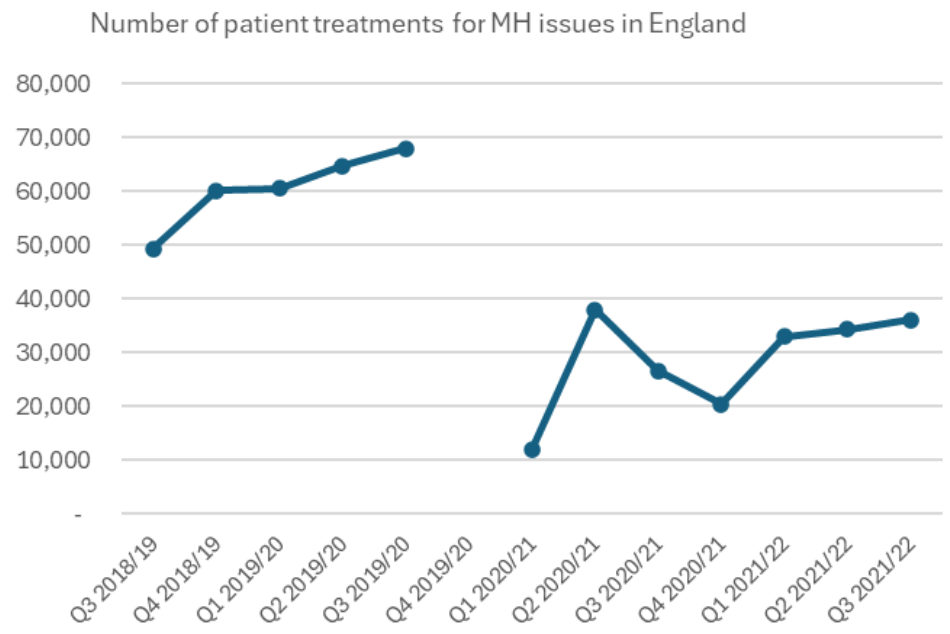
Imprisonment often results in social isolation and separation, loneliness and feelings of abandonment, stigma associated with being in prison, feelings of shame and low self-esteem, loss of personal freedom and autonomy and the resulting distress. In some prison environments, violence and victimization can be common, leading to increased stress, fear, and trauma among inmates. After release, individuals may face difficulties reintegrating into society. Some prisons offer limited access to mental health care[54].

It's important to note that the impact of imprisonment on mental health can vary widely based on individual factors, the conditions of incarceration, and the availability of mental health support within the prison system. Efforts to improve mental health care within the prison system and support for individuals both during and after their incarceration are critical steps in mitigating the negative effects of imprisonment on mental health.

The recent (2023) Survey of Prison Mental Health Services in England, based on over 7,700 sample representing 14% of the prison and Youth Offender Institution (YOI) population offers some estimates of prevalence of mental problems in that population. The most common diagnoses were anxiety and/or depression, and talking therapies were the most commonly offered main intervention. A diagnosis of personality disorder was the third most common presenting problem (over 17% nationally). Attention deficit hyperactivity disorder accounted for nearly 9% of main presenting problems nationally, and post-traumatic stress disorder and other trauma diagnoses accounted for 8%. Those with a recognised neurodiverse issue on the caseload accounted for over 17% (including those for whom this was not the main presenting problem), and research on the prevalence of various neurodiverse issues suggests the numbers of people in the custodial population with one or more will be much higher [55].

In England in 2021 there were nearly 124 thousand treatment episodes for mental health issues for adult prison population (excluding assessments), although rates were much higher prior to the COVID-19 pandemic (Figure 14).

Figure 14. Quarterly figures for mental health treatment in prison population in England before and after COVID-19 pandemic



(Source: NHS England NHSMH Dashboard Q3 2022/23)

There are two prisons within Leicester and Leicestershire for men - Leicester prison with an in-use uncrowded capacity (or Certified Normal Accommodation, CNA) of 212 population had a population of 307 in August 2023 (145%of in-use CNA) while Gartree prison in Market Harborough, with an in-use CNA of 621 had a population of 589 (95% of in-use CNA). In addition, HMP Fosse Way, a new Category C prison in Leicester received first prisoners on 29th of May 2023. It has a planned capacity of 1,930 male inmates. In June 2023 it had a population of 123 (in-use CNA of 301)[56].

Female prisoners are generally sent to Peterborough prison.

2.11.2. Migrant population and traveller communities

International migration is an important driver of population change. The usual resident population in England and Wales grew by more than 2.0 million because of positive net migration since 2011.

Migrant populations, including refugees, asylum seekers, immigrants, and displaced individuals, often face unique mental health challenges due to the complex and stressful nature of migration. These challenges can result from pre-migration experiences, the migration journey itself, and post-migration settlement conditions. Mental health issues in migrant populations can manifest in various ways and may include trauma and post-traumatic stress disorder (PTSD) as a result of events in their home countries, such as conflict, violence, persecution, or natural disasters. Migrant populations are at higher risk of depression and/or anxiety due to stressors associated with migration, language barriers, cultural adjustment, discrimination, and uncertainty about legal

status[57].

The process of adapting to a new culture and society can be stressful. Migrants may grapple with issues related to identity, discrimination, and navigating unfamiliar social norms and systems, may experience social isolation and loneliness due to language barriers, limited social networks, and the absence of familiar support systems. The challenges of finding housing, employment, and access to healthcare in the host country can be overwhelming for migrants, contributing to stress and mental health difficulties. Limited proficiency in the host country's language can hinder communication, access to services, and social integration, which may exacerbate mental health issues. Experiences of discrimination and racism can negatively impact mental health, leading to feelings of injustice, anger, and reduced self-esteem[58]. Some migrants may face barriers in accessing mental health care due to lack of insurance, limited resources, or insufficient culturally competent services. Migration can also disrupt family dynamics and roles, leading to additional stress within families.

However, it is essential to recognize that not all migrants will experience mental health issues, and many migrants are resilient and adaptable. Subgroups regarded as vulnerable such as asylum seekers, refugees, trafficked for forced labour, sexual exploitation, although these may be a minority in terms of numbers. Travellers are identified as a vulnerable population for a number of socioeconomic and health reasons such as barriers to employment and high levels of unemployment, which is recorded for almost a third of all adults in those communities (women are at a particular risk of unemployment), lower that national average educational attainment, lower level of homeownership, with a quarter of accommodation being caravans or other mobile homes (vs 0.3% nationally), high levels of perceived discrimination (community and service providers), barriers to accessing healthcare and other services, delayed healthcare seeking and poorer health outcomes[59].

There were just under 980 non-UK born short-term residents across Leicestershire recorded in Census 2021, the highest proportion (70%) in Charnwood, followed by Oadby and Wigston, and Blaby (both 8%) (Figure 15). The highest proportion (29%) place of birth of short-term residents was Eastern Asia (incl. China and HK), followed by 15% from Southern Asia (mainly India and Pakistan). More than a third (34%, N=328) were of European descent, 14% from countries which were part of EU in 2001 and 11% from those joining 2001-2011 (Figure 16).

Figure 15. Non-UK born short-term residents (number and as percentage of Leicestershire total) - Census 2021

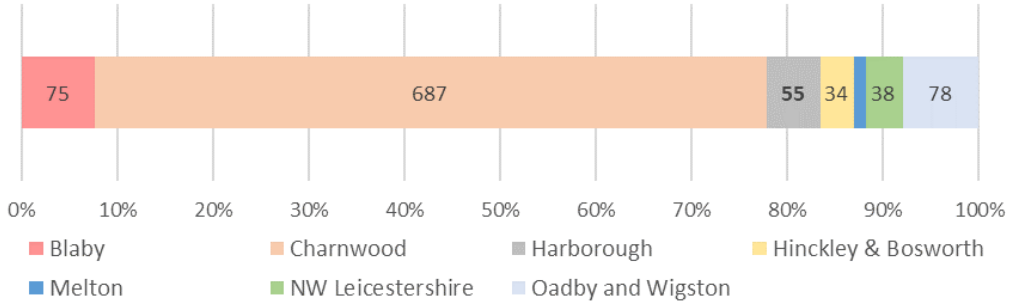
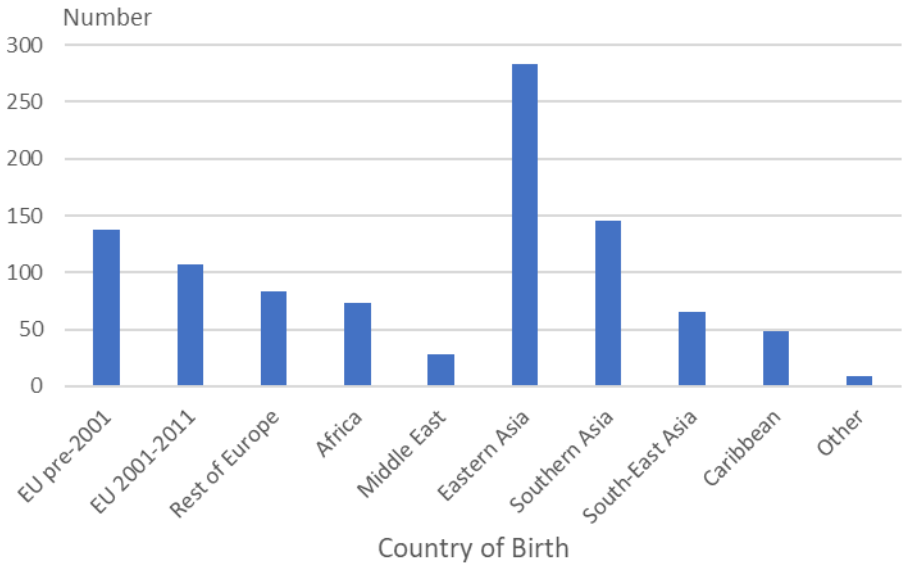


Figure 16. Non-UK born short-term residents - country of birth (Source: ONS)



(Source: ONS)

Census 2021 data show a total of 375 Leicestershire residents identifying as Gypsy or Irish Traveller and 389 as Roma. As a population rate this significantly lower than national or regional average (Table 6).

Table 6. Traveller population of Leicestershire - Census 2021

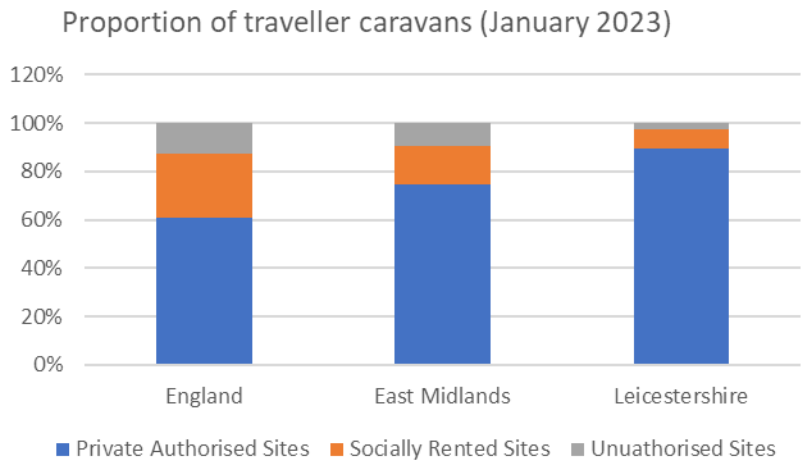
Area	Total	Gypsy or Irish Traveller		Roma	
	Population	Number	Rate*	Number	Rate*
England	56,490,070	60,073	10.6	99,138	17.5
East Midlands	4,880,047	4,160	8.5	7,196	14.7
Leicestershire	712,385	375	5.3	389	5.5
Blaby	102,927	78	7.6	55	5.3
Charnwood	183,948	48	2.6	165	9.0
Harborough	97,603	59	6.0	22	2.3
Hinckley and Bosworth	113,639	59	5.2	48	4.2
Melton	51,749	25	4.8	17	3.3
North West Leicestershire	104,708	98	9.4	63	6.0
Oadby and Wigston	57,738	6	1.0	18	3.1

** Rate per 10,000 resident population*

(Source: ONS)

The latest biannual count of traveller caravans in England (January 2023) reports 488 traveller caravans across Leicestershire, with highest number in Harborough (172), Blaby (142) and Hinckley and Bosworth (132). Melton and NWL were 16 and 26, respectively with none in Charnwood or Oadby and Wigston. Compared to the national and regional average, there were more caravans on private authorised sites (over 89% vs 61% nationally and 75% across East Midlands) (Figure 17).

Figure 17. Traveller caravans 2023



(Source: Department for Levelling Up, Housing and Communities 2023)

2.11.3. Crime

The relationship between crime rates and mental health of individuals is complex, multifactorial and bidirectional. On one hand, mental health of an individual can have an impact on their possible criminal behaviour, on the other, exposure to levels of local crime can affect the mental health of individuals[60].

Effects of crime on mental health vary depending on factors such as the type of crime, the frequency of crime in a community, individual vulnerabilities, and the availability of support systems. Some of the important factors, at individual and population levels include victimisation, fear and anxiety, community-level trauma, disruption of social networks or stigmatization, leading to a sense of injustice, anger, and negative impacts on mental health. Homicides and other violent crimes can lead to profound grief and loss within communities. Communities with high crime rates may also experience higher rates of drug and alcohol use, which can exacerbate mental health issues[61].

Police officers, emergency responders, and healthcare professionals who frequently deal with crime scenes and victims can experience significant psychological stress, leading to conditions like PTSD and depression[62].

It is important to note that individuals diagnosed with a mental health disorder are accountable for a fraction of violent offenders (1%) and are responsible for only a small percentage of societal violence and criminal behaviour (5%), on the contrary, they are more likely to be the victims of crime, being more vulnerable through impaired judgement, coping skills or social isolation. Exception are individuals with severe mental illness, namely schizophrenia and bipolar disorder, particularly people with triple morbidity (severe mental illness, substance use disorder and

antisocial personality disorder) who are substantially more likely to be violent than people with severe mental illness alone[63]. Despite this, persistent stereotypes continue to exist which often associates mental health disorders with criminal and violent behaviour; an image that is frequently reinforced through mass media outlets. Important factors include socio-economic, poverty, lack of education or employment opportunities, homelessness, substance use, rates of incarceration and access to mental health care.

The indirect costs of crime are likely to be much higher than the direct costs, although any intangible impacts (including anxiety and mental distress) are particularly difficult to measure or estimate. A 2012 study based on English survey data (British Household Survey Panel, BHPS, and English Longitudinal Study of Ageing, ELSA) found that crime caused considerable mental distress of residents, mainly driven by property crime, but also, at an individual level, by violent crime. Local crime appeared to create more distress for females and is mainly related to depression and anxiety[64].

It is important to monitor local rates as crime is not randomly distributed and is most commonly linked to high levels of deprivation and social disorganisation[65].

National and Police Force Area crime rates

There are two primary offence groups: victim-based crimes and other crimes against society. Victim-based crimes are those with a specific identifiable victim. All Crime Survey for England and Wales (CSEW) crime is victim based, as it is derived from a survey of people's experiences of crime and must have a victim for it to be recorded.

Police recorded crime includes both victim-based and other crimes that do not normally have a direct victim, referred to as "other crimes against society". Victim-based crimes include violence against the person (VAP), sexual offences, including rape, robbery, theft offences, and criminal damage and arson. Other crimes against society include drug offences, possession of weapon offences, public order offences and miscellaneous crimes against society.

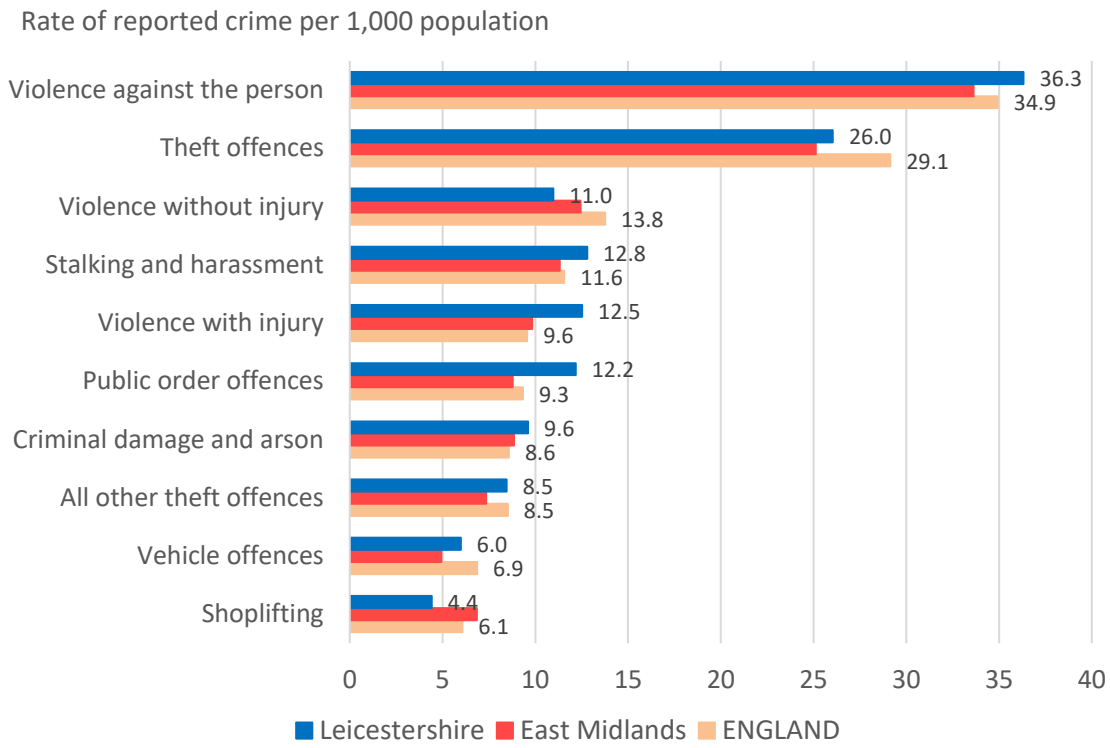
It is important to stress that these are not additive, as some events can be reported under more than one category.

Figure 18 presents the published comparative crime rates for police areas for year ending June 2023 for Leicestershire, East Midlands and England[66].

In the latest nationally reported year, the total crime rate for Leicestershire police force area (including Leicester, Leicestershire and Rutland) was 94.4 per 1,000 residents, compared to England's 92.5 per 1,000 residents and 86.4 per 1,000 residents for the East Midlands. The most common type of crime in England was violence against the person (VAP, 35 per 1,000 residents), closely followed by theft offences (29 per 1,000 residents). Violence without injury constituted 14 per 1,000 residents, stalking and harassment nearly 12 per 1,000 residents and violence with injury nearly 10 per 1,000 residents. While the local (LLR) rates of theft offences (26 per 1,000 residents)

and violence without injury (11 per 1,000 residents) were lower than national, the VAP rate was slightly higher (36 per 1,000 residents), as were stalking and harassment and violence with injury (both at 13 per 1,000 residents). It is important to stress that these are not additive, as some events can be reported under more than one category.

Figure 18. Police force area crime rates - year ending June 2023 (ONS 2023)



(Source: ONS 2023)

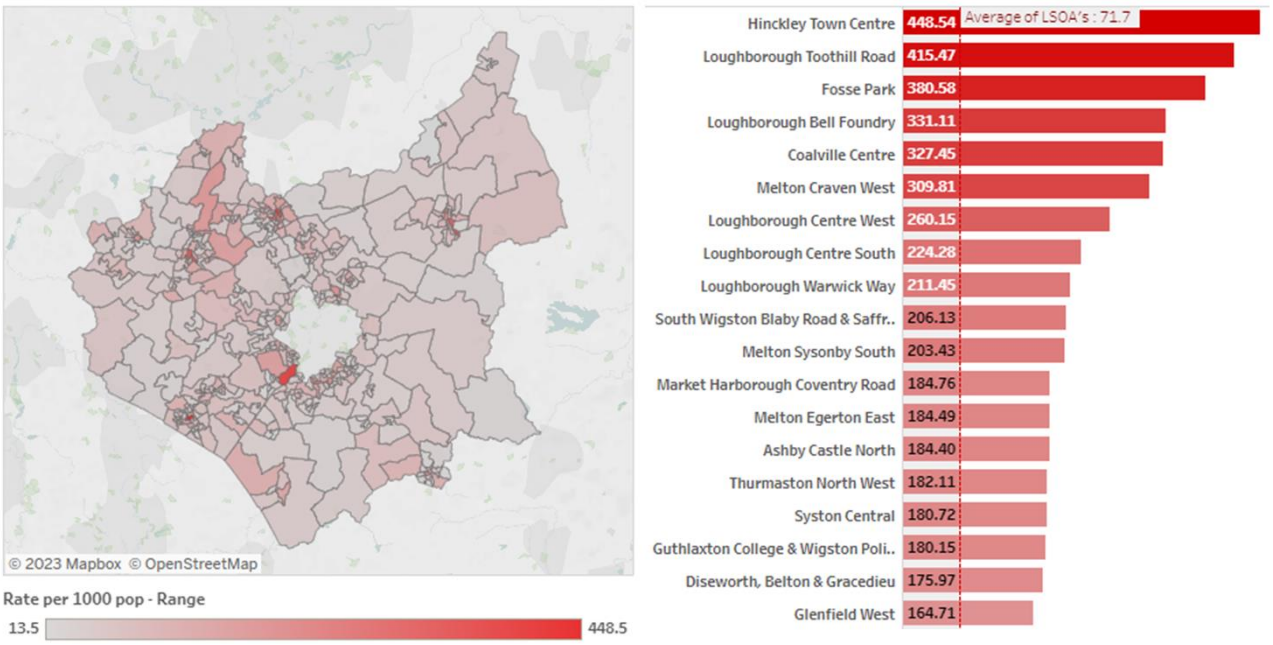
Crime rates in Leicestershire

Territorial police forces of England and Wales report crime and outcomes data on a monthly basis as a cumulative year-to-date aggregate (*Crimsec4* form). This system allows for a more up-to-date and granular look at the local rates. It is important to stress that this system records the outcome rather than where and when the original offence occurred, and as such the rates reflect police activity rather than the actual crime rate. Furthermore, all figures can be subject to revisions and, particularly for drug offences, time trends have to be treated with caution.

In the year between October 2022 to September 2023 there were just over 51,900 incidents of crime or anti-social behaviour (ASB) recorded, which constitutes a rise from just over 44,000 four years ago (2020). This equates to around 72 incidents per 1,000 residents on average.

At a local level there is significant variation - local LSOA rates varied 32-fold, between almost 450 (Hinckley Town Centre) and 14 (Harborough West) per 1,000 (Figure 19).

Figure 19. Variation in reported crime rate across Leicestershire



(Source: Leicestershire Crime Dashboard, 2023)

Table 7 presents the rates across Leicestershire using categories best matched to the national and regional averages presented in in Figure 18. It shows that VAP rates for Leicestershire County (rather than LLR total) were lower than national (28/1,000 vs 35/1,000), as was the rate of public order offences (8.2 vs 9.3/1,000), while rate of violence with injury was comparable (9.3 vs 9.6/1,000).

Table 7. Most common categories of reported in 2023

	Leicestershire	
	N°	*Rate*
Violence against the person (VAP)	19,696	27.6
Rural Crime	13,833	21.1
Violence w/o injury	13,080	18.3
Domestic crime	8,625	12.1
Domestic VAP	6,640	9.3
Violence w/injury	6,608	9.3
Public Order	5,813	8.2
Alcohol related crime	5,767	8.1
Total crime	**51,916**	**72.8**

(Source: Leicestershire Crime Dashboard, 2023)

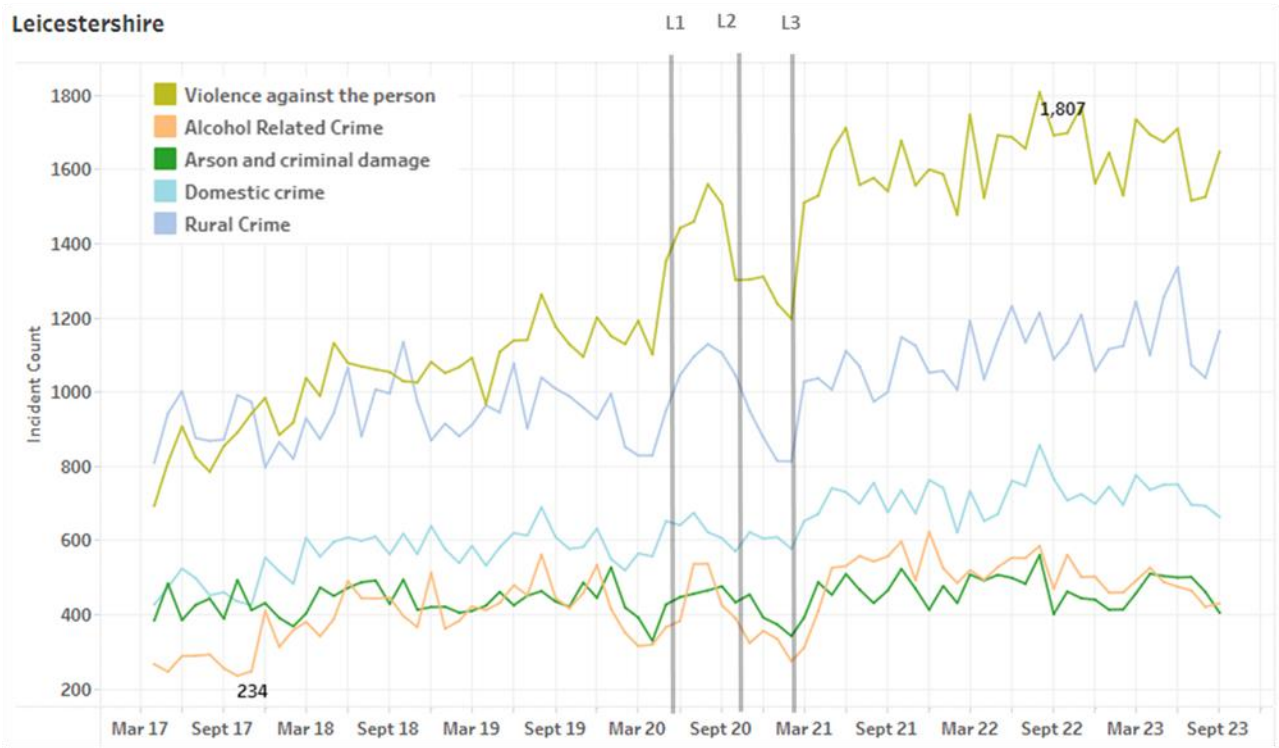
Figure 20 presents the time trends in the most commonly reported crime categories in the recent years, covering the period of COVID-19 pandemic (L1-L3 – approximate COVID-19 lockdown dates). In the last year (October 2022 to September 2023) the violence against the person (VAP) was the most commonly reported crime in Leicestershire (38% of all crime reported). This was equivalent to

rate of 28 per 1,000, below the national average of about 35/1,000. The numbers of reported incidents of VAP have doubled in Leicestershire since 2017.

Around two-thirds of reported VAP incidents was classified as domestic and about the same proportion of all violence was with, rather than without, injury. A large proportion of incidents are understandably classified across Leicestershire as "rural crime", with rates particularly high Harborough and North West Leicestershire.

The rate of VAP was highest in NWL (34/1000) and lowest in Blaby (25/1000) – further details of crime in individual districts are given in **the Appendix**.

Figure 20. Recent trends in reported crime in Leicestershire. L1–L3 COVID-19 lockdowns



(Source: Leicestershire Crime Dashboard, 2023)

2.11.4. Disrupted social ties

Disrupted social ties, such as the loss of social connections or the breakdown of relationships, can have a significant and negative impact on mental health. Individuals may experience a range of mental health challenges, including loneliness and isolation, depression, anxiety, loss of self-esteem and increased stress. Unresolved grief as result of a loss of close relations can lead to mental health issues such as complicated grief or depression. Substance use may become an unhealthy coping mechanism, as can overeating, or self-harm. Disrupted social ties can also have physical health consequences, as they are linked to higher levels of stress hormones, immune system dysfunction, and a higher risk of certain health conditions.

Mental health challenges resulting from disrupted social ties can interfere with daily functioning, including work, relationships, and overall quality of life[67].

2.11.5. Social care

Looking after a family member with a health problem, particularly a mental health issue, can significantly affect carers' mental health. Mental health problems of carers include emotional stress, depressive symptoms and, in some cases, clinical depression [68]. More than two-thirds (71%) of carers have poor physical or mental health[69]

According to the latest population Census, one in six Leicestershire residents in 2021 (16.6% of population) were disabled under the Equality Act, slightly below the national average of 17.3%. Over 4.4% declared having bad or very bad health, below the national average of 5.2%.

A substantial proportion of the local population (9.1%, which is slightly above the national average of 8.8%) provided unpaid care in 2021, with 4.1% providing more than 20 hours of care per week, just below the 4.4% England average. The needs of carers in Leicestershire are currently being assessed.

2.11.6. Students

The mental health of students can be impacted by various factors, leading to increased risks of developing mental health problems, such as high academic expectations, workload, performance pressure and fear of failure can all contribute to stress and anxiety. Many students face financial challenges, including tuition fees, living expenses, and student loan debt. Financial strain can lead to anxiety, depression, and difficulty accessing basic needs, such as food and housing. Transitioning to university or college can be socially isolating for some students, particularly if they are away from home or have difficulty making friends. Students who move away from home may have difficulty adjusting to a new environment. Relationship problems, breakups, social conflicts, and feelings of loneliness can exacerbate existing mental health issues. Some students may engage in substance use, such as alcohol, drugs, or prescription medications, as a coping mechanism for stress or to socialize. Perfectionistic tendencies, self-criticism and fear of failure can contribute to anxiety, depression, and burnout among students. Irregular sleep patterns, often due to academic demands, social activities, or stress. Some students may face barriers to accessing mental health services, such as long wait times, limited availability of resources, or stigma surrounding help-seeking behaviour.

In 2021/22, 119,500 of UK students said they had a mental health condition, which represents 5.5% of all home students. The number of students saying that they had a mental health condition was three and a half times as high as in 2014/15, and five times higher than in 2010. Higher rates of mental health conditions were reported among women, undergraduates, full-time students and those in their second or later years[70].

In Census 2021 19.7% of Leicestershire population aged five or over were classified as

'schoolchildren and full-time students', below the national average of 20.4%.

Using the economic activity classification within Census 2021, 5.8% of population over 16 classified as 'students', a total of 33,929 residents. Of that total over 5% (estimated at least 1,700) may require mental health support.

Loughborough University is the largest university with a total number of students for 2022-23 of 19,767, including postgraduate and other students.

2.11.7. Armed forces personnel and veterans

There are many risks to the mental health of armed forces personnel. Exposure to combat situations can lead to post-traumatic stress disorder (PTSD), anxiety, depression, and other mental health conditions. Deployments, whether in combat zones or other operational environments, can be stressful and disruptive, leading to feelings of isolation, separation from family, and adjustment difficulties upon return. The demands of military operations, including long hours, frequent deployments, and high-pressure environments, can contribute to chronic stress, exhaustion, and burnout among personnel. Physical injuries sustained during military service, such as traumatic brain injuries, amputations, and chronic pain, can have significant psychological impacts, including depression, anxiety, and PTSD[71].

There may be an increased risk of substance use, including alcohol and prescription drug misuse, as a coping mechanism for stress, trauma, or adjustment difficulties. Deployments and frequent moves can place strain on relationships and family dynamics, leading to increased stress, conflict, and challenges in maintaining social support networks. Some individuals may enter military service with pre-existing mental health conditions, such as depression, anxiety, or PTSD, which may be exacerbated by the demands and stressors of military life.

Stigma surrounding mental health issues within the military culture may prevent personnel from seeking help for mental health concerns, leading to delays in diagnosis and treatment, while logistical barriers, concerns about career repercussions, and limited access to mental health services may further hinder help-seeking behaviours[72].

Transitioning from military to civilian life can be challenging, as personnel may face difficulties adjusting to civilian roles, finding employment, accessing healthcare, and reintegrating into their communities.

There are no military bases in Leicestershire. However, in 2021 (Census) a total of 17,684 residents of Leicestershire reported to have served in the UK regular armed forces, with further 1,012 having served in both regular and reserve and 4,217 in reserve armed forces. As percentage of all-age population, the veteran population of Leicestershire is just over the average for England – 3.2% vs 3.1% nationally.

2.11.8. Homelessness

Homelessness is strongly associated with increased risks to mental health. Common mental health conditions among the homeless population include depression, anxiety disorders, post-traumatic stress disorder (PTSD), schizophrenia, and substance use disorders. Many homeless individuals have experienced significant trauma and adverse life experiences, such as childhood abuse, neglect, domestic violence, or traumatic events while living on the streets. These experiences can contribute to the development of mental health disorders and exacerbate existing symptoms[73].

Substance use is prevalent among homeless individuals, and there is a high rate of co-occurring mental health and substance use disorders (dual diagnosis). Substance use can exacerbate mental health symptoms and make it more challenging for individuals to access and engage with mental health services. Homelessness is often accompanied by physical health challenges, including inadequate access to healthcare, poor nutrition, exposure to harsh weather conditions, and increased risk of infectious diseases.

Homeless individuals often face social isolation, stigma, and discrimination, and face significant barriers to accessing mental health services and the stigma surrounding mental illness and negative past experiences with healthcare providers may deter individuals from seeking help.

In addition, there is an increased risk of experiencing violence, victimization, and exploitation. These traumatic experiences can have profound effects on mental health and contribute to the development of PTSD and other mental health disorders.

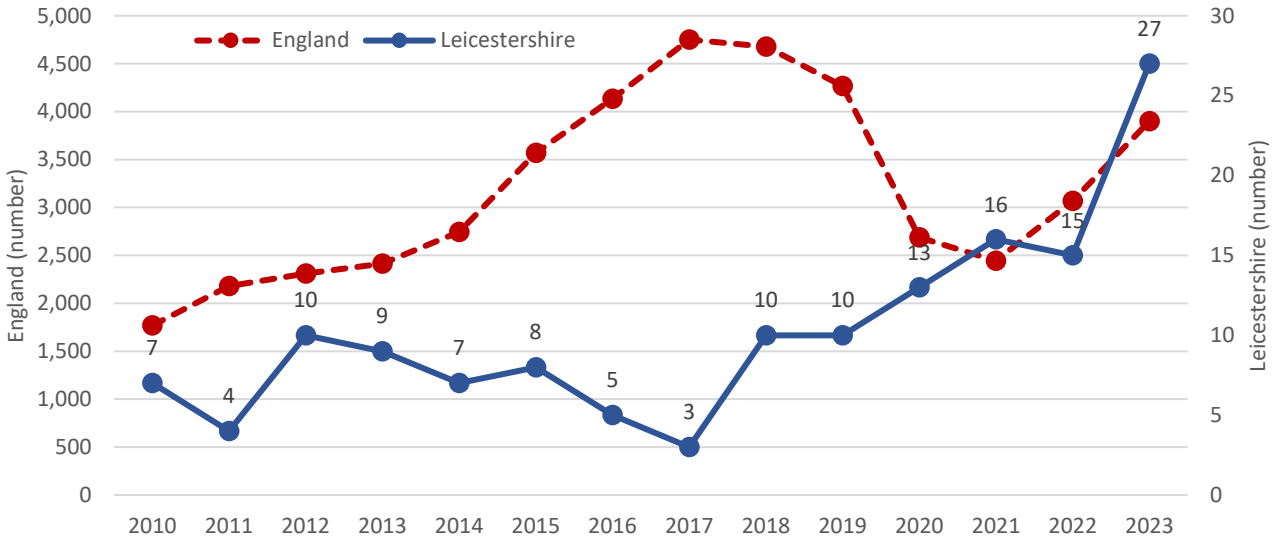
Homelessness and mental illness often form a vicious cycle, where mental health issues can contribute to homelessness, and homelessness can exacerbate mental health challenges. Breaking this cycle requires comprehensive support services addressing housing, healthcare, employment, and social integration.

The *Annual Rough Sleeping Snapshot in England*[74], reported on the numbers of people sleeping rough[‡] on one night in autumn in 2023. Across England there were nearly 3,898, which has risen for the second year in a row (by 27%) but remains lower than the peak in 2017, and 9% lower than pre-pandemic (2019) figures. The general national trend showed an increase up to 2017 with some reduction in 2018 and 2019. The East Midlands region followed a similar trend, with total or rough sleepers counted in 2020 at 187.

In Leicestershire the number of people sleeping rough (N=27, including 16 in Charnwood) in Autumn 2023 were the highest since 2010, with the increasing trend since 2019 (Figure 21).

[‡] The snapshot records only those people seen, or thought to be, sleeping rough on a single night and may exclude many groups, such as those in shelters.

Figure 21. Trends in numbers of people sleeping rough – Autumn Snapshot 2010-2023 (England and Leicestershire)



(Source: DLUHC Annual Rough Sleeping Snapshot, Autumn 2023)

The *Statutory Homelessness Statistics* for 2022/23 (Department of Levelling Up, Housing and Communities) show that across Leicestershire there were estimated 1,208 homeless households (owed a relief duty) and 897 households threatened with homelessness (owed a prevention duty). These numbers are equivalent to the rates of 5.2 and 3.9 per 1,000 total households[§] which are both lower than the 6.6 and 5.9/1,000 national rates.

Looking at their composition, homeless households were most commonly single adult male's (43%), followed by single adult females' or single female parents with dependent children (each at 23%). This last group is somewhat more prevalent than the national average of 18%.

For households threatened by homelessness, the most common comprised of single female parents with dependent children (32%), followed by single male households (22%) and single female households (21%).

Further district-level breakdown of homelessness statistics is included in the **Appendix**.

2.11.9. Multiple disadvantage

Multiple Disadvantage or Severe and Multiple Disadvantage (SMD) refers to people facing two or

[§] Charnwood data were not submitted for that year, thus total household numbers were removed from Leicestershire total to ensure rates were comparable

more of the following issues – mental health issues, homelessness, offending and substance use. SMD can include other sources of disadvantage, for instance poor physical health, domestic/sexual abuse, community isolation, undiagnosed brain injuries, autism and learning disabilities. In England, 2.3 million adults (5.2% of the population) face two or more of these primary domains in a single year[75].

A closely related term is that of multiple complex needs (MCN), a broad definition including severe and multiple disadvantage and multiple exclusion in a population experiencing co-occurring issues of homelessness, substance use, crime and mental health problems; overlapping vulnerabilities associated with extreme health inequalities[76].

SMD a higher degree of stigma and dislocation from societal norms when compared to other social inequalities. People affected by this form of SMD are predominantly young white men, aged 25–44, often with long-term histories of economic and social issues and, in most cases, childhood trauma of various kinds, very poor family relationships and/or educational experience. [77].

Despite having very high levels of morbidity and mortality, people with SMD encounter significant barriers to accessing healthcare and have lower patient enablement and they are more likely to have negative experiences of healthcare, including stigma and discrimination. GP appointment systems are often incompatible with their help seeking behaviours and the majority of general practice does not effectively include them [78].

An analysis, published by Lankelly Chase Foundation in 2015[77] and based on data for 2010 and 2011, estimated that an 'average' local authority might expect to have about 1,470 SMD (as defined by involvement in two out of the three relevant service systems) cases per year, however this would vary across the country. Specific rates were calculated for all local authority areas using data on homelessness (Supporting People), drug use (NDTMS) and offender data (Offended Assessment System). Leicestershire was placed among the 20 lowest prevalence areas, with a score of 47, with national average 100, ranging from 21 (Wokingham) to 306 (Blackpool). Thus, the rate of SMD is likely to be less than half of national average. Accordingly, one can broadly estimate the number of adults with SMD at 2,400 across Leicestershire.

3. Mental Health Needs

3.1. Mental Well-being and Mental Health Conditions

Mental well-being, also referred to as mental health and emotional well-being, encompasses a person's emotional, psychological, and social state of being. It reflects an individual's overall mental and emotional health and their ability to cope with life's challenges. While there is no universally agreed-upon definition, mental well-being is often characterized by emotional resilience, positive

emotions, self-acceptance, autonomy and self-determination, positive relationships, personal growth and development, mental and emotional stability, quality of life and respect for other[79].

The World Health Organisation states that “mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes”. It also defines mental health conditions as “mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm” [80].

It is important to note that mental well-being is not a fixed state but a dynamic and evolving aspect of a person's life. It can be influenced by various factors, including genetics, environment, life experiences, and personal choices. Additionally, mental well-being is not the absence of all negative emotions or challenges but the ability to navigate and overcome them in a healthy and adaptive way. Although people with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case.

3.2. Common Mental Disorders (CMD)

Common mental health conditions include a variety of, often overlapping, disorders such as depression, anxiety, phobias, obsessive-compulsive disorder (OCD) and panic disorder. Although they do not affect cognition, they may cause a significant level of distress and disability. They are relatively common and often undiagnosed, hence the importance of population-based estimates[81].

3.2.1. Wider determinants

Common mental disorders are influenced by a wide range of factors, including both individual and wider determinants. The wider determinants of mental disorders refer to the broader social, economic, environmental, and cultural factors that can affect an individual's mental health and well-being. These determinants often interact with individual-level factors to shape mental health outcomes.

The socioeconomic factors play a significant role in mental health. Unemployment, income inequality, and lack of access to basic resources (e.g., housing, healthcare, education) can contribute to stress and increase the risk of mental disorders. The nature of employment, job security, and workplace stress can impact mental health. High-stress jobs, job insecurity, and workplace discrimination can contribute to mental disorders. Strong social support systems and positive social relationships are protective factors for mental health. Loneliness, social isolation, and lack of social connections can increase the risk of common mental disorders [82].

Adverse childhood experiences, including trauma, abuse, neglect, and household dysfunction, can have long-lasting effects on mental health and increase the risk of mental disorders in adulthood. Education and literacy levels are associated with mental health outcomes. Higher levels of education

are often linked to better mental health, as they can provide greater access to resources and opportunities.

Access to safe and stable housing, as well as the quality of the neighbourhood environment, can influence mental health. Unsafe or unstable housing and exposure to neighbourhood violence can be detrimental. Access to mental healthcare services, as well as general healthcare, is crucial. Barriers to accessing healthcare, including stigma, cost, and availability, can hinder early intervention and treatment.

Cultural factors, social norms, and stigma related to mental health can affect individuals' willingness to seek help and access services. Experiences of discrimination, racism, homophobia, or other forms of marginalization can contribute to stress, depression, and anxiety among affected individuals. Health behaviours, such as diet, physical activity, substance use, and sleep patterns, can impact mental health. Unhealthy behaviours may increase the risk of mental disorders. Availability and accessibility of social services, including social welfare, housing support, and community programs, can provide important resources for individuals facing mental health challenges.

Communities with high levels of social capital, characterized by trust, social cohesion, and civic engagement, tend to have better mental health outcomes for their residents [83]. Environmental factors, such as exposure to pollution, natural disasters, or extreme weather events, can contribute to stress and affect mental health.

Addressing the wider determinants of common mental disorders requires a comprehensive, multisectoral approach involving government policies, social programs, community support, and individual interventions. Efforts to reduce social and economic inequalities, improve access to healthcare, promote positive social relationships, and reduce stigma can all contribute to better mental health outcomes for individuals and communities [84].

Depression

Depression is a highly prevalent mental health condition globally and a major risk factor for suicide. In 2019, an estimated 280 million people, including 5% of all adults and more than 10% of women in perinatal period, experienced depression. It is a major contributor to loss of productivity, together with anxiety it is estimated that nearly 1 trillion US dollars are lost each year due to lost productivity worldwide [85] .

Around one in five people (20%) across the world will experience depression at some point in their lives and the annual prevalence is somewhere between 5 and 10%. Although the condition can affect both men and women it is more common among females, and there is evidence the rates are higher among adolescents and young adults.

The prevalence varies across regions, a variety of cultural, socio-economic and health care access

factors can influence these patterns. COVID-19 pandemic had a negative impact on the prevalence of depression - apart from the psycho-social effects of the pandemic on the whole society, infection with COVID-19 was shown to lead to increased rates of major depression and anxiety, in those infected by the virus[86].

Dementia

The term dementia refers to several diseases that affect thought, memory, and the ability to perform daily activities. The illness mainly affects older people and gets worse over time. It is caused by many different diseases or injuries that directly and indirectly damage the brain. *Alzheimer's disease* is the most common form and may contribute to 60–70% of cases but other forms include vascular dementia, dementia with Lewy bodies, and a group of diseases that contribute to frontotemporal dementia. Dementia may also develop after a stroke or in the context of certain infections such as HIV, as a result of harmful use of alcohol, repetitive physical injuries to the brain (chronic traumatic encephalopathy) or nutritional deficiencies. The boundaries between different forms of dementia are indistinct and mixed forms often co-exist [87].

In 2019, it was estimated that 55 million people were living with dementia worldwide (with 10 million new cases every year), a number that is expected to increase to 78 million by 2030 and 139 million by 2050. Dementia puts a substantial burden on the healthcare system; in 2018 the cost of dementia was estimated at US $1 trillion and is estimated to surpass US $2 trillion by 2030[88], about half of these costs attributable to care provided informally.

Dementia is currently the seventh leading cause of death worldwide and is a major cause of disability and dependency among older people. Women are disproportionately affected, directly and indirectly, by the social and economic costs from dementia, because they provide 70% of care hours for people living with dementia and experience more disability-adjusted life-years and mortality caused by it.

Most of cases of *Alzheimer's disease* are diagnosed in individuals over 65 years old (known as late-onset Alzheimer's disease). The much less common early onset cases (under the age of 65 at diagnosis) are often linked to genetic factors. The disease tends to affect women more than men, partly because women tend to live longer. Some research suggests that hormonal and genetic factors may also play a role[89]. The prevalence can vary by region and country. Some regions, like North America and Western Europe, have higher rates compared to others. These variations may be due to differences in lifestyle, genetics, and healthcare access. With the aging population worldwide, the number of people affected by Alzheimer's disease is projected to increase significantly in the coming decades. This will pose substantial challenges to healthcare systems and caregivers. Alzheimer's disease has a substantial economic impact due to the costs associated with healthcare, long-term care, and lost productivity. It places a significant burden on individuals, families, and societies. The symptoms of Alzheimer's disease can vary in severity and typically

worsen over time. Memory loss is one of the earliest and most noticeable signs, including trouble remembering recent events, names, and appointments. Other common symptoms include difficulty with problem solving, confusion with time or place, difficulty with familiar tasks, usually followed by language problems, decreased judgment, loss of initiative, behavioural changes such as mood swings, irritability, or withdrawal from social activities can occur.

3.2.2. Prevalence of common mental disorders

Although the prevalence is not measured directly, triangulating estimates based on national surveys and other local information, such as access to local services (contact rates with mental health services), can give an indication of health need and aid planning of preventative and other services, such as the NHS Talking Therapies.

Comparative measures

The estimated prevalence of common mental conditions (published by OHID in 2019, based on data from 2014 Adult Psychiatric Morbidity Survey) for adults (population 16 and above in 2017) in Leicestershire is nearly 77.7 thousand, with almost 12 thousand among population aged 65 and above. These figures consider local age, sex and deprivation characteristics of the local population, although they are likely to be underestimates. They are expected to be lower than the national average, due to lower deprivation in Leicestershire.

Other broad indicators of need are rates of referral to outpatient and inpatient services, compared to the national average. In 2019/20 there were over 23 contacts with community or outpatient mental health services per 100 of adult population (N=163.2K), nearly 47.5 thousand referrals to secondary care services and 1,115 mental health in-patient stays in Leicestershire (Table 8). Although these indicators are derived from older data, they provide a useful comparison to the national average and other areas of similar socio-economic makeup with Leicestershire (CIPFA ‘peers’).

Table 8. Common mental health conditions in Leicestershire – estimated prevalence and rates of contact with services

Prevalence	Leicestershire		CIPFA range	England	Sig [5]
	Rate (95% CI)	Number			
Estimated prevalence, all adults [1]	13.7 (12.9-14.9)	77,698	13.5-16.2	16.9	●
Estimated prevalence, ages 65+	8.6 (7.5-10.3)	11,997	8.5-10.2	10.2	●
Contacts with community and OP [2]	23.2 (23.1-23.3)	163,220	18.0-36.5	30.7	●
Referrals to sec. care services [3]	6,730 (6,670-6,791)	47,475	4,381-8,842	6,897	●
Inpatient stays [4]	160 (150-169)	1,115	146-234	241	●

[1] Percent of population aged 16 and over with common mental disorders in 2017

[2] Attended contacts with mental health community and outpatient services, per 100, all ages 2019/20; directly standardised rate

[3] New referrals to secondary mental health services, per 100,000, all ages, 2019/20, directly standardised rate

[4] Directly standardised rate per 100,000, all ages in 2019/20

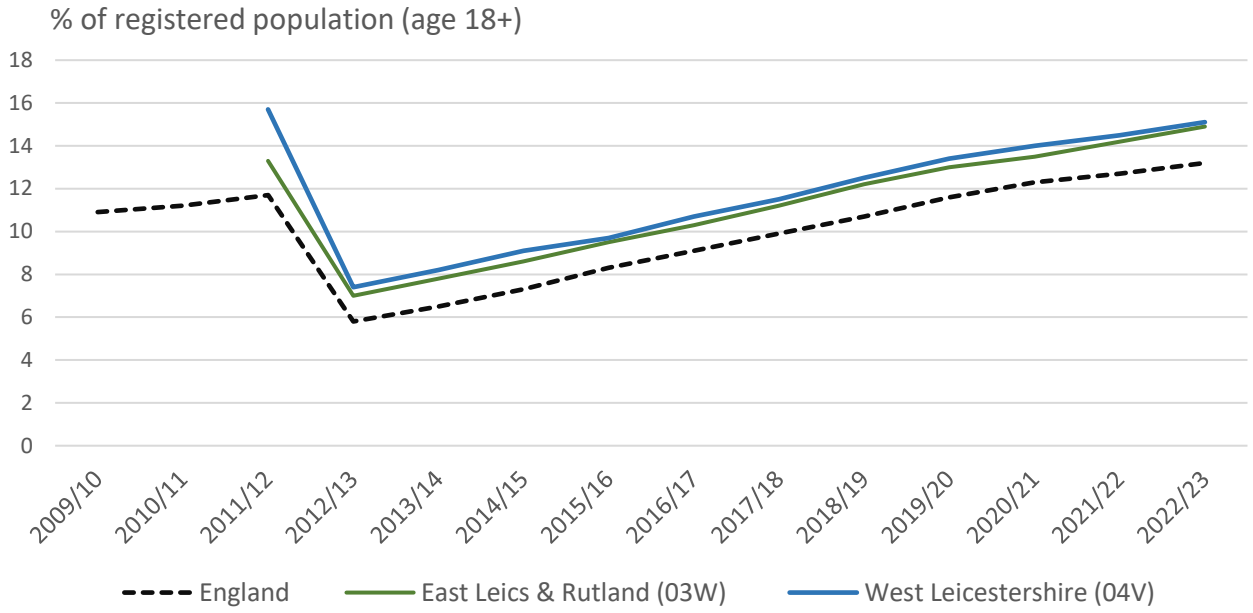
[5] ● not significantly different, ● significantly lower/better, ● significantly higher/worse than national average

(Source: OHID 2024)

Expressed as comparative rates, the measured prevalence indicators were below the national averages and low when compared with Leicestershire comparators.

In 2022/23 the prevalence of depression among adults registered in Leicestershire practices was 15.2% (nearly 89 thousand registered patients), which is 2% higher than national average. The rates were on the increase over the past five years, similar to the national trend (Figure 22).

Figure 22. Trend in the prevalence of depression (GP registered population) in Leicestershire 2009/10 – 2022/23



(Source: OHID 2024)

The rates of new diagnosis of depression recorded by general practices in Leicestershire (just under 8.2 thousand diagnosed cases in 2022/23), were decreasing in the last five years with rates similar to that for England.

The rate of GP-recorded prevalence of dementia (0.7 to 0.9%) in Leicestershire also appears to be falling and is similar to the national average. The rates of other mental health conditions appear to be stable and somewhat lower than that for England – 0.8% versus 1% nationally (Table 9).

Table 9. Summary of trends in QOF prevalence of common mental health conditions in population registered with Leicestershire GPs in 2022/23

	Number	%	Trend	England	
				%	Trend
Depression (adults aged 18+):					
West Leicestershire	50,486	15.1	↑	13.2	↑
East Leicestershire*	38,491	15.3	↑		
Leicestershire Total	**88,977**				
Depression: New Diagnosis (adults aged 18+):					
West Leicestershire	4,574	1.4	↓	1.4	↓
East Leicestershire*	3,621	1.4	↓		
Leicestershire Total	**8,195**				
Dementia (all ages):					
West Leicestershire	3,126	0.8	↓	0.7	↓
East Leicestershire*	2,806	0.9	↓		
Leicestershire Total	**5,932**				
Other Mental Health conditions (all ages):					
West Leicestershire	3,492	0.8	↔	1.0	↔
East Leicestershire*	2,496	0.8	↔		
Leicestershire Total	**5,988**				

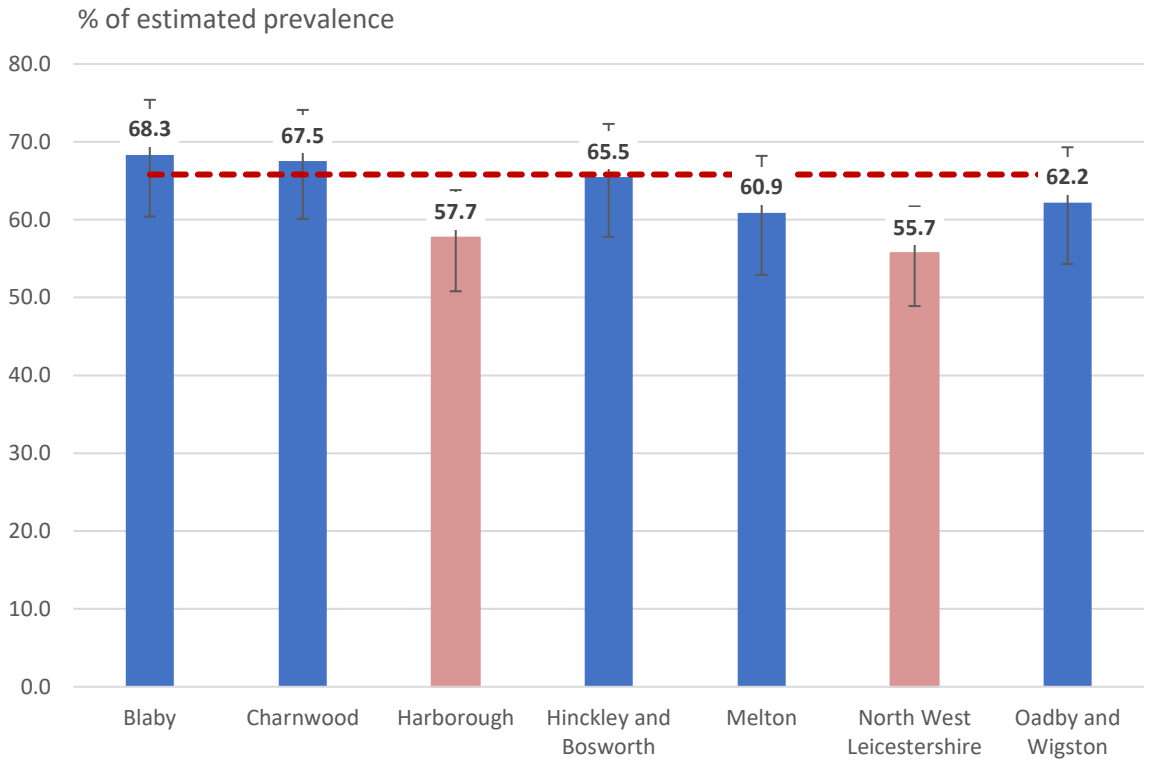
* LLR ICB 03W excluding Rutland

(Source: OHID 2024)

The estimated prevalence of dementia used to assess the coverage of GP registers was just over 10 thousand across Leicestershire, of which over 63% were registered with their GPs in December 2023.

North West Leicestershire and Harborough had the lowest rates of recorded dementia cases (55.7% and 57.7%) significantly below the commissioning target of 68.5% (Figure 23).

Figure 23. QOF prevalence of dementia in Leicestershire districts, against the LLR operational target of 68.5% (December 2023)



(Source: Leicester, Leicestershire and Rutland ICB 2024)

Estimated prevalence

The *Adult Psychiatric Morbidity Survey (APMS)* aims to provide information and analyses on both treated and untreated psychiatric disorders in the population aged 16 and over in England, as well as provide trend data through comparison with earlier surveys in the series. It is run every seven years, with the last published survey data from 2014 [90]. Because of the COVID-19 pandemic, the current survey edition was earmarked for 2022/23, these data have not been published yet.

APMS 2014 surveyed the symptoms of *depression and anxiety*, to estimate the prevalence of depression, generalised anxiety disorder (GAD), phobias, panic disorders, obsessive-compulsive disorder (OCD) as well as symptoms not otherwise specified (CMD-NOS), which mixed anxiety and depression which cannot by classified within any of the specific types mentioned. The revised Clinical Interview Schedule (CIS-R) was used - an interviewer assessed survey of 14 non-psychotic symptoms of CMD, scored according to their severity. A CIS-R score of 12 and above is a threshold applied to indicate that a level of CMD symptoms is present such that primary care recognition is

warranted. The Survey indicated a sex difference, CMD being more common in women (21%) rather than men (14%), significant socioeconomic differences (CMD three times more common in people out of work or in receipt of financial support), role of social isolation (a third of all adults under 60 living alone vs 17% overall rate) and ethnicity - prevalence higher among black or mixed groups (22%).

Applying the Survey results to 2022 Leicestershire population, a 98.7 thousand people could be suffering from any CMD, with approximate estimates for specific conditions as follows: GAD 34.2 K, depression 19.4K, phobias 13.5K, OCD 7.3K, panic disorder 3.5K, with other (not specified conditions) accounting for 45.3 thousand cases.

APMS also surveyed for *PTSD and trauma*. Trauma was defined as experience that either put a person or someone close to them at risk of serious harm or death. Over a third of adults (31%) have had a traumatic event in their lifetime and may go on to develop PTSD. Overall, just over 4% of adults screened positive for PTSD in the past month, with similar rates for men and women, the rate was highest among younger women (16–24-year-olds - 13%), declining sharply with age. The risk was higher in people under 60 living alone, those not in work and among benefit recipients. Only 13% ff those screening positive for PTSD had already been diagnosed by a health professional. These findings can indicate about 21.4 thousand people with possible PTSD across Leicestershire.

As they are based on population survey carried out a decade ago, these estimates need to be treated with some caution. Details for all districts are provided in **the Appendix**.

3.2.3. People accessing NHS Talking Therapies

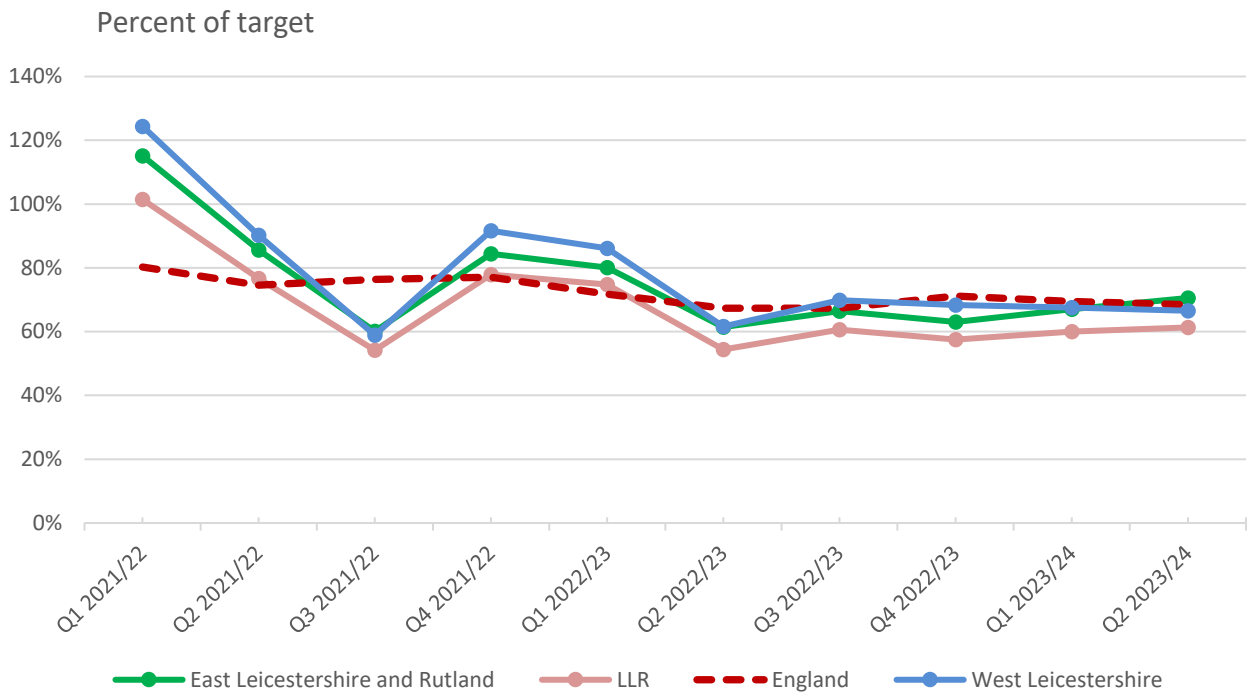
Formerly known as IAPT (Improving Access to Psychological Services), NHS Taking Therapies are NHS-funded, evidence based, psychological therapies for depression and anxiety. In 2022, nearly 1.22 million people accessed the service in England and 1.9 million should be able to access it in 2023/4.

Published data indicate that in 2022/23 12,950 people accessed these services in Leicestershire and Rutland. Although the access rates to this service are similar to the national average for both East Leicestershire and Rutland and West Leicestershire, they are below the target set for these services, at 68% and 67%, respectively (Figure 24).

In quarter 2 of 2023/24 just over six percent (6.5%) of all referrals for patients aged 65 and above in West Leicestershire and 8.9% in East Leicestershire and Rutland, against the 6.9% national average.

There are no sub-ICB data for 2022/23, but in 2021/22 the total spend on NHS Talking Therapies was over £5.6 million in two Leicestershire and Rutland CCGs, an increase from £4.3 million in 2017/18. As percentage of planned spend, the rate for the whole of LLR was just 82% of the target 2022/23, compared to 90% in the previous year (Figure 25).

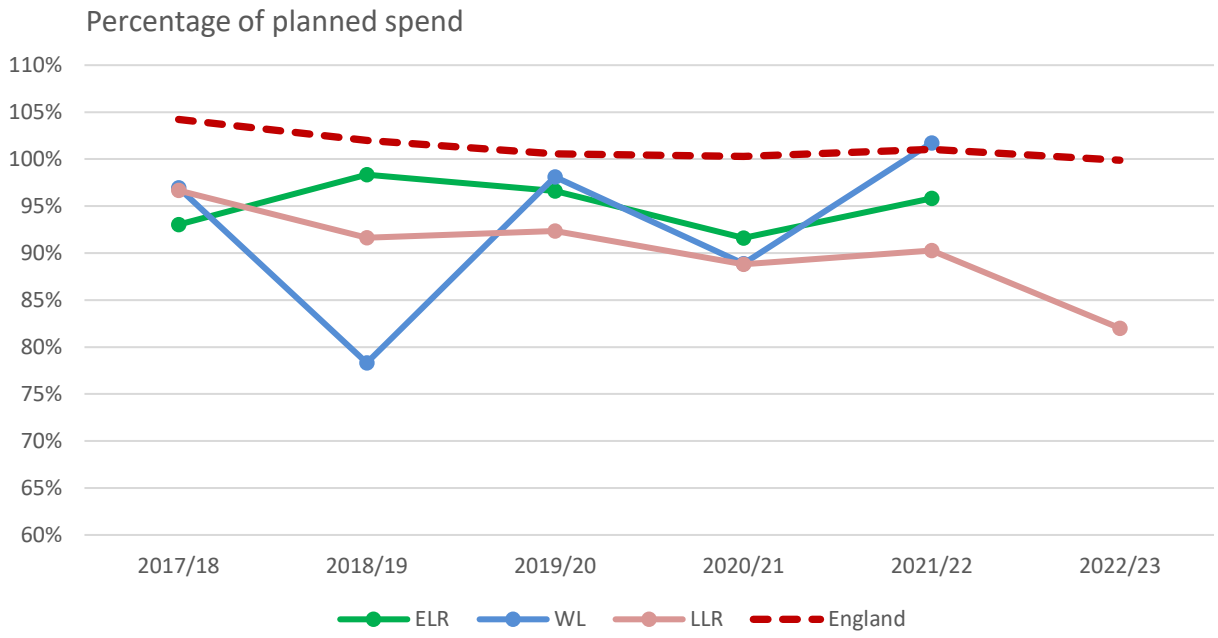
Figure 24. Talking Therapies – quarterly access rate as percentage of target between April 2021/22 and September 2023/24



Note: rates for Q1 2023/24 were not available and are imputed.

(Source: NHS Mental Health Dashboard - February 2024)

Figure 25. Talking Therapies – actual against planned annual spend since 2017/18 (note: no sub-ICB financial data after 2021/22)



(Source: NHS Mental Health Dashboard - February 2024)

Recovery rates

Nationally, the Talking Therapies recovery rates were consistently around 50%, including those for ethnic minority populations. On a background of substantial variation, particularly for ethnic minorities, from 2020/21 the local recovery rates seemed to be somewhat higher than the national average (Figure 26).

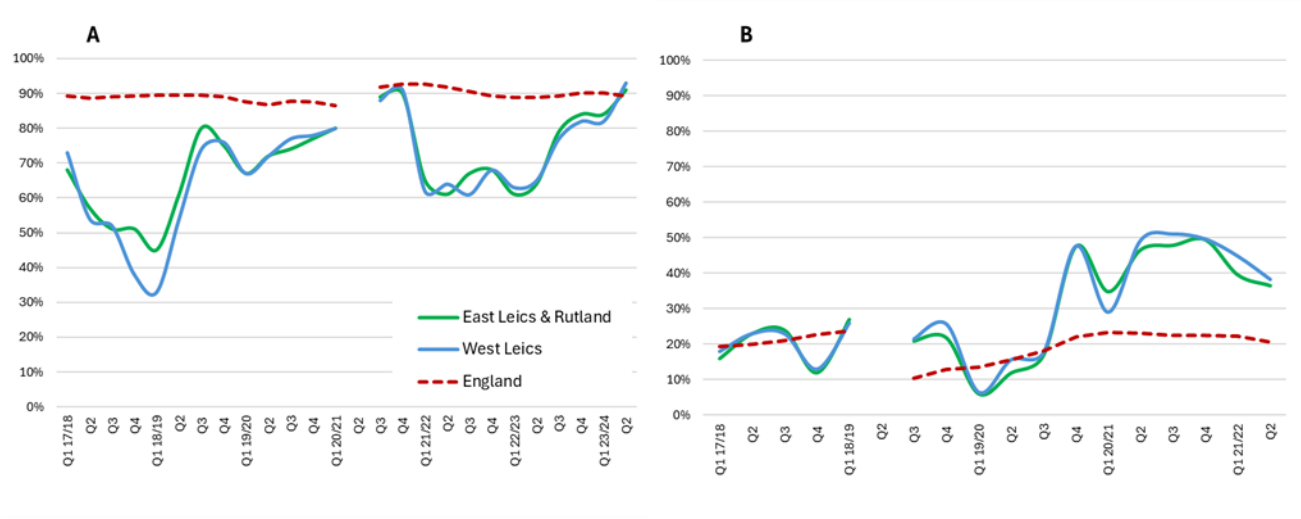
Figure 26. Recovery rates (proportion of people who attended at least two treatments contacts and are moving to recovery. A = all groups, B = ethnic minority groups (Black, Asian or other)

(Source: NHS England, NHS Mental Health Dashboard, February 2024)

Waiting times

Over the last five years, people tended to wait longer for their first appointment locally. For those waiting for their first appointment, the latest figures (for period July-September 2023) for Leicestershire and Rutland show that the waits improved, with 92% accessing services within 6 weeks (national average 89%) and 100% within 18 weeks (vs 98% across England). Recently more than a third (36% in July-September 2023) of those in treatment were waiting more than 90 days between their first and second appointment, against the national average of 21%, although this rate is decreasing (Figure 27).

Figure 27. Talking Therapies waiting times. A = Proportion of people receiving their first treatment appointment within 6 weeks of referral (denominator: those who finished treatment in reporting period). B = In-treatment pathway waits over 90 days.



(Source: NHS England, NHS Mental Health Dashboard, February 2024)

3.2.4. Memory services for people with dementia

Community based memory services teams assess people who have memory and other cognitive difficulties that might indicate a form of dementia, aiming to ensure early diagnosis and access to treatment. Across Leicestershire and Rutland there were 7,225 referrals to these services, over twice as many contacts (15,765) of which 77% were attended. This related to over 2,500 individuals in 2022/23. The highest population rates for Leicestershire were in Oadby and Wigston and Blaby and were a third higher in East Leicestershire than In West Leicestershire (19.7/1,000 vs 14.6/1,000). The overall rate for Leicestershire is somewhat below the national average, as are the attendance rates (percentage of contacts attended in the year) ((Table 10).

Table 10. Referrals and contacts with memory services teams for people with dementia in 2022/23

	Number of open referrals	Number of contacts	Attended contacts	%	Number of people in contact	Crude rate per 100,000 population (65 and over)
Rutland	270	740	570	77.0	210	2,039
Blaby	545	1,360	1,030	75.7	410	1,943
Charnwood	805	1,565	1,265	80.8	565	1,633
Harborough	535	1,305	975	74.7	395	1,829
Hinckley & Bosworth	600	1,015	790	77.8	405	1,594
Melton	255	700	525	75.0	190	1,583
North West Leicestershire	395	670	535	79.9	280	1,327
Oadby and Wigston	355	945	730	77.2	260	2,114
East Leicestershire & Rutland	1,990	5,185	3,925	75.7	1,500	1,969
West Leicestershire	1,745	3,020	2,415	80.0	1,205	1,464
Leicestershire	7,225	15,765	12,190	77.3	2,505	1,691
England	322,358	845,795	712,135	84.2	196,387	1,888

(Source: NHS Digital MHB 2022/23)

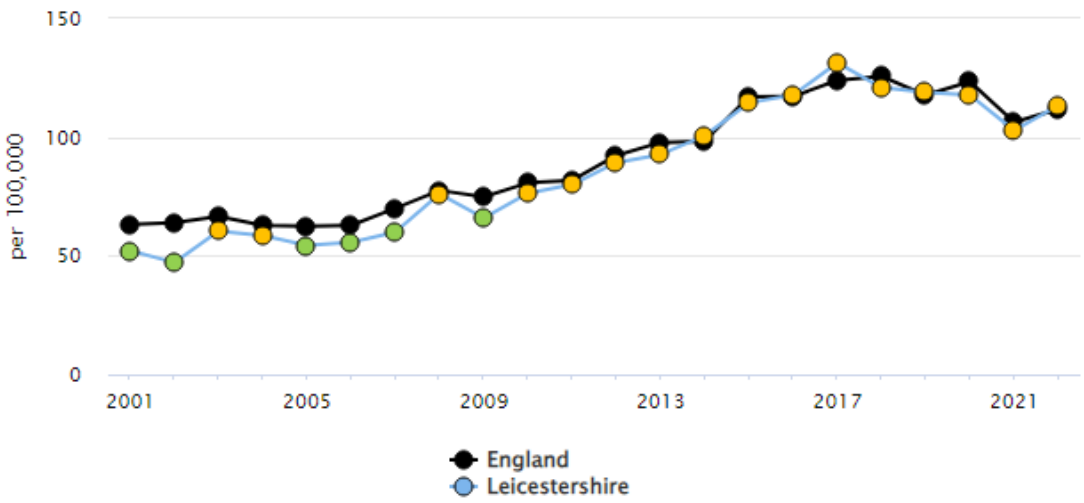
Mortality from Dementia

The rates of mortality from Alzheimer's' and other dementias have been increasing worldwide.

In 2019 in the UK, they were the most common cause of death for females and the second most common cause for males (preceded only by IHD), with rates for women almost twice as high as for men. In 2021, there were over 57.7 thousand deaths due to dementia in England, almost two-thirds in women.

In Leicestershire the rates were similar to the national average, accounting for 871 deaths in 2022 and with a relatively stable trend since 2015 and some reduction in the last five years (Figure 28).

Figure 28. Age-standardised mortality rate from dementia and Alzheimer's disease between 2001 and 2022



(Source: OHID)

Rates in the districts of Leicestershire were not significantly different to the national ones, although at district level rates may show year-on-year fluctuation and have to be treated with caution (Table 11).

Table 11. Dementia mortality 2022 in Leicestershire districts

District	Persons		Men		Women	
	Number	Rate*	Number	Rate*	Number	Rate*
Blaby	121	111.7	41	97.6	80	122.4
Charnwood	205	111.8	85	113.6	120	107.2
Harborough	137	119.4	53	115.8	84	124.0
Hinckley & Bosworth	159	123.7	66	120.7	93	124.3
Melton	60	101.1	21	87.9	39	106.8
North West Leicestershire	104	109.9	34	77.1	70	125.1
Oadby & Wigston	85	110.8	27	91.4	58	123.0
Leicestershire	871	113.3	327	81.8	544	118.3
ENGLAND	62,118	**111.7**	22,014	**92.8**	40,104	**118.1**

*Standardised all-age rate per 100,000 in 2022

(Source: OHID 2024)

3.2.5. Neurodevelopmental disorders

Autism spectrum disorders (ASD) and attention deficit hyperactivity disorder (ADHD) are

neurodevelopmental disorders which can coexist, particularly in children. Although adults can have both ADHD and ASD, the combination is less common. While ASD is considered a lifelong disorder, long-term studies have shown that in one-third to two-thirds of children with ADHD, symptoms last into adulthood.

ASD is characterised by impaired social interaction and communication, severely restricted interests, and highly repetitive behaviours [91].

Attention-deficit hyperactivity disorder (ADHD), also classically considered a disorder of childhood, is characterized by core symptoms of attention, impulsivity, and hyperactivity [92]. These symptoms persist into adulthood in about 40–60% of cases and even persist into later life, with around 3% of adults aged 50 and older reporting clinically significant ADHD symptoms [93].

Prevalence estimates

The *Adult Psychiatric Morbidity Survey (APMS)* in 2014 screened for ASD and ADHD. The prevalence of ASD in the English adult population was estimated to be around 0.8%, between 0.5% and 1.3% (95% confidence interval); higher in men (1.5%) than women (0.2%) and higher among people with no qualifications.

Nearly 10% of adults screened positive for ADHD, with higher rates in younger adults, those living alone, people without educational qualifications, the unemployed and those who are economically inactive. Only 2.3% of those screened positive had been diagnosed by a professional.

For Leicestershire this is equivalent to probable 4.9 thousand adults with ASD (between 2.0 and 12.4 thousand) and 55.6 thousand adults with ADHD (51 to 60.5 thousand).

Please note the high level of uncertainty about the autism estimate. The prevalence estimates for individual districts are provided in **the Appendix**.

Access to services

The national data[94] show a significant rise in the number of referrals for autism assessment – the number waiting in April 2019 was just over 17,400 in England, compared to 172,000 in December 2023 (almost a ten-fold rise).

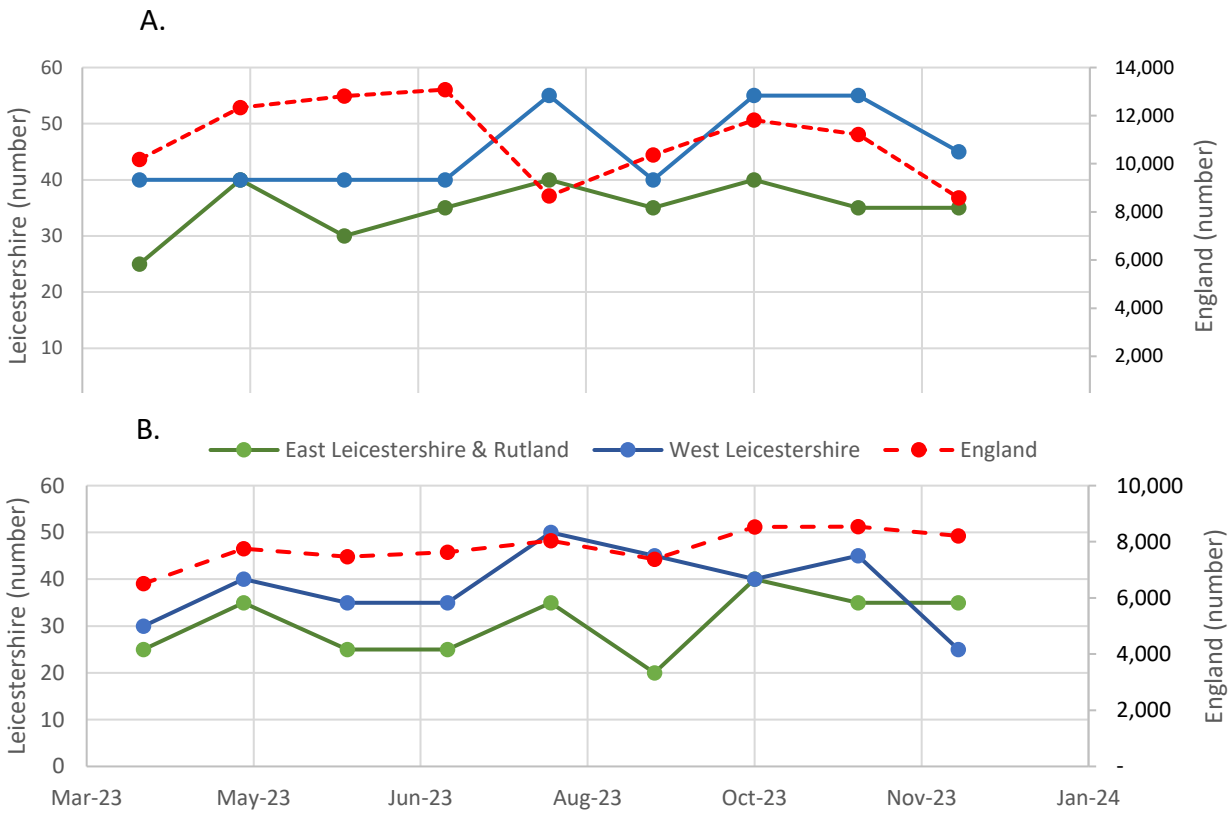
Local data are published at sub-ICB level – for East Leicestershire and Rutland (EL&R) and West Leicestershire (WL). Figures for December 2023 show that there were 415 adults (165 in EL&R, and 250 in WL)** with an open referral for suspected autism. Among those, 225 (N=90 EL&R and N=135 in WL, respectively) or 54% were waiting for more than 13 weeks. This proportion is lower than the national 87% average.

In 2023, there were on average 80 new and 69 closed autism referrals for adults across

** All numbers rounded to nearest 5

Leicestershire and Rutland, these numbers varied month-by-month without a discernible trend, similarly to the national picture (Figure 29).

Figure 29. Monthly new (A) and closed (B) cases of suspected autism in adults (18+ years) April to December 2023

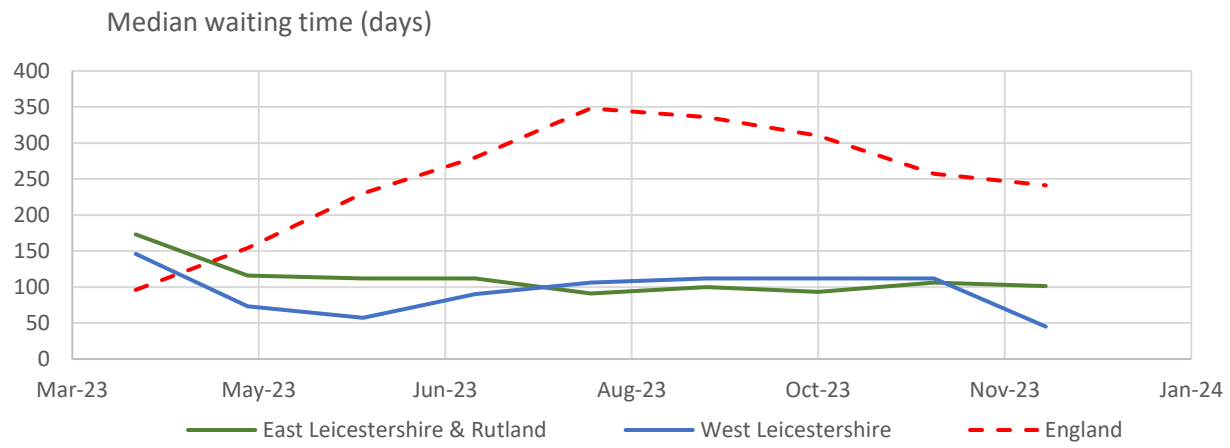


(Source: NHS Digital, Autism Waiting Time Statistics)

At the end of 2023, almost a third of adults with suspected autism (with an open referral for at least 13 weeks), had their first appointment within NICE-recommended timescale of less than 13 weeks (26% in EL&R, and 33% in WL). This is significantly better than the national average of 5.2%. Across England in 2023, a high proportion of adults waiting had no record of appointment at all (86%); this proportion was much lower locally – 40% in EL&R and 49% in WL.

Nationally, the median waiting time for children and adults has risen from 92 days in April 2019 to 281 days in December 2023. In 2023, the local waiting times for adults seemed to be significantly shorter than the national average, more similar to national pre-pandemic figures (Figure 30).

Figure 30. Average waiting time to the first appointment (adults only) in 2023



(Source: NHS Digital, Autism Waiting Time Statistics)

3.2.6. Medically unexplained symptoms (MUS)

The term 'Medically Unexplained Symptoms' (MUS) is used for 'persistent bodily complaints for which adequate examination does not reveal sufficiently explanatory structural or other specified pathology'. Other terms used for physical or bodily symptoms that cause distress or impairment but do not have a clear medical or organic cause are 'functional symptoms', 'somatoform disorders', or 'somatic symptom disorders'. For a proportion of patients with MUS, the symptoms may be part of a poorly understood syndrome, such as chronic fatigue syndrome (CFS), also known as ME, irritable bowel syndrome (IBS) or fibromyalgia (pain all over the body). They are often underdiagnosed [95].

Medically unexplained symptoms can be challenging to diagnose and manage because they often lack clear physiological markers or abnormalities that can be identified through medical tests or imaging. However, it's important to note that individuals experiencing these symptoms are genuinely suffering, and their symptoms can have a significant impact on their quality of life and daily functioning.

Some individuals with MUS may receive a diagnosis of a somatic symptom disorder or a related condition, such as 'somatic symptom disorder' (excessive focus on and distress about physical symptoms), illness anxiety disorder (hypochondriasis) or conversion disorder (functional neurological symptom disorder).

Treatment for individuals with MUS often involves a multidisciplinary approach, including psychological interventions (counselling, cognitive behavioural therapy or psychotherapy), medication (particularly for co-occurring depression or anxiety, education and supportive care[96].

It's important to approach individuals with medically unexplained symptoms with empathy, understanding, and a collaborative approach to care. A thorough evaluation is needed to rule out any underlying medical conditions before arriving at a diagnosis of MUS or a related disorder.

3.3. Severe Mental Illness (SMI)

People with severe mental illness are more likely to be in treatment, thus the prevalence recorded through GP registers is a more likely to be true representation of numbers in population.

3.3.1. Risk factors

Potential risk factors for SMI may be genetic (certain genetic variations or predispositions may make individuals more susceptible to conditions such as schizophrenia, bipolar disorder, or major depressive disorder, biological (e.g., abnormalities in dopamine and serotonin levels have been implicated in schizophrenia and depression, respectively, adverse childhood experiences, environmental (e.g., high levels of stress, exposure to traumatic events, chronic illness, substance use, or environmental toxins, and socioeconomic factors[97].

Cultural factors, including stigma surrounding mental illness, can also impact help-seeking behaviours and treatment outcomes. Certain chronic medical conditions, such as neurological disorders, autoimmune diseases, or endocrine disorders, may increase the risk of developing serious mental illnesses or exacerbate existing symptoms.

Certain personality traits, such as high levels of neuroticism, introversion, or impulsivity, may increase the risk of developing serious mental illnesses. However, personality traits alone are unlikely to cause mental illness but may interact with other risk factors.

It's essential to note that the development of serious mental illnesses is often multifactorial, with interactions between genetic, biological, psychological, and environmental factors playing a role. Additionally, having one or more risk factors does not necessarily mean that an individual will develop a serious mental illness, as protective factors and resilience can also influence outcomes. Early identification, intervention, and support can help mitigate the impact of risk factors and improve outcomes for individuals with serious mental illnesses.

3.3.2. Prevention

Prevention can be primary (preventing a disease from occurring), secondary or tertiary, after the onset of disease, providing earlier diagnosis and treatment, or reducing adverse symptoms, complications or long-term disability.

Factors that promote positive wellbeing and resilience are key in preventing mental illness and improving outcomes in those with mental illness[98]. Childhood and adolescence are the critical

periods for setting growth and wellbeing for the adult life; empowering youth with life skills and opportunities to reach their full potential in adult life has been shown to have positive effect on both physical and mental health outcomes. For severe mental disease, early identification and interventions are of key importance and have been shown to be highly cost-effective.

Although prevention of severe mental illness may not be possible, particularly in those with genetic predisposition, there are many strategies to help manage risk factors, such as early intervention (e.g. treatment of symptoms, cognitive behavioural therapy), providing supportive environments, healthy nutrition and maintenance of good physical health, and stress reduction. Avoidance of substance use, particularly drugs like cannabis or hallucinogens, which have been linked io the development of SMI is also important.

3.3.3. Prevalence

WHO estimates a global prevalence of all mental disorders at 12.5% of population[99]. There are different clinical criteria diagnostic practices for SMI across various countries, thus local estimates may not be comparable, particularly between more or less developed countries. Rate will also vary depending on various socio-economic and cultural factors[100].

In the Unites States, for example, the published estimate for 2020 (Substance Abuse and Mental Health Services Administration, SAMHSA) is that of 5.6% of all adults aged 18 or over. The estimate of prevalence of psychotic disorders (a subset within SMI) is around 0.7%, bipolar disorder 2% and 4.4% screen positive for symptoms of PTSD[101].

Estimates using Adult Psychiatric Morbidity Survey (APMS)

The *Adult Psychiatric Morbidity Survey (APMS)* in 2014 found that 2% of the surveyed English adult population screened positive for bipolar disorder; which was more common in younger age-groups (3.4% of 16–24-year-olds), in those not in employment or living alone. Over 3% of adults under 65 screened positive for ASPD, which was more common in men than women with 2.4% positive for BPD. The Survey also screened for 'any personality disorder', and found 14% of adults as positive, with similar rates in men and women. Screening positive on all three measures of personality disorder was more common among younger people, those living alone, and those not in employment or in receipt of benefits. Over 6% of people screening positive for ASPD and 13% for BPD believed that they have had a personality disorder (vs 1% of screen-negative cohort); in the majority this group also had a diagnosis of personality disorder from a professional.

In addition, APMS screened for *probable psychotic disorder*. The overall prevalence was low (0.7%); however, the rate was higher in black men (3.2%) and the socioeconomic factors are strongly linked – rates were particularly high among respondents who were economically inactive or on benefits (in these groups prevalence could reach 13%), or those in social isolation.

Applying APMS rates to Leicestershire population (2022) one can broadly estimate about 11

thousand (confidence limits 8.5-13.3 K) people with bipolar disorder and 77.5 thousand (73.2-83.2K) with a personality disorder. It is also estimated that there could be about 4 thousand of people with psychotic disorder.

These estimates have to be treated with caution, as they are based on 2014 survey and not fully adjusted for important socio-economic factors. The district-level data are provided in **the Appendix**.

Quality and Outcomes Framework (QOF) prevalence

The latest (2022/23[††]) published number of people on practice disease registers with a diagnosis of schizophrenia, bipolar disorder and other psychoses across Leicestershire is 6,074 (equivalent to 8.2/1,000 registered population[‡‡]). This is significantly lower than the national average (England – 10/1,000), but similar to other counties of similar socio-economic makeup (CIPFA range: 7.5-9.7/1,000)[§§].

The registered total of just under 6.1 thousand is also well below the estimated 15 thousand (bipolar disorder plus other psychotic disorders) from APMS (see above). Allowing for all caveats relating to APMS estimates described above, there could still be a substantial (9 thousand) gap in the diagnosis of SMI in primary care in Leicestershire.

Of the 6,300 patients registered with an SMI across both local *sub-ICB areas*, 2,808 were in East Leicestershire and Rutland, corresponding to 7.9/1,000 and 3,492 in West Leicestershire, the rate of 8.4/1,000. Although the West Leicestershire rate appears to be higher, the difference is not statistically significant and both areas were significantly below the national average of 10/1,000 (Table 12).

Table 12. The proportion of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers, by sub-ICB area (2022/23)

	Number	Rate per 1,000
East Leicestershire and Rutland	2,808	7.9
West Leicestershire	3,492	8.4
England	621,898	10.0

(Source: OHID Fingertips 2024)

3.3.4. People accessing community mental health services

Across England, the rates of access to community mental health services for adults with SMI are

[††] OHID, December 2023

[‡‡] 2021 registered population as denominator

[§§] There are no district-level data available

strongly correlated to deprivation, with those in the least deprived decile of deprivation under 560/100,000 population in the most affluent decile compared to 1,460/100,000 in the most deprived one, equivalent to 2.6 ratio. The average rate in England was 900/100,000, rates being higher for males (1,029) than females (719/100,000) in 2022/23, and highest among those aged 85 and over (over 1,600/100,000). National rates were highest among those of mixed or multiple ethnicity (over 1,000/100,000) and black (980/100,000) compared to just over 570/100,000 in Asian or Asian British population, and under 790 in white residents.

Rates of contact in Leicestershire and Rutland were slightly higher than England average (Table 13), with total of 7,630 adults with serious mental illness accessing those services in 2022/23. These rates are also higher than the QOF prevalence, summarised in Table 12 above. Although these are from two different sources, the data suggest that more people access mental health services with serious mental illness that are registered with the GPs, while the reverse is observed across England. A possible explanation is that of higher self-referral rates locally, particularly across West Leicestershire, when compared to the national picture.

Table 13. People accessing community mental health services (adults or older adults only) with serious mental illness who received 2 or more contacts within 2022/3.

	Number	Rate per 1,000
East Leicestershire and Rutland	3,235	9.4
West Leicestershire	4,395	10.8
England	508,214	9.0

(Source: NHS Digital MHB 2022/23)

3.3.5. Outcomes

People with serious mental illness are more likely to have adverse physical outcomes, resulting in higher rates of premature mortality.

In the three years between 2018 and 2020, the all-cause risk of death in people with SMI in Leicestershire was higher than the national average, despite the overall rate for people aged under 75 years being significantly lower. Cancer mortality in Leicestershire seems to be contributing to this apparent high risk, with around 150 premature deaths per year and excess risk estimated to be almost three-fold higher than expected.

It is of interest that cancer screening rates for patients with SMI are below that for the wider population, particularly for breast cancer with only 31% of eligible patients being screened across Leicestershire and Rutland at the end of December 2023 – see **section 3.3.7** below for further details.

Mortality from other common causes (CVD, liver and respiratory disease) appears to be lower than national rates with no excess risk among people suffering from SMI in Leicestershire.

The rates of smoking among people with SMI are high in England with more than four in ten adults reporting smoking tobacco in 2014/15. In Leicestershire more than a third of people with SMI report smoking, significantly below the national average (Table 14).

Table 14. Mortality related to severe mental illness in Leicestershire.

Severe Mental Illness (SMI)	Leicestershire		CIPFA range	England	Sig [5]
	Rate (95% CI)	Number			
Mental Health QOF prevalence [1]	0.82 (0.80-0.84)	6,074	0.75-0.97	1.0	●
Premature mortality [2]	95.2 (90.4-100.1)	1,500	52.2-103.8	103.6	●
Excess risk of mortality <75 [3]	493 (458-529)	n/a	331-580	390	●
Premature mortality due to CVD [2]	15.9 (14.0-17.9)	250	8.7-17.9	18.9	●
Excess risk of CVD mortality <75 [3]	352 (292-420)	n/a	269-472	307	●
Premature mortality due to cancer [2]	28.2 (25.6-31.0)	445	10.0-28.2	20.2	●
Excess risk of cancer mortality <75 [3]	295 (255-338)	n/a	87-295	126	●
Premature mortality due to liver disease [2]	5.1 (4.0-6.3)	75	3.4-8.5	7.6	●
Excess risk of liver disease mortality <75 [3]	444 (319-604)	n/a	326-1,102	550	●
Premature mortality due to respiratory disease [2]	9.2 (7.7-10.8)	150	5.6-12.4	12.2	●
Excess risk of respiratory disease mortality <75 [3]	626 (498-781)	n/a	469-855	560	●
Smoking prevalence [4]	33.8 (32.3-35.4)	1,251	33.8-42.1	40.5	●

[1] The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers in 2022/23

[2] Directly standardised rate per 100,000 (2018-2020) in people with severe mental illness (SMI)

[3] Excess risk (%) in people with severe mental illness (SMI); 2018-2020

[4] Adults (18+) in 2014/15, proportion (%) of people with severe mental illness (SMI)

[5] ● not significantly different, ● significantly lower/better, ● significantly higher/worse than national average

(Source: OHID Fingertips 2024)

3.3.6. SMI and physical health

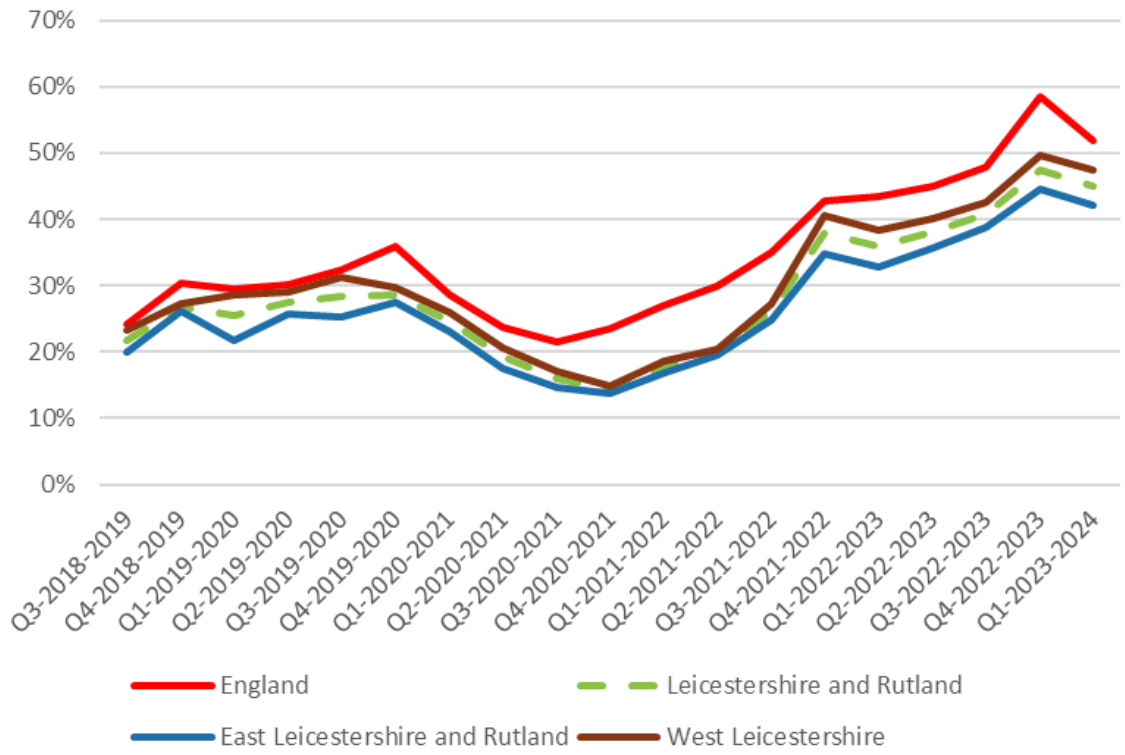
People with SMI are at higher risk of poor physical health, with higher levels of obesity, asthma, diabetes, COPD and CVD. Smoking prevalence is twice as high as in general population[102]. Improving the coverage of physical health checks was part of NHS Long Term Plan with a 390,000 minimum target to be achieved by 2023/4. The six health checks include alcohol, blood glucose levels, blood lipids, blood pressure, BMI and weight, and smoking. Nationally, the rate of health checks in people with SMI has increased since 2018/19 from 25% to over 50% 2023/24. The rates were lowest during

the COVID-19 pandemic.

Although the rates have been overall lower in Leicestershire and Rutland, when compared to England, the trends have been similar (Figure 31). Caveats include completeness of trend data (2018/19 included only checks done in primary care and are more comprehensive since then) and its coverage across England.

The latest data for June 2023 (Q1 of 2023/24) indicate that 45% of people registered with SMI across Leicestershire and Rutland had a full check in the previous 12 months (2,897 of 6,424 registered on 30th of June). This is lower than 62% in Leicester, 52% nationally and 55% across the Midlands region.

Figure 31. Trends in the health checks coverage for people with SMI (% of people registered with SMI getting all six checks)



(Source: NHS England NHSMH Dashboard)

3.3.7. SMI and cancer screening

Cancer screening programmes are designed to help early diagnosis and to improve the likelihood of successful treatment. Currently there are three NHS programmes - cervical screening, breast and bowel screening. Then latest comparative screening coverage figures quoted here are for year 2022/23[***].

[***] Source: OHID 2024 (Fingertips: Cancer Services)

Cervical screening – all women aged 25 to 49 are invited for screening every 3 years, while those aged 50 to 64 every 5 years, except for those without a cervix. In 2022/23, the overall coverage in England for the younger age group was 67% and 75% for the older group. The corresponding rates in the East Leicestershire and Rutland (ELR) were 73% and 78%; in West Leicestershire (WL) they were 78% and 75%.

Breast screening through a mammogram is offered to women from the age of 50 to their 71st birthday, or at earlier age for those at higher risk of breast cancer. The coverage of breast screening programme in England was 67% in 2022/23, with the rate in ELR and WL higher (72% and 69%, respectively.

Bowel screening aims for an early diagnosis, as 90% can be treated successfully when discovered early. It is offered to people aged 60 to 74 years of age. In 2022/23, the coverage for this screening programme across England was 72%, with higher levels locally – 76% in ELR and 75% in WL.

The most recent (end of December 2023) data for cancer screening coverage for people with SMI in Leicestershire and Rutland indicate that cervical screening rate is lower than in general population locally (71%), while bowel screening coverage is higher in this group (over 87%).

However, breast cancer screening coverage for women with SMI is low, approximately half of the previous national or local rates in the general population (31% vs 70%) (Table 15).

Table 15. Cancer screening coverage for people with SMI – Q3 2023/24

	Period	Number Screened	Total Eligible	% Screened
East Leicestershire and Rutland				
Cervical screening (women 25-64)	60 months	794	1135	70.0%
Breast cancer (women 50-70)	36 months	386	1129	34.2%
Bowel cancer (men and women 60-74)	24 months	664	757	87.7%
West Leicestershire				
Cervical screening (women 25-64)	60 months	918	1276	71.9%
Breast cancer (women 50-70)	36 months	382	1317	29.0%
Bowel cancer (men and women 60-74)	24 months	718	827	86.8%
Leicestershire and Rutland				
Cervical screening (women 25-64)	60 months	1712	2411	71.0%
Breast cancer (women 50-70)	36 months	768	2446	31.4%
Bowel cancer (men and women 60-74)	24 months	1382	1584	87.2%

(Source: Leicestershire Health Informatics Service 2024)

Research carried out in Northern Ireland suggests that women with poor mental health are less likely than others to come forward for breast screening. Not attending cancer screening could partly

explain why people with mental health conditions die younger than the general population, as cancer is more likely to be diagnosed later when it is less treatable. The authors suggest that health services should explore targeted interventions, such as more frequent appointment reminders [103].

In Leicestershire, groups identified so far as requiring enhanced support for breast screening include those seeking asylum or homeless, people with physical disabilities, learning disabilities and autism (LDA), LGBTQ+ community and unpaid carers. Several initiatives to improve uptake of breast screening in these groups is on-going, for example using appropriate standard operating procedures (SOP) for asylum seekers and homeless, promotional videos, and the Equality Access Clinic (EAC). LDA registered patients are supported by Leicestershire Partnership Trust specialist LDA nursing team. One of those models could be utilised to enhance uptake for women suffering from severe mental illness.

3.4. Suicide and Self-Harm

Suicide is a global public health issue. According to the World Health Organization (WHO), approximately 800,000 people die by suicide each year worldwide. This number represents a significant but preventable loss of life. Understanding the distribution, causes, risk factors, and trends related to suicidal behaviours within populations is crucial for developing effective prevention and intervention strategies. Suicide rates vary by age and gender. In many countries, suicide rates are higher among males than females. However, suicide attempts are more common among females. The highest suicide rates tend to occur in older adults (especially males) and young individuals (especially females) [104].

Suicide rates vary widely by country and region. Factors contributing to these variations include cultural norms, access to healthcare, social support systems, and economic conditions. The choice of suicide method varies by region and cultural factors. Common methods include hanging, poisoning, firearms, and jumping from heights. Access to lethal means, such as firearms, can significantly increase the risk of fatal suicide attempts[105].

A significant proportion of individuals who die by suicide have a diagnosable mental health condition, such as depression, bipolar disorder, or substance use disorders. However, not all individuals who die by suicide have a known mental health diagnosis.

Suicide attempts are far more common than completed suicides. Many individuals who attempt suicide do not go on to complete it. Non-fatal suicide attempts are often a strong predictor of future suicide risk. In addition to a history of previous suicide attempts, the risk factors include family history of suicide, access to lethal means, social isolation, chronic illness, exposure to trauma or abuse, and stigma associated with seeking help. Conversely, protective factors against suicide include access to mental healthcare, strong social support networks, coping skills, and a sense of belonging and purpose.

Suicide prevention efforts involve a combination of public health initiatives, mental health promotion, crisis helplines, gatekeeper training, and access to mental healthcare services. Reducing access to lethal means, such as restricting firearm access, can be an effective suicide prevention strategy. Ongoing surveillance and data collection are essential for monitoring trends in suicide rates and evaluating the effectiveness of prevention efforts.

Rates of self-harm, suicide and undetermined injury are a broad indicator of underlying mental health of the population. Because of the relatively small numbers of suicides, it is often difficult to show significant differences between areas or establish significance of trends over time.

3.4.1. Rates of self-harm and suicide in Leicestershire

Table 16 below summarises the available data on *admissions for intentional self-harm* in Leicestershire. In 2021/22 the local emergency hospitalisation rates were similar to the national average (as well as to other similar areas, CIPFA comparators) with a total of 820 admissions, equivalent to 25 per 100,000 population. However, in the preceding period (2016/17 to 2020/21), the local rates were about 30% lower than England average (emergency admission ratio). For children and young people, the rates were significantly below the national average[†††].

Table 16. Admissions for Intentional Self-Harm

	Leicestershire		CIPFA range	England	Sig [5]
	Rate (95% CI)	Number			
Emergency admissions rate [1]	24.7 (20.7-28.7)	820	19.3-38.7	28.0	🟡
Emergency admissions ratio [2]	69.3 (67.3-71.4)	n/a	69.3-160.0	100	🟢
Admissions (10-24 y/o) [3]	266 (237-296)	330	266-766	427	🟢
- Admissions (10-14 y/o) [4]	170 (130-213)	70	116-590	307	🟢
- Admissions (15-19 y/o) [4]	358 (303-421)	150	358-1,185	642	🟢
- Admissions (20-24 y/o) [4]	268 (222-325)	110	251-633	341	🟢

[1] Indirectly standardised rate per 100,000 (2021/22)

[2] Indirectly standardised ratio per 100, 3-year average (2016/17-2020/21)

[3] Directly standardised per 100,000 (2021/22)

[4] Crude rate per 100,000 (2021/22)

(Source: Office for Health Improvement and Disparities, Fingertips)

Between 2020 and 2022 there were 172 suicides in Leicestershire: 47 in 2020, 62 in 2021 and 63 in 2022. Across the three year period, the majority of suicides were among men (128 compared to 44

[†††] More detail in 2023 CYP Mental Health JSNA Chapter

for women). Although the three-year suicide rate in Leicestershire is somewhat lower, it is not statistically different from the national average - 9.2/100,000 (95% CI 7.8-10.5) against the national 10.3/100,000. For adults below the age of 75, around 50 years of life are lost each year due to suicide, which is similar to the national average for both men and women (Table 17).

Local suicide rates fluctuate; historically the rates were lower (albeit not always significantly) than the national average. However, there was a slight upward trend since 2017-19 (Figure 32). This is largely due to increase in men – there were 107 suicides in men in Leicestershire in 2017-19 and 128 in 2020-22 (a 20% increase). The relative increase for women is also about 20%, although the numbers are lower and there is much more variation in the 3-year average rates.

Table 17. Suicides - mortality and Years of Life Lost

	Leicestershire		CIPFA range	England	Sig [4]
	Rate (95% CI)	Number			
Mortality (all)[1]	9.2 (7.8-10.5)	172	8.7-15.1	10.3	●
Mortality (male)[1]	14.0 (11.5-16.4)	128	13.1-22.7	15.8	●
Mortality (female)[1]	4.5 (3.3-6.1)	44	3.8-7.4	5.2	●
YLL (all)[2]	29.7 (24.5-35.4)	152	29.7-49.7	34.6	●
YLL (male)[2]	43.4 (34.6-53.4)	109	43.4-73.0	51.8	●
YLL (female)[2]	16.4 (11.2-22.9)	43	12.2-27.9	17.3	●
Mortality (males, 65+)[3]	8.8 (5.8-12.9)	27	8.8-15.9	12.4	●

[1] directly standardised rate per 100,000 (2020-2022)

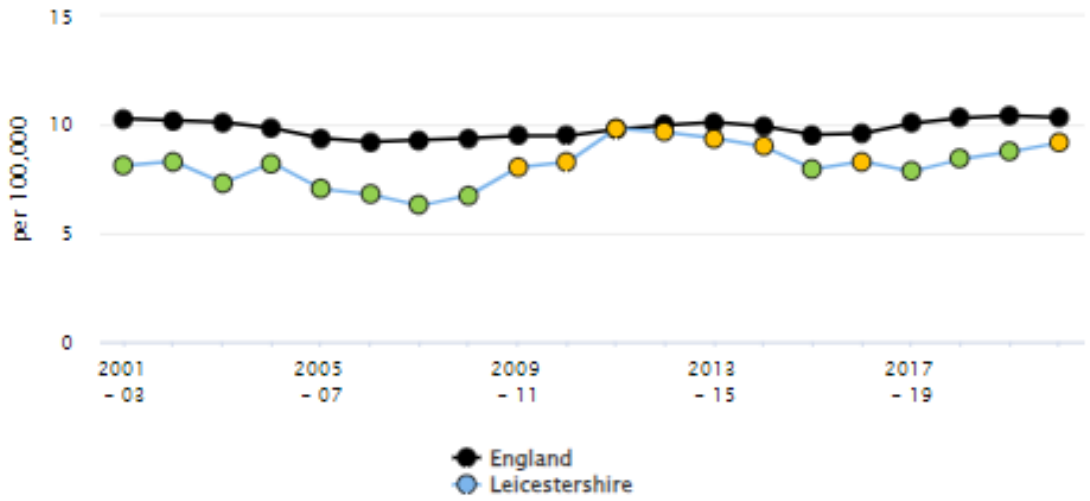
[2] Years of Life Lost, age-standardised rate 15-74 years (2019-21 - 3-year average, per 10,000)

[3] crude rate, 5-year average (2013-2017), per 100,000

[4] ● not significantly different, ● significantly lower/better, ● significantly higher/worse than national average

(Source: OHID 2024)

Figure 32. Trend in suicides in Leicestershire - persons, 3-year averages (2001-03 to 2020-22)



(Source: OHID 2024)

Estimated prevalence of attempted suicide and self-harm

The *Adult Psychiatric Morbidity Survey (APMS)* in 2014 assessed the prevalence of suicidal thoughts, attempted suicide and self-harm through both the face to face and the self-completion survey. Younger women (16-24) were more likely to self-harm (26%) than men of the same age (10%), or older women; the gap between young men and young women has grown over time. Over 5% of adults reported suicidal thoughts in the past year, a significant increase on the 3.8% reporting this in 2000. Groups more likely to report these thoughts and behaviours included those who lived alone

or were out of work (either unemployed or economically inactive). Two-thirds of Employment and Support Allowance (ESA) recipients had suicidal thoughts (66.4%) and approaching half (43.2%) had made a suicide attempt at some point[106].

For Leicestershire, these findings can be translated into estimates of nearly 119 thousand people with suicidal thoughts, 38.6 thousand of suicidal attempts and 40.2 thousand people self-harming. These are broad estimates and need to be treated with caution.

Detailed figures for Leicestershire districts are provided in **the Appendix**.

3.4.2. Suspected suicide surveillance

A near to real time suspected suicide surveillance system (nRTSSS) was launched on 30 November 2023. It is designed to act as an early warning system for changes in patterns of deaths by suicide to enable appropriate intervention. It collects data on all suspected suicides, where cause of death was not yet confirmed by coroners' inquest. Any suspected suicide assignation is provisional and not the whole of England is yet covered - not all PFA (police force areas) participating. Overall, a coverage of 75% of population of England aged 10 and above[107].

The national report (based on nearly 5,000 deaths, 75% men) presents statistics for the most recent 15-month period (June 2022-August 2023). It describes monthly suspected suicide rates by age group and sex to show any variations, and 3-month aggregated data to describe suspected suicide methods. Generally, the rates were three times higher for men than for females, except for the month of October (four times higher). The rate was highest in June (13.1/100,000) and lowest in February (10.1/100,000), although monthly variations were not statistically significant. Rates were highest among 45–64-year-olds (14/100,00) and lowest for those 65 and above (6.5/100,000). The most common method was hanging, strangulation and suffocation (more than half of all deaths), followed by poisoning (20%). The results indicate higher rates in summer, for both men and women, with a seasonal variation among younger adults (those aged 25-44). In the older group (65 years of age and above) the rates are possibly increasing, with a recommendation to be monitored. There is also an indication of changes in method of suicide, an increase in jumping/lying in front of moving objects, as well as in drowning[108].

Sub-national data have not been published.

3.5. Substance Use and Smoking

Estimated 86% of people who access alcohol services experience mental health problems and 70% of those accessing drug use treatment have a mental illness. A 30-year-old concept of 'dual diagnosis'. More than a third of people with mental health problems and more than two-thirds of people in psychiatric units smoke tobacco[109].

Both substance use and smoking contribute substantially to morbidity and mortality among those with mental health issues but there are problems with access to appropriate services as substance use and mental health services are separate.

Nearly a quarter of people in treatment for drug use in England are concurrently treated for mental health problems. This proportion was lower in Leicestershire (15% in 2016/17). For alcohol, Leicestershire rate is similar to the England average (21.5% vs 22.7%, respectively). The rates of admission for mental and behavioural disorders due to alcohol, although substantial (nearly 2 thousand per year, according to broad definition) are significantly lower when compared to the national figures. It is estimated that over 23% of people with mental health conditions are concurrent smokers in Leicestershire, similar proportion to the national average. People with mental health conditions are almost three times as likely to be current smokers (Table 18).

Table 18. Substance use and smoking

Substance use	Leicestershire		CIPFA range	England	Sig [6]
	Rate (95% CI)	Number			
Dual diagnosis - drugs [1]	15.2 (12.2-18.7)	93	8.4-50.2	24.3	●
Dual diagnosis - alcohol [1]	21.5 (17.1-26.5)	62	8.0-47.9	22.7	●
Admissions due to alcohol (persons) [2]	45.8 (40.9-51.1)	319	41.9-98.9	67.2	●
Admissions due to alcohol (male) [2]	63.6 (55.3-72.7)	216	53.8-140.0	96.0	●
Admissions due to alcohol (female) [2]	28.9 (23.5-30.3)	103	20.3-59.1	39.8	●
Admissions due to alcohol (persons) [3]	277 (265-289)	1,995	227-667	404	●
Admissions due to alcohol (male) [3]	402 (381-424)	1,404	329-925	587	●
Admissions due to alcohol (female) [3]	160 (147-173)	591	131-438	233	●
Smoking prevalence [4]	23.1 (19.9-26.3)	n/a	15.0-27.1	25.2	●
Odds of current smoking [5]	2.9 (2.3-3.5)	n/a	1.7-3.1	2.5	●

[1] Concurrent contact with mental health services and substance misuse services, proportion (%) in 2016/17

[2] Narrow definition, admissions for mental and behavioural disorders due to alcohol 2021/22, directly standardised rate per 100,000

[3] Broad definition, admissions for mental and behavioural disorders due to alcohol 2021/22, directly standardised rate per 100,000

[4] Current smokers (GPPS), smoking prevalence in adults with long term mental health condition (18+ y/o) 2021/22

[5] Ratio, self-reported smoking

[6] ● not significantly different, ● significantly lower/better, ● significantly higher/worse than national average

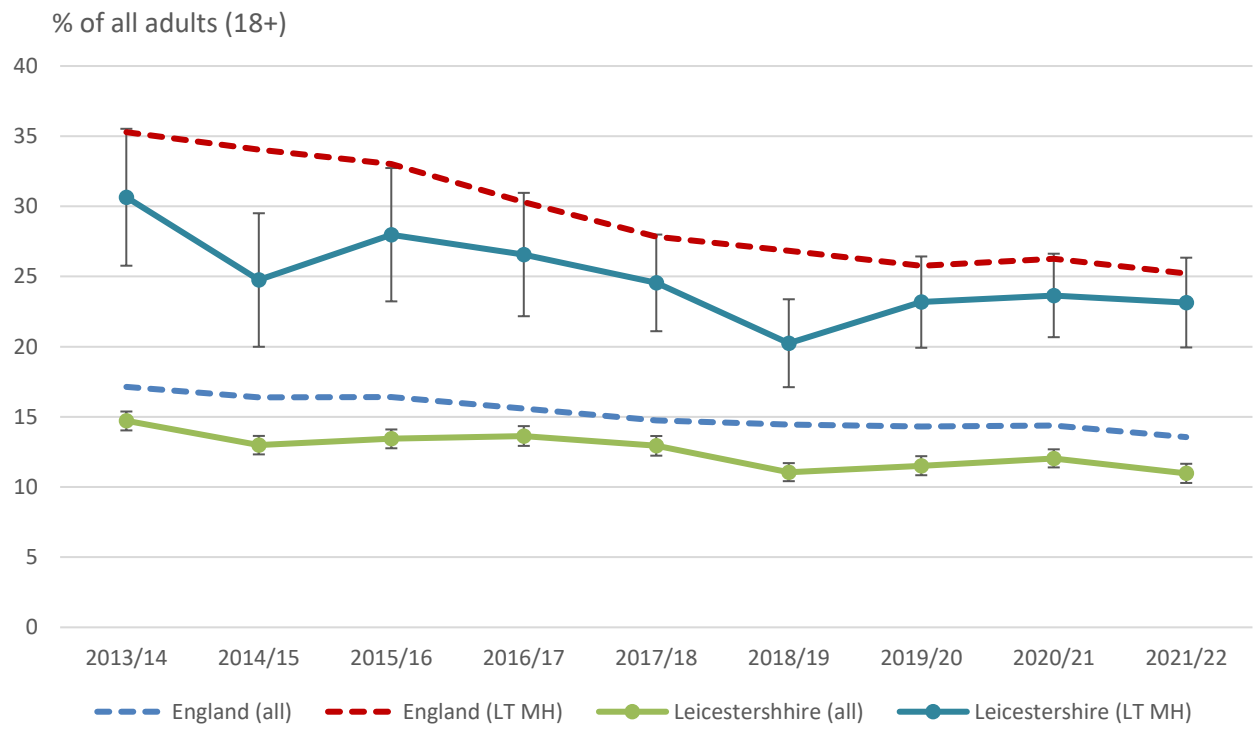
(Source: OHID 2024)

In 2021/22 the national rate of smoking among adults with a long-term mental condition was about twice as high as in the general population, 25% compared to 14%, although it has fallen substantially in the last nine years, from 35% in 2013/14, and faster among those with a mental health condition than in the general population (Figure 33).

In Leicestershire, the general rate of smoking in adults is significantly below the national figures, and

has been in the past years, but smoking among adults with a long-term mental condition is statistically similar to the national average and showing a similar reduction from 31% in 2013/14.

Figure 33. Proportion of adult (18+) reporting to be occasional or regular smokers in general population (= all) and those with a long-term mental health condition (= LT MH) in GP Patient Survey between 2013/14 and 2021/22



(Source: OHID 2024)

3.6. Eating Disorders

Eating disorders are relatively common mental health conditions, with estimates suggesting that they affect millions of individuals worldwide. The most prevalent eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Eating disorders disproportionately affect females compared to males, with rates typically higher among women and girls. However, it's important to recognize that males also experience eating disorders, though they may be less likely to seek treatment or receive a diagnosis. They can develop at any age, but they often emerge during adolescence or young adulthood. However, they can also occur in childhood or later in life.

Various risk factors contribute to the development of eating disorders, including genetic predisposition, psychological factors (e.g., low self-esteem, perfectionism), sociocultural influences (e.g., media portrayals of body image), interpersonal factors (e.g., history of trauma or abuse), and

biological factors (e.g., alterations in brain chemistry).

Eating disorders frequently co-occur with other mental health conditions, such as mood disorders (e.g., depression, anxiety), substance use disorders, and personality disorders. Individuals with eating disorders may also experience medical complications related to their disordered eating behaviours. They can have serious consequences for physical health, including nutritional deficiencies, electrolyte imbalances, gastrointestinal problems, cardiovascular complications, and bone density loss. They also significantly impact psychological well-being and quality of life.

Due to stigma surrounding eating disorders and barriers to accessing care, many individuals may not seek treatment or receive a formal diagnosis. As a result, the true prevalence of eating disorders may be underestimated. While eating disorders are recognized as a global health concern, prevalence rates may vary between countries and cultures due to differences in sociocultural norms, access to healthcare, and awareness of eating disorders.

3.7. NHS Secondary Mental Health Services

Although health service use data are not a direct representation of mental health needs in a population, being representative of demand for care rather than of need, they do contribute to the understanding, prevention and control if diseases. Under careful analysis, they can provide crucial information on prevalence, incidence, patterns of disease, inequalities, health care utilisation, risk factors and populations at risk, health care costs and effectiveness, and patient behaviour and preference, among others.

Published annually by the NHS England *Mental Health Bulletin* (MHB) provides the most detailed picture available of people who used NHS funded secondary mental health, learning disabilities and autism services in England[110]. At the time of writing, the latest data are for financial year 2022/23 (April 2022 to March 2023).

While some of the MHB data are available at a local level, there is also a wealth of contemporary national-level intelligence providing useful insights into the current trends and inequalities in access to mental health services (some selected ethnic and deprivation examples are presented below) and, as proxy, in the prevalence of mental health conditions in the population. It is important to stress that subset of population in contact with specialist mental health services are already at a health disadvantage, nationally their mortality rate that is 3.6 times higher than the general population [111].

This section aims to report on the recent local trends and broader, national, patterns of inequality in access to specialist mental health services.

3.7.1. Contact and admission rates

Broadly, the 2022/23 data show rising rates with 6.3% of people (5.2% of all males and 6.1% of

females) in England in contact with secondary mental health, learning disabilities and autism services in 2022/23, compared to 5.8% in 2021/22 and 5.0% in 2020/21– a 16% year-on-year rise.

Less than one in 25 (3.6%) of adults (18 and above) in contact with services spend time in a hospital, fewer than in the previous (2021/22) year (4.2%). Prior to 2021/22, this proportion fluctuated between 4.2 and 5.1%.

The year-on-year rise across England was 10% between 2021/22 and 2022/23, less than 16.2% between 2020/21 and 2021/22. Across Leicestershire the trend was higher (14.6%) and varied across the districts – highest proportionate increase in Harborough (22%) and lowest in Melton (10%) (Table 19). Data for adults only were unavailable at district level.

Table 19. Number of people in contact with NHS funded secondary mental health, learning disabilities and autism services for residents of districts (all ages)

	In contact 2022/23 *	Admitted 2022/23 **	% Admitted	In contact 2021/22	Trend (%)
Blaby	6,345	130	2.0	5,430	16.9
Charnwood	11,105	235	2.1	9,845	12.8
Harborough	5,595	105	1.9	4,580	22.2
Hinckley & Bosworth	6,720	110	1.6	6,045	11.2
Melton	2,720	55	2.0	2,475	9.9
NW Leicestershire	5,840	120	2.1	5,035	16.0
Oadby & Wigston	3,585	85	2.4	3,165	13.3
Rutland	2,055	40	1.9	1,800	14.2
Leicestershire	41,910	840	2.0	36,575	14.6
England	3,582,864	91,945	2.6	3,256,659	10.0

* Number of people in contact with NHS funded secondary mental health, learning disabilities and autism services

** Number of people admitted as an inpatient while in contact with NHS funded secondary mental health, learning disabilities and autism services

(Source: NHS Digital MHB 2022/23)

The Mental Health Bulletin provides demographic data down to sub-ICB (previously CCG) level, where people are classified using their GP registration status rather than residence. Data presented here are for Leicestershire and Rutland, combined from East Leicestershire and Rutland CCG (03W, ELR) and West Leicestershire (04V, WL), which are covered in **the Appendix**.

Across Leicestershire and Rutland in 2022/23, women were 40% more likely to be in contact with secondary mental health services than men, although also 30% less likely to be admitted as in-patients. People from the most deprived quintile were more than twice as likely to be in contact with service, although the socio-economic gradient in hospital admissions is not consistent with that finding. The rates of contact were highest among those with mixed ethnicity and among white population (Table 20 and Figure 34).

Table 20. Number of people in contact with mental health services, access and admission rates for GP registered population across Leicestershire and Rutland, by population group, in 2022/23

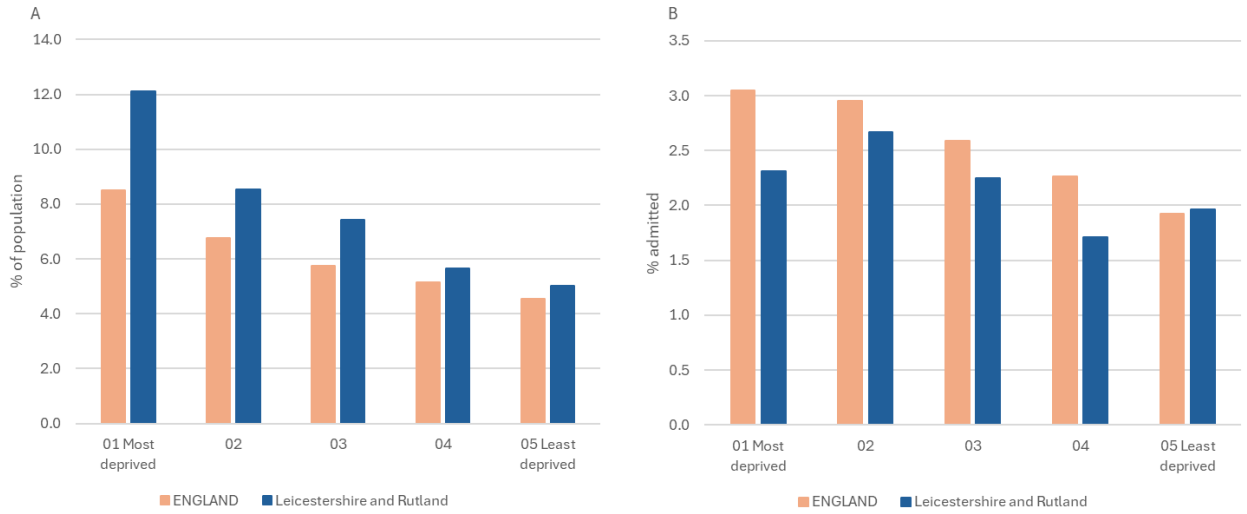
	Leicestershire & Rutland			
	In contact	**Contact rate (% of population)***	**Admitted****	**% Admitted**
All	44,090	6.2	935	2.1
Age:				
<18	9,470	6.4	30	0.3
18+	34,615	5.7	900	2.6
Sex:				
Male	18,445	4.8	465	2.5
Female	25,255	6.8	465	1.8
Ethnicity:				
Asian or Asian British	1,810	3.3	55	3.0
Black or Black British	345	4.1	15	4.3
Mixed	870	5.3	20	2.3
White	34,055	5.1	725	2.1
Other Ethnic Groups	360	3.2	15	4.2
Not Stated	5,315	-	75	1.4
Not Known	835	-	25	3.0
Unknown	505	-	0	0.0
Deprivation:				
01 Most deprived	2,160	12.1	50	2.3
02	6,185	8.5	165	2.7
03	8,675	7.4	195	2.2
04	13,180	5.7	225	1.7
05 Least deprived	13,770	5.0	270	2.0

* Calculation for ethnicity excludes 'not stated', 'not known' or 'unknown' – rates to be treated with caution as for 15% of people in contact ethnicity was not known

** Number of people admitted as an inpatient while in contact with NHS funded secondary mental health, learning disabilities and autism services

(Source: NHS Digital MHB 2022/23)

Figure 34. Rates of access to secondary mental health service (A) and proportion of admitted to hospital (B) across Leicestershire and Rutland in 2022/23, by deprivation quintile.

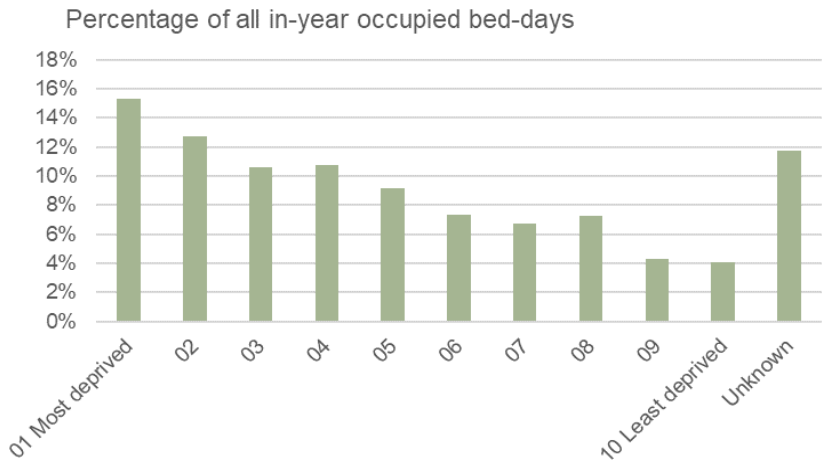


(Source: NHS Digital MHB 2022/23)

3.7.2. Bed occupancy

Bed occupancy in mental services is strongly linked to socio-economic deprivation. Across England, the most deprived quintile of deprivation contributed 28% of all occupied bed-days, while the least deprived just 8% (Figure 35).

Figure 35. Bed occupancy by Indices of Multiple Deprivation, England 2022/23



(Source: NHS Digital MHB 2022/23)

The Leicestershire rate of bed occupancy, expressed as the number of in-year bed days in NHS

funded secondary mental health service per 1,000 population (all ages) was about 38% lower than the national average (105 vs 168 per 1,000) and ranged between 80/1,000 (Hinckley and Bosworth) and 149/1,000 (Blaby).

The registered population Leicestershire and Rutland CCG had a relatively high rate of 162/1,000, when compared to 110/1,000 in West Leicestershire. In both CCGs there was a clear difference between most deprived and affluent areas (3/4-fold) (Table 21).

Table 21. In-year occupied bed days in 2022/23 across Leicestershire

	Number of in year bed days	Rate (per 1,000)	Rate Q1 (most deprived)	Rate Q5 (least deprived)
Blaby	15,555	149.3	-	-
Charnwood	21,280	115.2	-	-
Harborough	8,190	81.5	-	-
Hinckley and Bosworth	9,110	79.7	-	-
Melton	5,290	100.9	-	-
North West Leicestershire	10,670	99.1	-	-
Oadby and Wigston	5,655	96.9	-	-
Rutland	2,660	64.6	-	-
East Leicestershire and Rutland*	53,425	161.7	367.5	125.9
West Leicestershire *	42,210	109.6	288.4	72.0
Leicestershire	75,750	104.9	-	-
England	9,512,771	168.4	269.2	75.4

* Calculated for GP registered rather than resident populations (not comparable to other rates in the table)

(Source: NHS Digital MHB 2022/23)

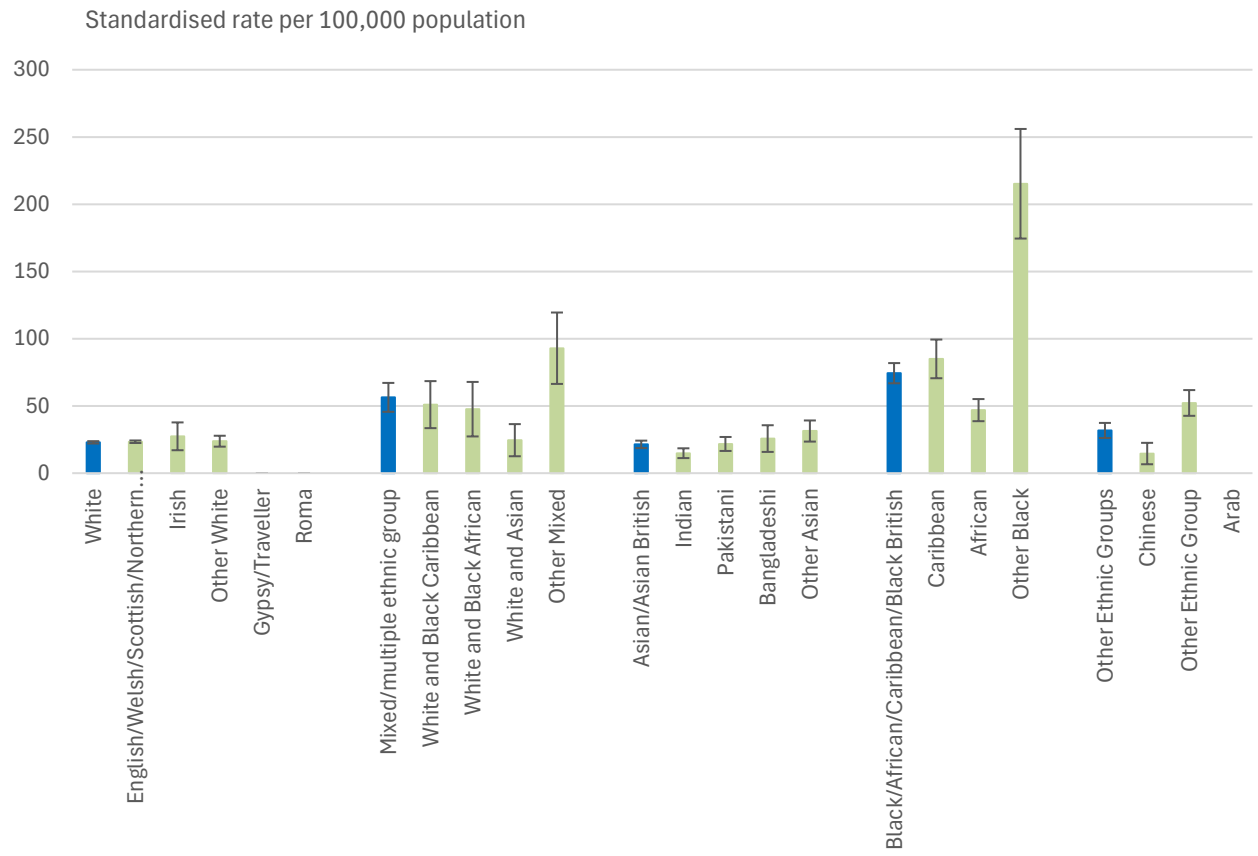
3.7.3. Inequalities at the national level

This section presents some of the more notable examples of ethnic differentials for adult patients in the NHS secondary mental health services in England in 2023. Although local data were not available, the national picture can give a useful indication of potential groups at higher risk. The underlying data were sourced from the 2022/23 NHS Digital Mental Health Bulletin.

For example, for adults aged 18-64 the highest rates of *long hospital stays* (60 days or more) in 2022/3 were for the 'other black' ethnic category (331/100,000 population) and 'other mixed' category (92/100,000), compared to the overall 32/100,000 and 25/100,000 in white population. It follows that these groups can be at significantly higher risk of log-term hospital stays. It has to be stressed that for 14% of cases in the national set ethnicity was poorly recorded ('not known', 'not stated' or 'other ethnic group') and these figures need to be treated with some caution.

The rates of *restrictive intervention* also varied significantly across ethnic groups with highest rates among those classifies as 'other black' with over 200 of interventions per 100,000 population compared to just over 21/100,000 in those from Asian or Asian British background, differing almost ten-fold. 'Other mixed' group and those of Caribbean descent also had relatively high rates (a five-fold differential with Asian groups) (Figure 36).

Figure 36. Rates of people subject to a restrictive intervention per 100,000 population, England 2022/23



(Source: NHS Digital MHB 2022/23)

Although the link of long hospital stays and restrictive interventions to deprivation was less pronounced, there were twice as many restrictive interventions in the most deprived quintile than in the most affluent one. And a three-fold gradient in the rates of long stays (60+ days) for adults in England in 2022/3.

3.7.4. Outpatients

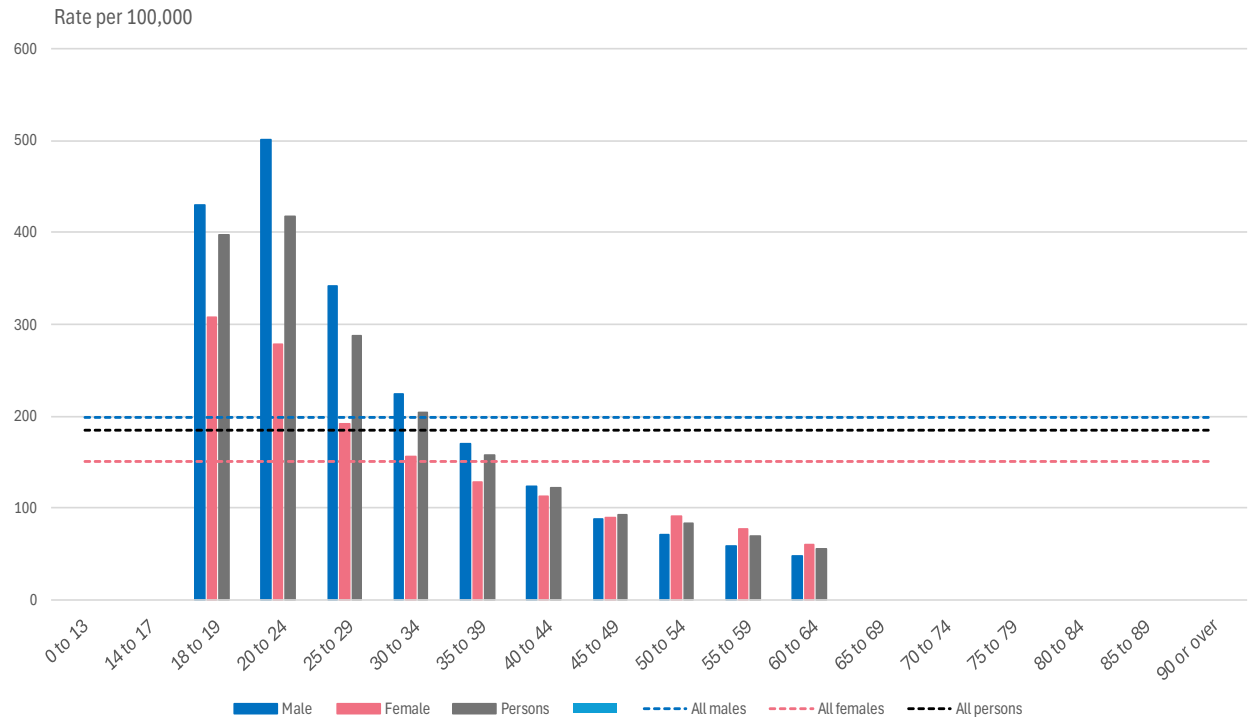
Across England, the main groups of people in contact with services, but not admitted as inpatients, were with Core Community Mental Health (38%), followed by activity in general hospitals (11%) and Crisis & Acute MH Activity in Community Settings. Notably a large proportion (over a half) of activity is described as 'other services', further 8% were not classified.

3.7.5. Early Intervention for Psychosis (EIP) pathway

Evidence suggests that early intervention for psychosis can lead to better long-term outcomes, including reduced hospitalisation rates, improved symptom control, higher rates of employment and educational engagement[112]. Individuals experiencing psychosis for the first time have multifaceted needs, which necessitates rapid access to treatment, integrated service delivery (across psychiatric treatment, psychological therapies and work-based and family support), psychoeducation and support, medical management and psychological therapies, e.g. cognitive-behavioural therapy (CBT).

The national data show that the majority of all active referrals are for younger adults 18 and 34, with higher rates for men (by about a third) and with very few referrals among those aged 65 or above; the difference between men and women reduces with age (Figure 37).

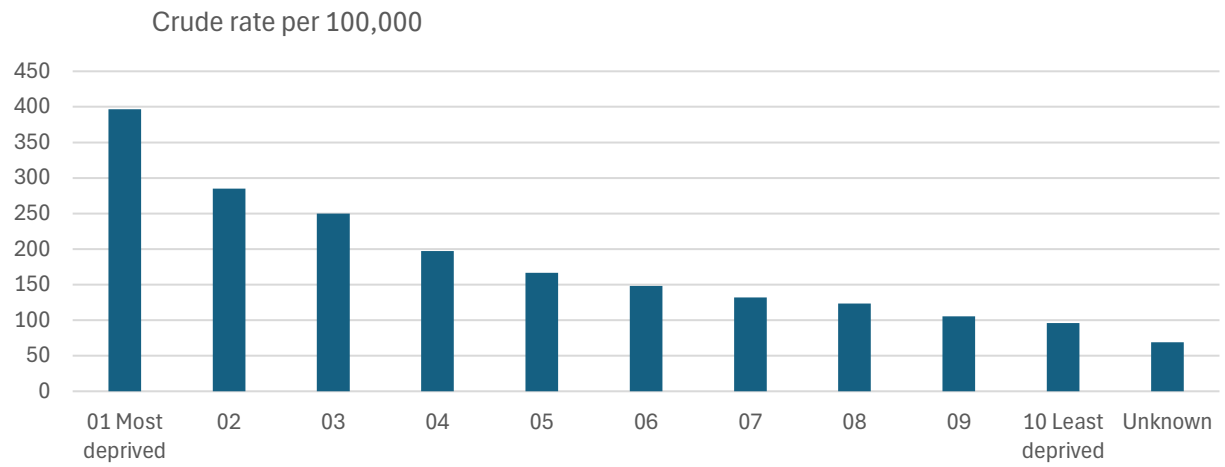
Figure 37. Referrals on EIP pathway in England in 2022/23 by age and sex



(Source: NHS Digital MHB 2022/23)

There is a strong correlation between the rates of referral and deprivation with rates over four times higher in the most deprived quintile of population when compared to the most affluent quintile in England (Figure 38).

Figure 38. Referrals on EIP in England in 2022/23 by deprivation



(Source: NHS Digital MHB 2022/23)

Specialist Perinatal Mental Health Community Services

Are described in **section 2.2.4**, page 26 (Pregnancy and Maternity)

Memory Services for People with Dementia

Are described in **section 3.2.4**, page 53 (Dementia)

4. Impacts

4.1. COVID-19 Pandemic

The COVID-19 pandemic has had a significant impact on mental health worldwide, affecting individuals of all ages and backgrounds. Some of the mechanisms include increased stress and anxiety (through fear of contracting the virus, financial concerns, and social isolation), depression and loneliness (distancing measures, lockdowns, and restrictions on gatherings) and in some cases grief and loss, due to the loss of loved ones due to COVID-19, as well as disruptions to important life events such as weddings, graduations, and funerals, leading to feelings of grief and bereavement[113].

The economic impact of the pandemic, including job losses, reduced income, financial insecurity, has contributed to stress, anxiety, and depression for many individuals and families. The disruption to daily routines, including work, school, and leisure activities, has led to feelings of uncertainty and a loss of purpose for some individuals, which can impact mental well-being.

The prolonged nature of the pandemic, combined with ongoing uncertainty and stress, has contributed to feelings of fatigue and burnout for many people, impacting their mental well-being.

Certain populations, including healthcare workers, older adults, people with pre-existing mental health conditions, and marginalized communities, may be disproportionately affected by the mental health impacts of the pandemic due to various factors such as increased exposure to stressors and barriers to accessing support. There is evidence of widening inequalities as result of the pandemic. In England, COVID-19 mortality rates were higher in the more deprived parts of the country[114]; the same evidence emerged from other parts of the world, the Americas, Europe, Africa and the Western Pacific[115].

A recent systematic review of published evidence found that generally studies reported higher prevalence of some mental health problems during the pandemic compared with preceding years, but that in most cases this increase reduced over time. The studies of health records showed reduced incidence of new diagnoses at the start of the pandemic, which further declined during 2020. Mental health service use also declined at the onset of the pandemic but increased later, although rates of use did not return to pre-pandemic levels for some services. Studies reported mixed patterns of effects of the pandemic on mental health and social outcome for adults already living with mental health conditions[116].

4.1.1. The workplace

COVID-19 pandemic has a significant impact on the mental health of people in employment and those on furlough, at its worse in period November 2020 to January 2021, with some improvement reported since then. The level of this improvement depends on the type of the industry, particularly how fast a sector has bounced back after the pandemic.

It is estimated that the total cost of mental ill-health has increased by 25% since 2019 and – reaching £53-56 billion 2020/21, contributed to by presenteeism (attending work while ill) as the contributing the highest cost, higher turnover of staff, and, to a lesser degree by absenteeism. Mental health of younger workers and those from ethnic minorities was more affected by the pandemic, while the key workers were under more pressure than non-key workers, due to increased risk of infection, pressure at work and wider pandemic-related stresses [117].

4.2. Employment and economy

Work is generally good both for physical and mental health and wellbeing and is a key part of recovery process. There is a complex, two-way relationship between mental health and employment, with poor mental health decreasing the likelihood of meaningful employment and unemployment affecting mental health negatively. Getting back into employment increases the likelihood of improved health (from poor to good) almost threefold, and boosts quality of life almost twofold. People living with mental illness have employment rates of just 16 to 35%, a significant gap

to general population[118].

One of the forms of support for people with disability or health conditions affecting ability to work is ESA (Employment and Support Allowance). At the national level, the rates of claiming ESA for mental or behavioural disorders are strongly linked to deprivation, with rates in most deprived decile 2.5 times higher than in the least deprived.

In 2021/22 there was a 10% gap in employment between those with a physical or mental condition and the general population in England. The gap in Leicestershire (8.6%) was not significantly different and the actual employment rate for those with LTCs was significantly higher when compared with the national average (72.5% vs 65.5%). The rate of claiming ESA in 2018 was also lower in Leicestershire when compared to England average (19.5/1000 vs 27.3).

However, for people in contact with mental health services, the employment rates appear to be significantly lower in Leicestershire and the gap separating this population group from general employment rates significantly higher. Also, relatively low proportion of this population locally were in stable and appropriate accommodation in 2021/22 (11% vs 26% nationally) (Table 22).

Table 22. Differentials in employment and economic factors for those with mental health conditions in Leicestershire

	Leicestershire		CIPFA	England	Sig [10]
	Rate (95% CI)	Number	range		
Employment rate (LTC) [1]	72.0 (66.5-77.6)	n/a	61.1-72.7	65.3	●
Gap in employment rate (LTC) [2]	8.0 (3.06-12.9)	n/a	4.6-13.0	10.4	●
ESA claimants 2018 [3]	19.5 (19.1-19.9)	8,200	15.2-30.2	27.3	●
Employment rate, mental illness or LD [4]	51.1	n/a	38.7-77.6	48.0	n/a
Paid employment, contact with services [5]	3.0 (2.7-3.4)	283	2.0 – 19.0	6.0	●
Employment – people in contact with 2° service [6]	6.0 (4.4-8.1)	38	3.0-21.0	9.0	●
Gap in employment – 2° services, 2020/21 [7]	70.9 (67.5-74.3)	n/a	54.6-72.6	66.1	●
Gap in employment – 2° services, 2021/22 [8]	78.1 (75.5-80.7)	n/a	59.6-78.1	69.4	●
Stable and appropriate accommodation [9]	11.1 (10.4-11.6)	n/a	11.0-53.0	26.0	●

[1] Proportion of people with a physical or mental long term health condition (LTC) in employment, percentage of population aged 16 to 64 (2022/23)

[2] Gap in the employment rate between those with a physical or mental health long term health condition and general population aged 16 to 64 (2022/23)

[3] ESA claimants for mental and behavioural disorders, crude rate per 1,000 population (2018)

[4] Employment rate of people with mental illness or learning disability, % of those with mental illness or disability (2018 Q4)

[5] Proportion of population in contact with 2° mental health service that are in paid employment in (2021/22)

[6] % of population who are in contact with 2° mental health services and on the Care Plan Approach, that are in paid employment (19 to 69 in 2020/21)

[7] Percentage gap in the employment rate for those in contact with 2° mental health services and on the Care Plan Approach, and the overall employment rate in 2020/21

[8] Percentage gap in the employment rate for those in contact with 2° mental health services and the overall employment rate in 2021/22

[9] Adults in contact with 2° mental health services living in stable and appropriate accommodation 2021/22

[10] ● not significantly different, ● significantly lower/better, ● significantly higher/worse than national average

(Source: OHID 2024)

Across Leicestershire and Rutland in 2022, 250 people accessed Individual Placement Support (IPS) services, an increase from 135 in 2021. The latest IPS monitoring figures for LLR show that since July 2022 access was higher than the set target of 773, with 935 accessing services in May 2023.

4.3. Return on investment

In 2019 mental health conditions are estimated to have accounted for 7% of all ill-health with the cost to the UK's economy estimated at nearly £118 billion per year (5% of UK GDP), with the majority of this cost falling outside of the health care system – through lost employment and informal care costs [119].

Of the total £101 billion is attributed to England. More than a half of the estimate (56%) is for ages 15-49, with 27% for those aged 50-69. The largest component by condition is depression (23%), anxiety (18%) and bipolar disorder (17%). Thus prevention of depression and anxiety would have the most significant impact.

Evidence indicates that there is a positive return of around £5.30 on every £1 spent on mental health interventions in the workplace [120] [121].

Although important, and easier to quantify, workplace is not the only setting where prevention is likely to have economic impact, others include perinatal depression prevention (health visiting), parenting programmes, school and education (antibullying programmes, exercise and physical activity, early identification in young adults, psychological interventions in those living with long-term conditions, and prevention in older people (such as measures to reduce social isolation and/or increase physical activity).

As with other public health interventions, these are likely to have long-term effects, often difficult to quantify though, typically shorter-term, research.

Return on investment for early intervention in psychosis (EIP, described in **section 3.7.5**) is estimated to be significant, with net cost savings of almost £8,000 per person after the first four years, and nearly £6,800 per person in the next four to 10 years if full EIP provisions are provided. Over a 10-year period this would result in £15 of costs saved for every £1 invested in EIP services. The majority of these cost savings can be attributed to the reduction in use of crisis and inpatient services, improved employment outcomes and the reduction in risk of future hospitalisation as a result of improved management and reduced risk of relapse[122].

5. Current Services

5.1. Summary of Adult Mental Health Services in England

Mental health services for adults in England are provided mainly by the National Health Service (NHS) and a variety of Voluntary, Community and Social Enterprises (VCSE).

The **NHS services** are traditionally grouped as primary, secondary, and tertiary care, but under the NHS Long Term Plan, transformation is ongoing to create integrated community mental health services.

- General practitioners (GPs) are often the first point of contact for individuals seeking mental health support. They can provide assessments, referrals to specialist services, and prescribe medication.
- Talking Therapies (previously Improving Access to Psychological Therapies, IAPT) program offers therapies like cognitive behavioural therapy (CBT) for common mental health issues such as depression and anxiety. It aims to provide timely and evidence-based interventions.
- Community Mental Health Teams (CMHTs) consist of various professionals, including psychiatrists, psychologists, social workers, and community psychiatric nurses. They provide comprehensive support to individuals with severe and enduring mental health problems.

- Crisis Resolution and Home Treatment Teams (CRHT) offer intensive support to individuals experiencing a mental health crisis, aiming to prevent hospital admissions and support individuals in their homes.
- Inpatient Services are offered to individuals requiring more intensive support, there are psychiatric hospitals and units available across England. These provide care and treatment for acute mental health conditions.

In addition, there are specialized services for specific mental health needs, such as eating disorders, personality disorders, and psychosis. These services offer tailored interventions and support.

VCSE organisations play a significant role in the delivery and enhancement of mental health services, providing complementary specialised services, innovation and flexibility in response to emerging needs, advocating for policy changes and reforms in mental health care, and community engagement and outreach. VCSE organisations work through partnerships and collaborations providing crucial expertise in developing local networks to enhance local service delivery and reach, as well as research and evaluation to inform broader service improvements.

Increasing emphasis is placed on recovery-oriented approaches, promoting individuals' independence, resilience, and social inclusion. Many organizations offer peer support and self-help groups where individuals with lived experience of mental health problems can connect, share experiences, and support each other's recovery. There is a growing emphasis on digital mental health services, including online therapy platforms, apps, and helplines, providing accessible support options for those who may not access traditional services. Efforts are made to integrate mental health services with social care and other support services to provide holistic support for individuals with complex needs.

Most services are commissioned locally by Integrated Care Boards (ICBs); however, some specialist services are commissioned by NHS England. NHS England is in the process of delegating responsibility for commissioning specialised mental health, learning disability and autism services to NHS-Led Provider Collaboratives[123].

5.2. Local Mental Health Services for Adults

Most of the mental health services for adults in Leicestershire are commissioned and operate across Leicester, Leicestershire and Rutland (LLR).

For urgent mental health support, people in Leicestershire may contact the **Mental Health Central Access Point**, a 24/7 freephone, operated by Leicestershire Partnership Trust and Turning Point, **NHS111 service** or a **Crisis Café**.

5.2.1. Mental Health Central Access Point

The phone line is staffed by recovery workers from Turning Point, who, after an assessment, can transfer callers to an appropriate staff member at Leicester Partnership NHS Trust (LPT).

5.2.2. Neighbourhood Mental Health Cafés

(https://www.leicspart.nhs.uk/service/neighbourhood-mh-cafes/

The cafes are drop-in centres operated by supportive, trained staff.

For non-urgent mental health support people can contact their general practice or the **NHS Talking Therapies**, a self-referral, free confidential service provided by Vita Minds (Vita Health part of Spire Healthcare).

5.2.3. NHS Talking Therapies

Formerly known as IAPT (Improving Access to Psychological Therapies), NHS Taking Therapies are NHS-funded, evidence based, psychological therapies for depression and anxiety. The service is provided by Vita Health Group (previously VitaMinds) for all adults who live and are registered with a GP in Leicester, Leicestershire and Rutland (https://www.vitahealthgroup.co.uk/nhs-services/nhs-mental-health/leicester-leicestershire-rutland .

5.2.4. LLR Self Harm Service

The national voluntary organisation Harmless has been commissioned to deliver an all-age LLR wide service for people who self-harm, their friends, families and professionals, through face to face support and counselling, email and online support. (http://www.harmless.org.uk/)

5.2.5. JOY Platform

https://services.thejoyapp.com/

An online service provided by LPT. Joy helps you to find local community activities, groups and support, including instant referrals.

5.3. Leicestershire Partnership NHS Trust

LPT provides the following inpatient, outpatient and community services:

5.3.1. The Bradgate Mental Health Unit

The Bradgate Mental Health Unit (Glenfield Hospital, Leicester) is an acute mental health admissions unit with six recovery-focused general psychiatry wards, two psychiatric intensive care wards and one low-secure ward.

5.3.2. Adult Community Mental Health Teams

There are eight community multidisciplinary mental health teams providing a secondary care, planned assessment and treatment service. This might involve psycho-social interventions, medical prescribing or, if eligibility criteria are met, social care commissioning of services. They aim to provide support with mental health needs, all aspects of daily life such as self-care, well-being and health promotion.

5.3.3. Forensic Mental Health Services

This is both an inpatient and a community service for people with a history of offending who also suffer from mental ill health. It operates from the Herschel Prins Centre, Glenfield Hospital in Leicestershire.

5.3.4. Perinatal Mental Health Service

A team of health professionals at Bradgate Mental Health Unit, Glenfield Hospital, providing personalised and specialist care to people with moderate to severe mental health problems relating to pregnancy, childbirth and the first year following a child's birth (also known as the perinatal period).

5.3.5. Maternal Mental Health Service

Based at Prince Philip House, St Matthews Health & Community Centre, Malabar Road, Leicester this is a psychology-led, trauma-informed service, helping women and birthing people with moderate to severe difficulties related to birth trauma, baby loss, and tokophobia.

5.3.6. Psychosis Intervention & Early Recovery (PIER) Team

Based at Merlyn Vaz Health and Social Care Centre, Leicester, the team offers support to people recovering from a psychotic episode. The service offers help to people aged 14 – 64 years who are experiencing first symptoms of psychosis, as well as providing help to their families.

5.3.7. Mental Health Liaison

This is a multidisciplinary team of liaison professionals providing assessment and treatment for people who experience mental health problems as a result of physical illness. The service provides a specialist *Chronic Fatigue Syndrome (CFS) Service*.

5.3.8. Mental Health Services for Older People (MHSOP)

MHSOP provides inpatient, outpatient and memory services for older people. *MHSOP Inpatients* operates across two sites, The Evington Centre and the Bennion Centre, with three wards. Working closely with community intensive teams, community mental health teams and outreach services for older people with functional and organic mental health problems. *MHSOP Memory Service*

operating from Evington Centre, provides diagnostic assessment and treatment for people with dementia within a clinic setting, care home or their own home. People of all ages with possible dementia can be referred, while the *MHSOP Outpatient Service* provides assessment and treatment for people over 65 years with moderate/complex functional mental health issues in clinics held across Leicester, Leicestershire and Rutland.

There is also an *MHSOP In-reach Team,* based at Neville Centre*,* Leicester General Hospital Site, helping patients who live in a care, residential or nursing home, and are experiencing difficulties due to their dementia and require specialist support and advice.

5.3.9. Mental Health Wellbeing and Recovery Support Service (MHWRSS)

This service is aimed at providing a first point of access for people who need mental health support. P3 (https://www.p3charity.org) provides this service for Rutland and Leicester City.

5.3.10. Crisis Resolution and Home Treatment Team

This team provides a rapid assessment of people who are experiencing a mental health crisis and would otherwise require a hospital admission to an acute mental health ward, due to mental health crisis which impacts on the person's ability to cope with day-to-day activities.

5.3.11. Adult Eating Disorders Service

Is an outpatient service for patients from LLR and a regional inpatient service for the East Midlands for adults aged 18 and over who have eating disorders such as anorexia nervosa, bulimia nervosa, binge eating disorder and other diagnosable eating disorders.

5.3.12. Therapy Services for People with Personality Disorder (TSPPD)

The service provides psychotherapy programmes drawn from a number of different models of psychotherapy for people age 18+ who have been assessed for the group therapy service and discussed it with their referrer.

5.3.13. Severe and Enduring Mental Illness Rehabilitation

These are rehabilitation inpatient units providing multidisciplinary care for patients who have severe and enduring mental illness.

5.3.14. Acute Recovery Team

Is providing specialist care, including an ECT clinic and Clozapine clinic, blood tests and monitoring.

5.3.15. Clinical Neuropsychology

Based at the Leicester General Hospital, the team serves both inpatients and outpatients who are having cognitive difficulties as a result of a neurological condition, providing neuropsychological

assessment and advice, intervention, rehabilitation, and training.

5.3.16. Leicestershire Psycho-oncology Service (LPOS)

Helping those with emotional and mental difficulties following a diagnosis of cancer, providing a range of interventions in hospital or in patient's home.

5.3.17. Huntington's Disease Inpatient and Community Service

Is a community inpatient unit for people with Huntington's disease for patients with severe and enduring mental health needs and require complex care due to physical, psychiatric, behavioural and psychological needs or rehabilitation. The community team is also based there.

5.3.18. Assertive Outreach (AO) Service

The service is provided within a multidisciplinary team approach, predominantly delivered within people's homes. The service offers a range of therapeutic interventions. It has been specifically set up to work in partnership with people with long-standing mental health needs which are 'psychotic' in nature.

5.3.19. Central Referral Hub/Unscheduled Care service

All referrals into Mental Health Services for Older People from across Leicester, Leicestershire and Rutland are received by the Central Referral Hub. People of all ages with probable dementia and adults over the age of 65 with depression, anxiety or psychotic illnesses.

5.3.20. Criminal Justice and Liaison Diversion

The service assesses people's mental health needs who have had any contact with the criminal justice system or police for any reason, victim, suspect, defendant, witness or bystander, who it is felt would benefit from mental health intervention.

5.3.21. Employment Support Service

The service is delivered to adult patients (17 and above) open to community mental health teams, psychosis intervention and early recovery (PIER) and assertive outreach, providing information, advice, guidance and support to find paid work, as part of an individualised recovery plan. Currently operates employment clinics in nine locations across Leicester, Leicestershire and Rutland (LLR).

5.3.22. Leicestershire Recovery College

Based at the Mett Centre, Leicester, this is an NHS college offering a range of recovery-focused educational courses and resources for people aged 18 and over who have lived experience of mental health challenges, along with their friends, family and LPT staff.

5.3.23. Medical Psychology

A service for adults who are having difficulties with managing the impact of medical/physical health problems on their psychological well-being or are finding that their mental health is having a direct impact on their physical health. The service can offer assessment and treatment to adult patients from all medical specialities. Referrals only from University Hospitals of Leicester (UHL) Consultants (or a member of their team).

5.3.24. Mental Health Urgent Care Hub

A team of mental health practitioners with the expertise to treat people of all ages; this includes mental health nurses, support workers, and consultants. It is specifically for people with mental health needs that don't need any physical health support from an emergency department.

People are referred to the hub by emergency services, social care or health professionals.

5.3.25. Op Community

Op Community is a telephone line for the armed forces community (including veterans, reservists, serving personnel, families and the wider armed forces community) to offer support and guidance around navigating NHS services and advice regarding other services that can support with issues.

5.3.26. Outreach Team for Adult Learning Disabilities Service

The Outreach Team works with adults aged 18 years + with a diagnosed learning disability and their carers where the person with a learning disability has challenging behaviours that might mean they cannot continue to be supported in the community/at home.

5.3.27. Psychological Awareness of Unusual Sensory Experiences (PAUSE)/At Risk Mental State (ARMS)

Planned to launch in Autumn 2023, initially in a targeted geographical area rather than across Leicester, Leicestershire and Rutland. To offer NICE-recommended psychological and psychosocial interventions to people aged 14 – 35 years who may be experiencing the early signs of psychosis.

5.3.28. Reconnect

The service offers care to those aged 18 and above with identified vulnerabilities after custody service. Provides up to 12 weeks pre-release and six months post-release person centred support, including assertive outreach, digital guidance, system navigation, signposting to support from wider health and wellbeing services.

5.3.29. The Involvement Centre and Café

The Involvement Centre is an information, IT and social resource, open to inpatients, outpatients, service users, carers and visitors.

5.3.30. Arts in Mental Health

The team delivers a range of artistic projects for mental health service users whilst supporting service users.

5.3.31. The Mett Centre

A mental health day resource centre in Leicester city centre, offering recovery-focused support, through individualised programmes of meaningful activities, physical and mental health promotion, social inclusion and therapeutic interventions.

5.4. PAVE Team (Pro-Active Vulnerability Engagement)

This is a partnership between police, mental health practitioners, and substance use practitioners providing targeted support for people who intensively use health and police services. The aim is to reduce the number of people with mental ill health being held inappropriately in police cells. The multi-disciplinary team includes police officers, mental health practitioners, and substance use Recovery Workers. In addition clinical support is available as required from a Consultant Psychiatrist.

5.5. Voluntary and Community Sector Services

In Leicestershire, voluntary and community based services include:

Norton Housing Support (http://nortonhousingandsupport.org.uk/) provides support and accommodation to adults with ongoing mental health needs and/or learning disabilities.

Leicestershire Action for Mental Health Project (LAMP) (https://www.lampadvocacy.co.uk/) provides independent mental health advocacy (IMHA).

The Singing Café (https://thesingingcafe.co.uk) is a charity initiative run by Without Walls, which is based within Hinckley and Bosworth and offering services for vulnerable members of Leicestershire population, seeking to address loneliness and mental health conditions.

The Carers Centre (https://www.claspthecarerscentre.org.uk/) aims to support unpaid carers across the diverse communities of Leicester, Leicestershire and Rutland.

Living Without Abuse (https://lwa.org.uk/) offers information and advice to anyone experiencing domestic abuse and/or sexual violence.

Voluntary Action Leicester (VAL https://valonline.org.uk/) is an active part of the local voluntary, community and social enterprise (VCSE) sector, providing advice, support and training to charities and community groups across Leicestershire. They are a source of information on other voluntary initiatives for people with mental health across LLR.

SSAFA Leicestershire and Rutland: A charity which provides support for serving personnel, veterans

and their families across Leicestershire, Leicester and Rutland.
(https://www.ssafa.org.uk/leicestershire-rutland)

FreeVA (Free form Violence and Abuse) is a lead specialist provider of support for people affected by domestic and/or sexual violence. Services include a helpline, advocacy support and counselling. Services also available for the perpetrators through behavioural change programmes and for young people who are violent or abusive towards parents or carers. (https://www.freeva.org.uk/)

Quetzal project: A charity which provides counselling and support to women who have suffered domestic abuse or sexual abuse. (https://quetzal.org.uk/)

Harmless is a national voluntary organisation for people who self-harm, their friends, families and professionals, through face to face support and counselling, email and online support.
(http://www.harmless.org.uk/)

This is not an exhaustive list. There are many more local organisations and groups providing services and support for people with mental health problems. More information can be found at (www.valonline.org.uk)

5.6. Local Authority and Other Mental Health Services

Leicestershire County Council (LCC) provides support for all adults over the age of 18 who approach LCC for social care support in relation to either mental health or substance misuse issues. The services work to a social model of Mental Health but the expectation is that people are likely to need specialist support on the basis of their mental health and substance use. This in the main will be linked to whether people will be supported through the LLR Integrated Community Mental Health System. This support is provided on the basis of guidance as laid out in the Care Act 2014 and the Mental Health Act 1983 is aimed to promote well-being and independence.

5.6.1. Mental Health Locality and Reablement Teams

Teams include Community Reablement Workers (CRW) who focus on people who can be supported through information and advice on how to access support, and the development of a recovery plan. CSWs focus on Care Act assessment and support planning for local authority paid support. Social Workers and Approved Mental Health Professionals (AMHPs) provide support for complex mental health issues.

5.6.2. Mental Health Hospital Team

Supports the discharge of residents of Leicestershire from in-patient mental health wards. The team covers both the Evington Centre, Bradgate Unit, The Willows, Stewart House and out of county

mental health hospitals such as St Andrews. This includes people in the Transforming Care cohort if they are admitted to the specified wards.

The team's key functions are to carry out care and support assessments and complete support plans and recovery plans where necessary.

5.6.3. Approved Mental Health Team

The Local Authority has a statutory duty under the Mental Health Act 1983 to appoint and warrant Approved Mental Health Professionals **(**AMHP's). They have the key decision-making powers in regard to the detention of people to hospital and placing people on Guardianship or Community Treatment Orders, as well as having recently been given further statutory duties under The Debt Respite Scheme (Breathing Space Moratorium and Mental Health Crisis Moratorium) Regulations 2020[‡‡‡].

5.6.4. Mental Health Wellbeing and Recovery Service

Commissioned jointly between, Leicestershire County Council, Leicester City Council, Rutland County Council, and the three CCG's and currently provided by three different providers, the service offers support networks focused on wellness and recovery, encouraging independence and developing own personal support networks.

5.6.5. Integrated Substance Misuse Treatment Service

The Integrated Substance Misuse Treatment Service (ISMTS) for Leicestershire and Rutland is jointly commissioned by Leicestershire County Council (Public Health) and Rutland Council. Leicester City tendered separately and both contracts have additional funding by the Office of Police and Crime Commissioner (OPCC) and the Ministry of Justice (MoJ). It is currently provided by the Turning Point for both contracts.

There is a specific dual diagnosis offer across Leicester, Leicestershire and Rutland that is funded by the ICB with Leicestershire County Council leading. This is a specific substance use and mental health team within the ISMTS who work with service users that require support for the mental health and substance use in tandem. Whilst the team cover low and medium level mental health they do link directly with mental health services for those with high level mental health needs.

5.6.6. Local Authority Public Health Services

The Public Health Department approach involves finding ways to improve the mental wellbeing of the population in Leicestershire, through assessing health needs, assessing evidence base for interventions, direct commissioning/contracting of services, and working with other departments

[‡‡‡] https://www.legislation.gov.uk/ukdsi/2020/9780348209976/contents

and partners. The department jointly leads (with Leicester City PH) the Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group. In addition to the suicide prevention work, currently the department commissions and/or contributes to a number of local initiatives aimed at improving mental wellbeing and supporting recovery:

First Contact + offers access to a range of low level preventative services through a single point of contact. This is an online service ensuring that people can access information, advice and support across a range of issues.

Local Area Co-ordinators (LAC's) is a community based intervention delivered in specific areas by Local Area Co-ordinators. The team work on an asset-based model to increase individual and community capacity, preventing people reaching crisis, and thereby reducing demand on public services. Whilst not a specific mental health service, much of the work undertaken supports improving people's mental wellbeing and addresses issues that impact on individual mental health.

Health Inequalities Team has a key role in supporting communities and individuals with early intervention to help reduce the likelihood of problems accruing or worsening. Working both reactively and proactively, offering advice and guidance using a community centred approach. Supporting individuals with their wellbeing; identifying people struggling with a range of issues including loneliness, isolation, bereavement, debt, housing, addictions, or simply concerned about the rising cost of living and requesting information on how to heat their homes efficiently. The Team have supported Community groups to apply for funding and this has greatly supported their efforts to continue or even start up.

LLR Suicide Bereavement Service (Harmless)

The Tomorrow Project suicide bereavement service, operated by Harmless, supports anyone who might be struggling following a suicide, people of any age with any relationship to the person that they have lost, including friends and colleagues, first responders, health professionals, acquittances or passers-by. The service is able to communicate with families within 72 hours of their loss, informing them of the service and establishing the immediate needs of the family, providing them with information and putting in place support that responds to their short- and long-term needs. This includes liaising with other services, providing emotional support or helping to secure practical and financial help to the bereaved. Self-referral and referral by a professional is available.

5.6.7. Social Prescribing

Sometimes called a community referral, social prescribing is a way to link individuals with non-clinical activities within their community to help improve their health and wellbeing.

Social prescribing can be adapted in many different ways across a number of different sectors. Within the local authority, both Local Area Coordinators (LAC) and Health Inequalities Team, described in the paragraph above, use social prescribing. Within GP practices, social prescribing link

workers connect people over 18 to community-based support, such as groups, activities and local services which provide emotional support, information and advice. They focus on non-medical factors that are having an impact on health and wellbeing. Social prescribing is aimed towards groups including those who need support with low level mental health issues and people who are lonely or isolated.

5.6.8. Other Services

Getting Help in Neighbourhoods

This service is commissioned by the ICB and in partnership with Leicestershire County Council this service offers proactive, preventative support in addressing mental health issues. The service remit varies according to the needs of the different neighbourhoods. It is available to anybody aged 18 and over.

Student Mental Health

The ICB is leading on a workstream focussing on the needs of the student population across the universities in Leicester and Leicestershire in conjunction with the university health and wellbeing services.

Mental Health Practitioner/Facilitators

Is a Primary Care based service for patients with more severe and enduring mental illness such as schizophrenia and bipolar disorder.

Mental Health Central Access Point

Is a 24/7 self-referral service for people in need of mental health support for themselves or others, commissioned by the ICB and staffed currently by Turning Point, this is an all-age service that provides signposting, assessment and intervention.

Place of Safety

This is the Section 136 (S136) suite at the Bradgate Mental Health Unit. This suite is used for emergency psychiatric assessment by an AMHP detained by police, under S136 of the MHA. S136 is used on an exceptional basis, although when it is appropriate to be used, it is preferable for the individual to be detained in a healthcare setting rather than a criminal justice setting.

Triage Car

Leicestershire Police and a mental health nurse from LPT respond to people with mental health problems in public places.

Transition work

The ICB is leading on services and pathways for those aged 18-25,

6. Identified Needs and Gaps in Provision

- Leicestershire population is on average older than national, with fastest demographic growth among older adults (aged 65 and above). This has direct implications for future levels of morbidity and multimorbidity, including mental health conditions.
- As many areas of Leicestershire are predominantly rural, issues of loneliness and social isolation, access to services and hidden pockets of deprivation are best investigated at a neighbourhood level.
- There is a strong correlation between socio-economic deprivation and rates of access to mental health services across Leicestershire, however there is no deprivation link to inpatient mental health admissions. The national data indicate significantly higher risk in black or mixed ethnicity groups.
- Local crime rates, particularly violence against person (predominantly of domestic nature and with injury) seem to have increased in the recent years.
- There are no local data available, but nationally the levels of mental ill-health among students have been increasing sharply.
- The numbers of women accessing community perinatal mental health services in Leicestershire and Rutland are increasing, in line with the national trend.
- Whilst rates of people with Severe and Multiple disadvantage (SMD) are likely to be lower than average, it is estimated that there are 2,400 people with SMD in Leicestershire.
- There is a perceived lack of flexible mental health outreach for people who sleep rough.
- It is likely that the total prevalence of common mental disease is close to a 100 thousand of adult population of Leicestershire. The local access to NHS Talking Therapies is just around 13 thousand referrals per year (less than 70% of planned target) which may indicate a gap in provision, although there could be a number of reasons for this apparently low demand.
- The proportion of people waiting for NHS Talking Therapies for a long time was higher than expected in previous years but has shown improvement recently (92% seen within 6 weeks across Leicestershire and Rutland).
- There is a perception that the current 'cost of living' crisis is impacting on more people and affecting their mental health and wellbeing and leading to higher demand for services, particularly in some neighbourhoods. Other important wider determinant impacts on mental health include housing and transport.
- The estimated prevalence of severe mental illness is 15 thousand in Leicestershire (a minimum of 12.5 thousand), against just 6 thousand registered prevalence on GP registers. The gap in registration is further highlighted by the fact that over 7.5 thousand of adults with SMI accessed

community mental health services in 2022/23.

- Comparative data show higher rates of premature mortality among people with SMI, with cancer mortality seemingly contributing to this in Leicestershire. Of note in this context are very low coverage rates for breast cancer screening - less than a third of eligible women with SMI are screened, compared to 70% of those in the general population.
- Only half of people with severe mental illness receive full physical health checks (50% in West Leicestershire and 45% in East Leicestershire and Rutland), against the current 60% performance target - a preventive measure that could be improved.
- People with personality disorders (PD), estimated to account for between 73 and 83 thousand in Leicestershire, experience considerable stigma, and, as was previously assumed, less chances of effective recovery. However, there is evidence that treatment for PD can be effective; a trauma-informed understanding of PD would consider it as complex trauma. Currently, care for PD is perceived to be fragmented with gaps in service provision offering a compassionate understanding about PD and treatment.
- Although comparative figures show the Leicestershire rates of suicide and self-harm as similar or lower than national average, approximately 60 people lose their life through suicide annually and an estimated 40 thousand could be self-harming and/or attempting suicide. Surveillance of suspected suicide is on-going.
- There are perceived gaps in the continuity of care for people self-harming, attending Emergency Department and returning back to locality primary care and local services, particularly for those at university who may be at a part-time address.
- Although the indicators relating to dual diagnosis (mental health condition and substance misuse) are below (better than) the national average, the use of alcohol is comparable to the national figures.
- The rate of access to secondary NHS mental health services (around 33 thousand of Leicestershire residents are accessing annually) has been increasing year-on-year, while remaining lower than the national average. On average, about 2% of these patients are admitted as inpatients, comparable to the national average.
- The employment gap between those in contact with mental health services and general population seems to be wider in Leicestershire than is the national average, with lower than expected proportion of those in contact in stable and appropriate accommodation. This may indicate a higher economic impact on the local population with mental health issues.
- It is recognised that 50% of mental health problems are established by age 14 and 75% by age 25, and although one in ten children and young people aged 5-16 have a clinically diagnosable condition, 70% have not had appropriate interventions at a sufficiently early age (MH

Foundation 2024).

7. Recommendations

- Undertake further modelling of the impact of current demographic trends on future mental health needs and demand for health care to enhance planning of future services.
- In parts of Leicestershire which are predominantly rural, issues of social isolation, access to services and hidden pockets of deprivation should be recognised and addressed at a neighbourhood level, through improved joint working. Needs of some at risk groups such as unpaid carers, prisoners, travellers, vulnerable migrants, and armed forces veterans should also be assessed at a neighbourhood level.
- Enhance local data collection on mental health inequalities, prevention and services, including mapping of services and patient pathways, particularly for vulnerable groups such as pregnant women, veterans or students.
- Investigate potential impact of rising crime rates in neighbourhoods.
- Seek opportunities for prevention and early detection of mental health conditions, particularly for those in high risk groups such as carers of people with mental health difficulties to provide support before that person reaches a crisis.
- Continue raising awareness of the risk factors of dementia and prevention measures for these.
- Work should be undertaken to target individuals with Severe and Multiple Disadvantage (SMD) with access to support and services, particularly at a neighbourhood level.
- Explore opportunities for developing flexible mental health outreach for people who sleep rough.
- Develop a prevention programme as part of Prevention Concordat to promote mental health and wellbeing to wider population. To include wellbeing support and access to services, and interventions to mitigate, where possible social factors (wider determinants of health) which are contributing to poorer mental wellbeing.
- Explore opportunities to further understand and address, as appropriate, premature cancer mortality among people with severe mental illness (SMI) which may be linked to low breast screening coverage.
- Improve the uptake of breast screening for women with SMI through better understanding of patient pathways, patterns among those non-attending and appropriate outreach, possibly using the current successful learning disability model.

- Monitor and improve uptake of physical health checks, particularly among those with SMI.
- Explore opportunities to improve awareness of and access to effective treatments for personality disorders (PD).
- Enhance the continuity of care for people who are self-harming, including emergency services, primary and social care and other local services.
- Continue to support and develop interventions to enable people in contact with mental health services to engage in employment and have access to stable and appropriate accommodation.
- Improve access to mental health services particularly in communities where there may be a stigma attached to living with a mental health problem.
- Improve the transition from children's services such as CAMHS into adult services, with a focus on prevention. The ICB is leading on this piece of work and the system plays a key part in shifting the focus from separate children and adult services into considering children's mental health as part of the preventative offer across the whole life course.

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