NHS
Herefordshire
Clinical Commissioning Group

Chapter 2: Herefordshire Profile

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Contents

Chapter 2: Mental Health: Herefordshire Profile

2.1. Herefordshire

Herefordshire is a predominantly rural county, with the 4th lowest population density in England. It is situated in the south-west of the West Midlands region bordering Wales. The city of Hereford, in the middle of the county, is the centre for most facilities; other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington.

Herefordshire produces an annual overview of the health and well-being needs of the county ("Understanding Herefordshire"), the content of which will not be rehearsed in this document.

The current (mid-2012) resident population is 184,900, with 22 per cent of the population aged 65 years or above (40,800 people), compared to 17 per cent nationally. This includes 5,500 residents aged 85 and over. There is a similar proportion of under-16s as nationally (17 compared to 19 per cent).

2.1.1. Rurality and Mental Health

There is some evidence to suggest that levels of mental illness are lower in rural areas, particularly relating to psychosis[i], depression and anxiety[ii]. However, many of these studies fail to adjust for confounders such as unemployment, socio-economic status, ethnicity, educational status and marital status. In studies where these factors are adjusted for, the differences between rural and urban rates of mental ill health become less pronounced[iii]. As will be discussed in chapter 10, people employed in agricultural industries are at higher than average risk of suicide, suggestive of under-detection of mental health need in rural areas, as well as indicating risk factors such as cultural stoicism, social isolation and lack of access to supporting services[iv].

As with all areas, stigma around mental health (see chapter 4) remains an issue in rural areas, but may be compounded by small, close social networks and a lack of anonymity (an aversion to "people knowing your business") which might discourage help seeking behaviour[v].

As part of this needs assessment, service users and mental health professionals were asked about issues relating to the rural context of Herefordshire. Rurality was seen as a barrier to accessing services and engaging with patients, a point particularly raised in relation to young people's services (see chapter 8). It also results in services that cost more per head of population than a comparable urban area. There is a potential for technological solutions to overcome some of the issues.

What was offered was often dependent on how far you lived out from the city patient.
Patient/ Service User

There are more opportunities for support groups in the city; people living in rural areas struggle to locate local support groups
Patient/ Service User

People suffer from isolation in outlying areas and have little opportunity to access support.
Voluntary Organisation

In rural areas, there is difficulty in finding continuation of care from local agencies
Private Organisation

The Large geographical area means that there is a lot of travel. You cannot get the economies of scale in Herefordshire so you don't get the same cost per patient
Mental Health Practitioner

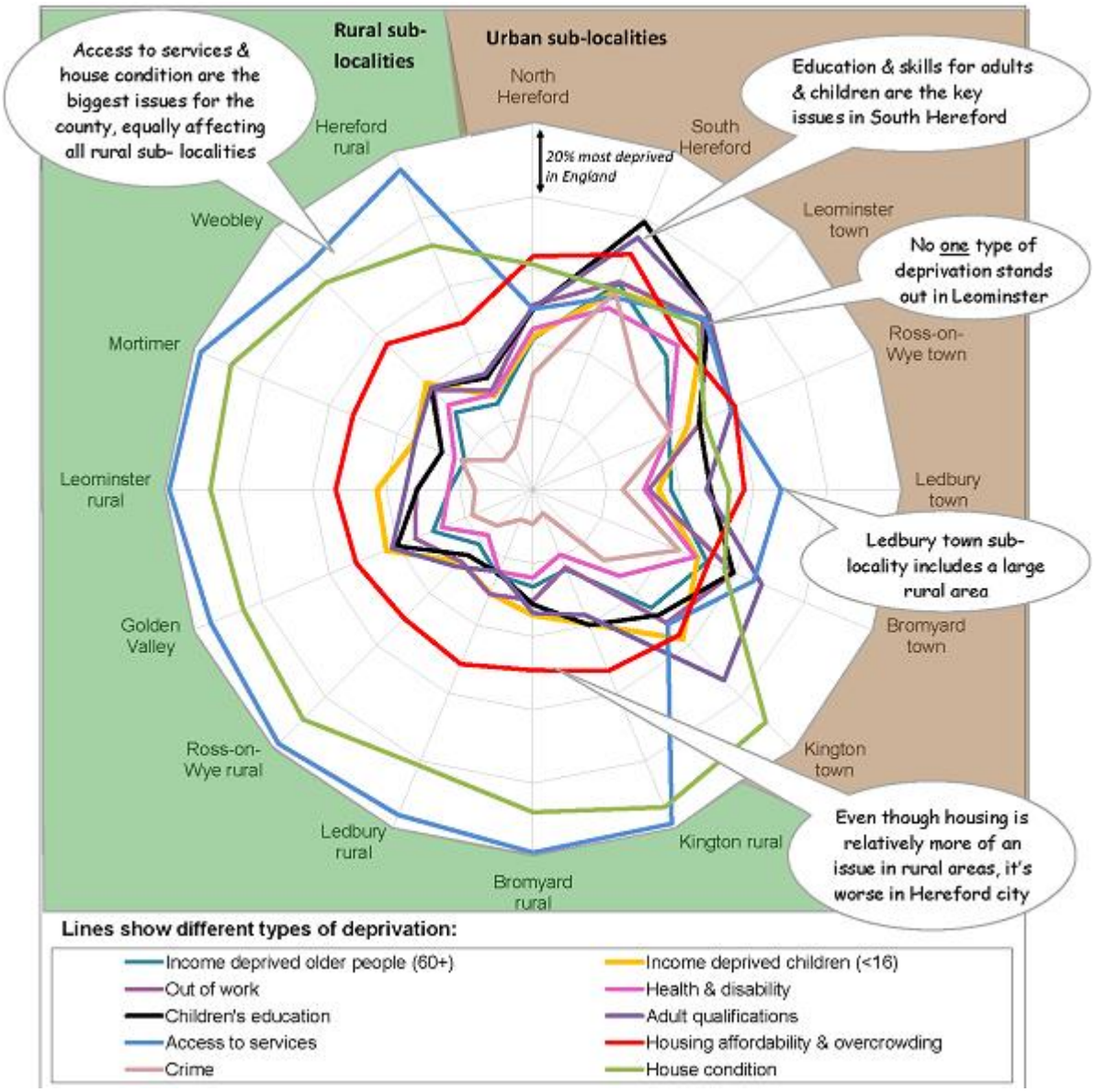
We should be able to remotely upload notes rather than returning to the office.
Mental Health Practitioner

2.2. Risk Factors for Mental Ill Health in Herefordshire

2.2.1. Socio-Economic Determinants of Mental Health

As a whole, Herefordshire has relatively low levels of deprivation. In general people are healthy, live longer compared with nationally, and have positive experiences of the things that affect their lives and well-being. However, some areas of South Hereford, Leominster and Ross are amongst the 25 per cent most deprived in England and have become more deprived relative to other areas. Different types of deprivation affect different areas, which function as determinants of various physical and mental health outcomes– figure 2.1 shows how the issues vary around the county.

Figure 2.1: Deprivation in Herefordshire localities relative to all of England (a point nearer the outside of the chart indicates greater relative average deprivation)



Source: Understanding Herefordshire, 2013

Information on determinants affecting mental health in Herefordshire are presented below:

<u>People with no Qualifications</u>

- In total, just under a third (30 per cent) did not have the equivalent of five GCSEs grades A*-C (up to Level 2 qualification).
- The last few years has seen an apparent increase in the proportion of Herefordshire's working age population without qualifications, although analysis of the 2011 Census shows that qualification rates are very similar to those across England. There are however noticeable differences by age: generally speaking younger county residents are less well qualified than older residents when compared to England as a whole.

Absenteeism (Children and Young People)

- Pupil absenteeism (the % of half days missed by pupils due to overall absence authorised and unauthorised) was at 5.5% in 2012/13; a reduction from 5.8% in 2010/11, though up from 5.1% in 2011/12.
- Persistent absenteeism rate was almost 10% in 2010/11 though the rate decreased to less than 4% in 2012/13, similar to national rates (*Source, CINA 2014*)

People living alone

- 15% of adults living alone equating to 1 in 7 adults. Across the county, there were now 11,200 pensioners (aged 65+) living alone – 700 more than in 2001 (+7%). This equated to three in every ten pensioners. (*2011 census*)

Lone parents claiming benefits

- The lone parent group accounted for 10% of out of work benefits claimants, accounting to approximately 900 people. (*Herefordshire Facts and Figure, 2014*)

People providing unpaid care

- The 2011 Census recorded that 21,000 residents (11 per cent) were providers of at least an hour a week of unpaid care to family members, friends, neighbours or others because of long-term ill-health or disability or problems related to old age – an increase of over 3,000 and one percentage point since 2001. This included 6,700 who were providing 20 hours or more. *(Carers Analysis, Strategic Intelligence Team, 2014)*

Young Carers

- There were approximately 400 children aged under 16 providing unpaid care in Herefordshire, which represented 1per cent of all children in this age group in the county. This proportion was similar to nationally. (*2011 Census, Carers Analysis, Strategic Intelligence Team, 2014*)
- The Herefordshire Carer's Support has approximately 300 children and young people registered with them (*Carers Analysis, Strategic Intelligence Team, 2014*)

Homeless Families

- The county's homelessness rate is one of the worse when compared to the statistical local authority neighbours, the best performing rate is 0.68 per 1,000 households (East Riding of Yorkshire) compared to 3.23 per 1,000 households in Herefordshire. In the last three quarters (Q1-Q3 2013/14), there were 200 families labelled as homeless in Herefordshire *(Source: Department for Communities and Local Government, Homelessness Statistics.*

Table 2.1 provides a summary of some further socio-economic determinants in relation to Herefordshire.

Table 2.1: Socio-Economic Determinants of Mental Health within Herefordshire

Socio-Economic Determinants of Mental Health		Compared to England
Employment and income	9,120 people out of work claiming benefits (2013)	Same
	14,500 Households on low incomes (2007/8)	Same
Education	55,050 People with no qualifications	-
	840 People aged 18 and over with learning disabilities and are known to the GP (2011/12)	Higher
	1,025 Children achieved a good level of development at the end of reception (2012/13)	Significantly better
	1,024 Children GCSEs achieved (5 A*-C inc. English and maths) (2012/13)	Significantly worse
Family and caring	27,525 People living alone (2011 Census)	-
	900 lone parents claiming benefits (2007/8)	-
	21,000 People providing unpaid care (2011)	-
	240 Looked after children and young people (Dec 2013)	-
Crime and antisocial behaviour	92 (547/100,00 population)First time entrant to the youth justice system	Worse
	7,800 crimes recorded by West Mercia Police in 2013/14	-
	15.92/1000 population, 18+ domestic violence incidents reported to West Mercia Police in 2012/13.	Significantly better
Housing	200 homeless families (3.2/1000 population)	-
Health	6,400 people self-reporting long-term mental health	Same

Table 2.2 outlines how a number of wider determinants may inform mental health outcomes.

Table 2.2: Main factors associated with different types of mental health needs (Jenkins et al, 2008)[vi]

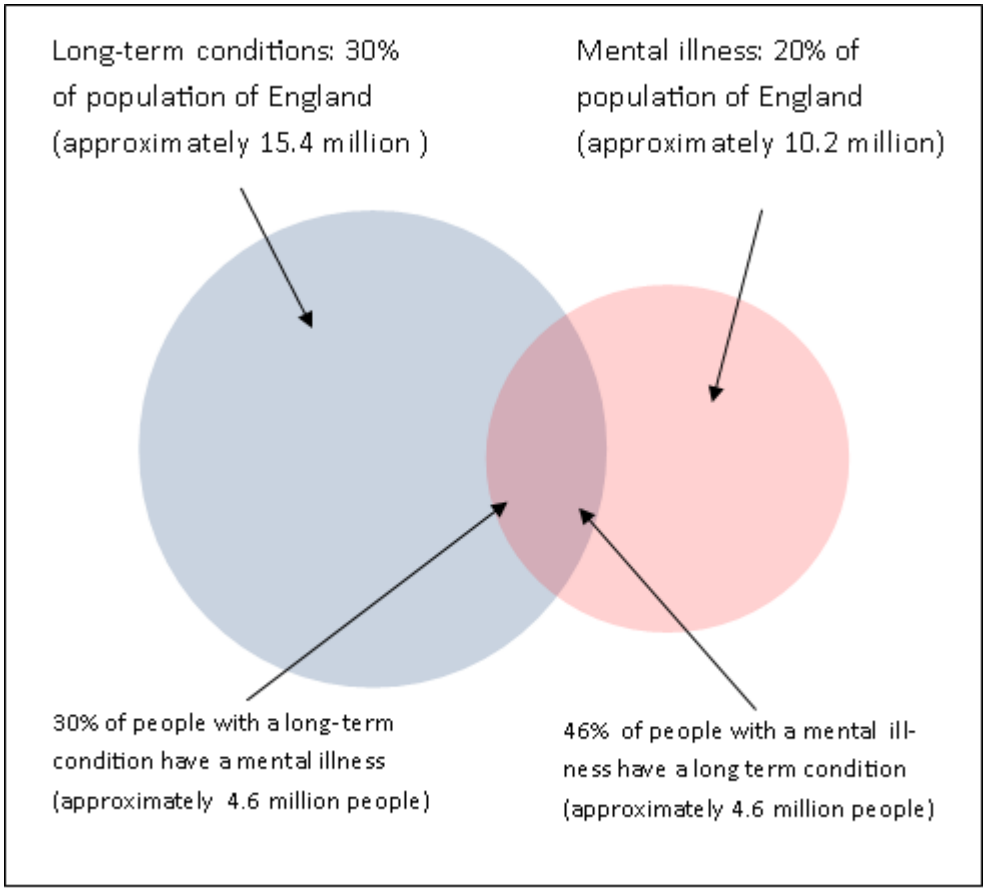
	Childhood Disorders	Adult Common Mental Disorders	Psychosis	Dementia	Personality disorders	Suicidal thoughts	Addictions		
							Alcohol abuse	Substance abuse	Tobacco
Age	Increases with increasing age	Highest rates in 35-54 age group	Highest rates 20-34 age group	Increase with age, 5% of over 65s, 20% of over 80s.	Increased in younger people	Highest in young adults	Highest in 16-24 age group	Highest in 16-24 age group	Increased onset in 16-24 age group. Highest rates 25-55 age group.
Gender	M>F	F>M	M>F but secondary peak in women 40-45 age group	M=F	M>F	F>M, but actual suicide M>F	M>F	M>F	M=F
Ethnicity	Lower rates in young Indian girls	Higher rates in Irish and Black Caribbean	Higher rates in several BME groups						
Marital status	n/a	Increased in separated & divorced			Increased in single	Increased in single, separated and divorced	Increased in single, separated and divorced	Increased in single	Increased in single, separated and divorced
Family Composition	Increased in lone parents and reconstituted families	Increased in lone parents				Increased rates in those living alone	Couple with children have lower rates		
Employment	Increased in poor education of parents, lack of employment and low incomes of parents	Increased in social class V and unemployed.	Increased in social class IV & V, and in economically inactive. Little evidence that parental social class is influential.		Increased in those with lower socio-economic status and poorly educated	Higher rates in lower educational qualifications and lower social class	Increased in manual occupations	Increased in unemployed	Higher rates with lower educational qualification, nursing and teaching, lower social class.
Housing tenure	n/a	Increased rates in	Increased rates in people who rent			Increased rates in those	Increased rates in	Increased rates in those	

	Childhood Disorders	Adult Common Mental Disorders	Psychosis	Dementia	Personality disorders	Suicidal thoughts	Addictions		
							Alcohol abuse	Substance abuse	Tobacco
		people who rent rather than own home.				living alone	those who rent from LA or housing association and in those with a mortgage	who rent	
Social supports	Increased with psychological distress in mother and family discord	Increased in those with few social supports	Increased in those with few social supports			Increased rates with few social supports			
Immigration status			Higher rates in immigrants, probably due to increased stressful life events, urban living, discrimination & social isolation.						
Deprivation	Increased rates with neighbourhood deprivation and lack of social cohesion		Increased rates with neighbourhood deprivation and lack of social cohesion, both in childhood neighbourhood and current neighbourhood.					Increased rates with neighbourhood deprivation and lack of social cohesion.	

2.2.2. Links between Physical and Mental Health

There is a complex, dynamic relationship between mental and physical health. People with a chronic medical condition have a 2.6-fold increase in the likelihood of having a mental illness, compared to those without a chronic medical condition[vii]. Conversely, people with mental illness experience poor physical health with higher than expected mortality, which is not explained by suicide[viiiix]. Much of this excess mortality is potentially avoidable[x].

Figure 2.2: Overlap between long-term conditions and mental illness



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

A number of reasons have been suggested for the increase in mortality of people with mental illness:

- Health behaviours e.g. smoking, diet, exercise, alcohol and drugs[xi]
- Altered help seeking e.g. delayed presentation,
- Reduced treatment adherence, poor uptake of health screening, impaired mental capacity leading to treatment refusal
- 'Diagnostic overshadowing' e.g. failure by health professionals to recognise physical health problems in people with mental disorders.

- Discriminatory policies
- Iatrogenic factors e.g. obesity caused by antipsychotic medication[xii].
- Social conditions e.g. homelessness, unemployment,
- poverty
- Suicide and violent victimisation
- Direct physical impacts of mental disorders e.g. changes to immune function.

Within Herefordshire therefore there is a need to identify and address these contributory factors and so reduce the prevalence of mental ill-health in the county. Further information on this topic can be located in chapter 4.

2.3. What are the costs of Mental Ill Health?

2.3.1. Primary Care Costs

In a group of 2000 patients at any one time, a GP with an average list will be treating:

- 352 people with a common mental health problem
- 8 with psychosis
- 120 with alcohol dependency
- 60 with drug dependency
- 352 with a sub-threshold common mental health problem
- 120 with a sub-threshold psychosis
- 176 with a diagnosed personality disorder
- 125 (out of the 500 on an average GP practice list) with a long-term condition
- with a co-morbid mental illness
- 100 with medically unexplained symptoms not attributable to any other psychiatric problem (MUS).

This means about one in four of a full- time GP's patients will need treatment for mental health problems in primary care[xiii]. Reducing the prevalence of mental ill health and addressing the contributory factors (outlined above), whilst supporting GPs in Herefordshire to better support people experiencing mental ill health will improve outcomes and quality of service for all patients.

2.3.2. Secondary Care Costs

More than £2billion is spent every year on secondary care services for people with poor mental health[xiv] . In 2013/14, HCCG allocated £15.3 million to its contract with the current provider of secondary and community mental health services, 2Gether NHS Foundation Trust (HCCG, 2014)[xv]. Spend on other areas of mental health spend are laid out in table 2.3, below. As a result of demographic changes in the population, particularly in the number of older people, the cost of mental ill health could double over the next 20 years.[xvi]

Table 2.3 Programme budgeting detail- components of Mental Health spend, Herefordshire CCG 2013/14

Categories of Spend	Mental health disorders
	£ '000s
Main Mental Health Provider	15,366
Other NHS Providers	823
Continuing Health Care	3,171
Funded Nursing Care	1,559
Nursing Home	277
Additional Dementia services	210
Other (Zero Priced Mental Health)	1,195
Total ex. Overheads	**25,104**

2.3.3. Societal Costs

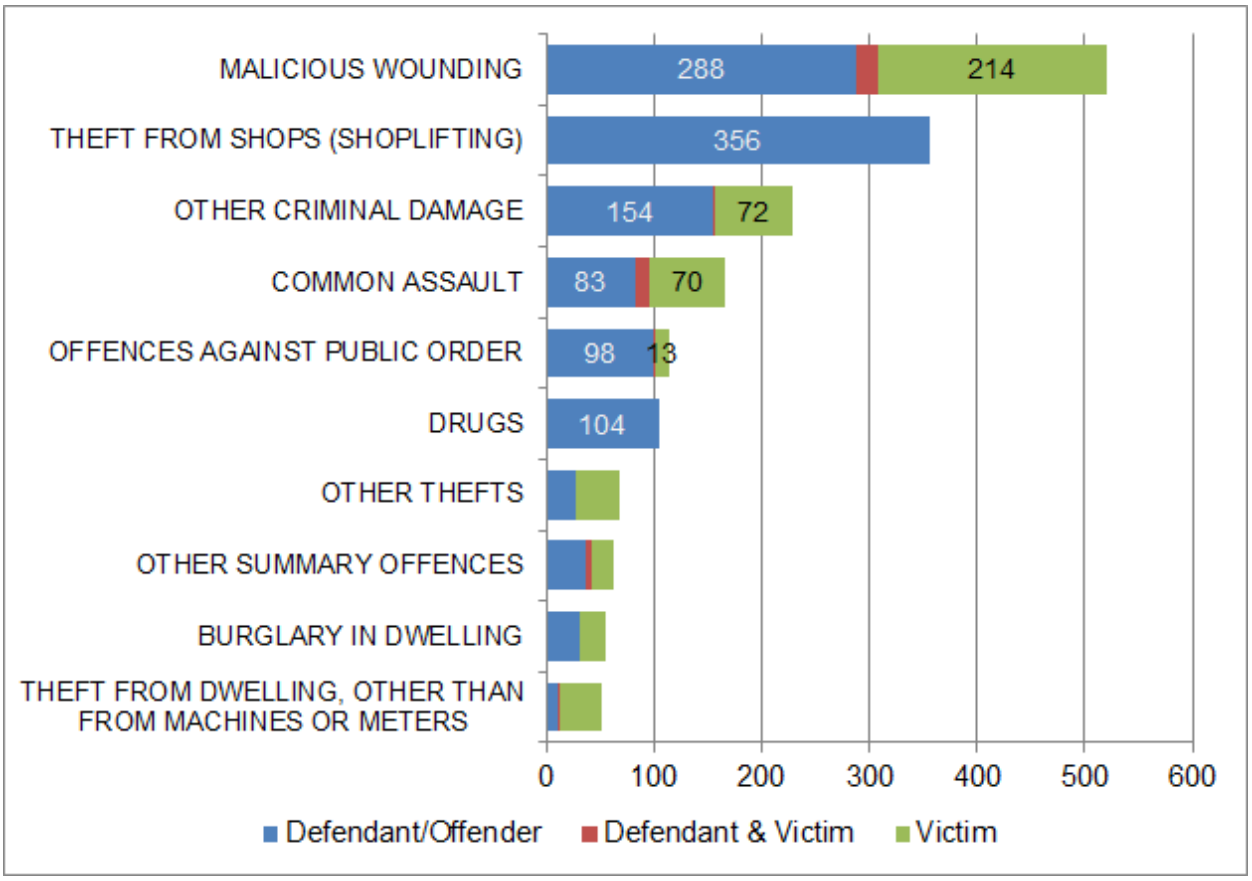
Mental ill health also has an enormous negative impact on the quality of life. In 2010 the Centre for Mental Health estimated these costs at £53.6 billion per year.

The latest figures available (Centre for Mental Health, October 2010) suggest that mental ill-health costs in England approximately £105 billion each year once its impact on work, benefits and the criminal justice system have been taken into account[xvii] . Approximately £30 billion of this estimate is work related, a result of sickness absence and reduced productivity; mental illness is responsible for more sickness absence than any other illness [xviii]. Government figures show that 43% of those on long-term benefits due to health issues have a primary mental health problem[xix] .

Links between crime and mental health are contentious, given the complexity surrounding crime, deprivation, social exclusion and offending. Notwithstanding, the costs of criminal activity related to conduct disorder in England and Wales alone amounts to £22.5 billion each year, with a further annual cost of £37.5 billion attributable to sub-threshold conduct disorder[xx]. Over 25 years, the total return from parenting programmes for children with conduct disorder is between 2.8 and 6.1 times the intervention cost, much of this through reduced crime[xxi].

Figure 2.3 below shows the number of crime and disorder incidents in Herefordshire flagged as having a mental health component between 2011 and 2014. As can be seen, people with mental health are represented as both victims and perpetrators of crime. Indeed, people with a recorded mental health issue are as likely to be victims of violent crime, and more likely to be victims of theft (other than shoplifting), than they are to be perpetrators.

Figure 2.3. Pooled Data of Incidents with a Mental Health flagging for financial years between 2011-14 in Herefordshire

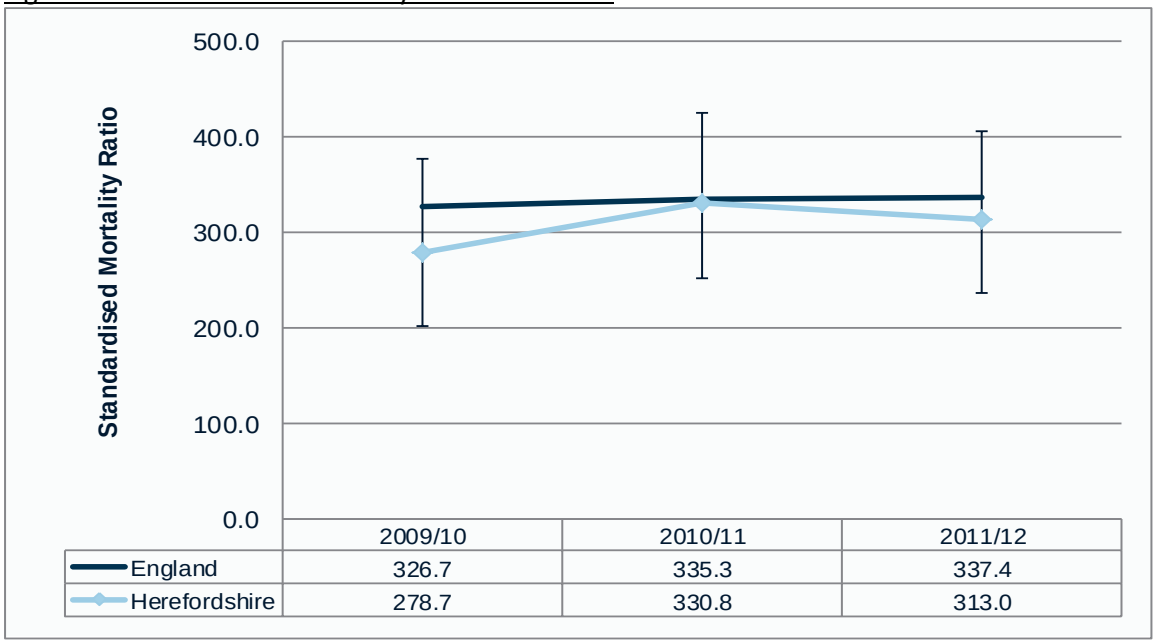


Source: Herefordshire Community Partnership, (2014)

2.3.4 Mental Health Mortality

Approximately 12% of all deaths in Herefordshire (around 230 per annum) in 2012-13 have a mental health-related diagnosis as a cause (underlying or contributory) on the death certificate. The vast majority of this mortality is coded to various forms of senility and organic mental disorder, with almost 40% having a code of vascular dementia (ICD10 F01) specifically. A further 5% of deaths reference alcohol or substance misuse as a contributory factor.

Figure 2.4: Standardised Mortality Ratio 2009-2012



Source: NHS Outcomes Framework

The ratio of the directly age standardised mortality rate for people aged 18 to 74 in contact with secondary mental health services to the directly age-standardised mortality rate for the general population of the same age expressed as a percentage.

Generally mortality rates among those with a serious mental illness are around 300% greater than among the general population in Herefordshire. This is not significantly different from the national picture.

2.4. Conclusion

This Chapter provides some background to Herefordshire and its people. The risk factors show a number of determinants that affect the number and severity of mental health conditions. These are present in the communities of Herefordshire therefore the design of services and consideration of the local population's needs requires an understanding of these risk factors and active targeting to overcome them. This stretches beyond the NHS to the whole system. The financial and human cost of mental health is also a reminder why this issue is important. Years can be added to life if the mental health needs of the population are addressed.

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