LONDON BOROUGH OF RICHMOND UPON THAMES

NHS Richmond Clinical Commissioning Group

Richmond borough: Profiles of mental health and wellbeing

January 2010

Executive summary

Purpose

This paper is part of the assessment of needs relating to mental health and wellbeing among the adult and older populations in Richmond borough.

The paper sets out:

- the main factors that determine patterns of mental health and wellbeing in the borough of Richmond.
- estimates of levels of mental health conditions, and
- some implications for improving mental health and wellbeing.

A previous paper considered evidence-based frameworks relating to mental health and wellbeing. A further paper will assess profiles of current health and social care services and changes aimed at improving mental health outcomes.

Related needs assessment work (in development) covers the emotional wellbeing and mental health of children and young people, early years, risky behaviours and substance misuse (drugs and alcohol).

Determinants of overall levels of mental health need

The projected increase in the total resident population of Richmond of 4% by 2015, and 9% by 2020, will increase the need for mental health and related services. The growth in the older population will be particularly important. 14% of the population (around 28,400) will be aged 65 years and over by 2015.

Relatively higher levels of affluence in Richmond, coupled with high levels of social cohesion, explain in part the positive ranking of Richmond against more deprived areas on a number of indicators of mental health. Nevertheless the absolute scale of mental health problems in Richmond is considerable and increasing.

Furthermore there are marked variations within the borough of Richmond, with clear geographical pockets of deprivation, and groups that are at higher risk of experiencing poor mental health.

Risk and protective factors for mental health and wellbeing

The role of certain risk and protective factors are particularly significant at different points in the life course.

Childhood experiences are known to have a critical influence on emotional wellbeing and mental health through the life course. Half of all lifetime mental illness begins by age 14 and three quarters of lifetime mental illness arise by mid twenties.

Social and emotional wellbeing in childhood provides the building blocks for healthy behaviours and capacity for learning and educational attainment. It helps prevent

negative outcomes in adolescence and adulthood including anti-social behaviour, mental health problems, involvement in crime and violence and drug and alcohol misuse.
In Richmond the majority of children and young people have positive scores on indicators related to emotional health and mental health. However substantial numbers of children and young people are vulnerable to developing emotional and behavioural problems, particularly those living in circumstances of disadvantage.

The recent findings of the Richmond Young People's survey (2012) highlight issues relating to bullying, self esteem, attitudes towards weight and dieting and use of drugs and alcohol.

Work has an important role in promoting and protecting mental health. For adults with mental health problems (including those with schizophrenia and psychosis), evidence shows employment leads to better health outcomes, recovery and rehabilitation, reduced risk of long term incapacity and improved quality of life. In Richmond 14% of those in contact with specialist mental health services are in employment. While this is slightly higher than averages for London and England, there is potential for improvement.

The costs to employers of mental ill health are significant. Around 40% of sickness absence is attributable to mental illness.

Trends in unemployment rates show the impact of the economic recession on Richmond residents. Currently around 5000 Richmond residents are unemployed (4.3% unemployment rate).

Social isolation and lack of social support are important risk factors for both mental and physical illness, particularly among older people. The number of 65-74 year olds living alone in Richmond is projected to increase from 3,500 in 2012 to 4,300 in 2020 (an increase of 23%). The number of those 75 years and over living alone is projected to increase from 6,000 in 2012 to 7,100 in 2020 (an 18% increase).

Mental health disorders

Estimates of numbers of people with mental health conditions in Richmond are presented. These are based on application of national prevalence rates (primarily from the Adult Psychiatric Morbidity Survey, 2009).

However use of national prevalence rates can only provide broad estimates of local mental health patterns. In Richmond the relatively low levels of deprivation and increasing aging population are distinct factors influencing levels of mental illness.

Common mental disorders (such as depression and anxiety) are the most prevalent mental health conditions. An estimated 20,000 people in Richmond have a common mental disorder. About 50% of those with common mental health problems may require some form of treatment. Primary care is the principal setting for the management of these conditions. Management should include access to psychological therapies.

Around 1,500 people are estimated to have some form of severe mental illness. Co-morbidity among psychiatric conditions is also high. Dual diagnosis of substance misuse and psychiatric illness is frequent.

Levels of depression and dementia are the most significant mental health conditions among older people. An estimated 3,000 older people have some level of depression. This number is expected to increase significantly over the decade.

The number of older people with dementia in Richmond is projected to increase from around 2,000 individuals in 2012 to 2,300 in 2020 – an increase of 18%. Two thirds are likely to live in the community, and cared for by family and mainstream primary and social services. The remaining third are likely to be living in care homes (probably with more advanced illness).

Detection of mental health conditions

A significant number of people with a common mental health disorder do not access primary care and are not diagnosed. Around 10,500 (6.7%) Richmond are diagnosed as having depression (QOF 2011/12). This is a lower proportion compared to London and England as a whole. The lower figure may be due to actual lower levels of common mental health problems in Richmond, but in part may be due to lower detection rates.

Evidence suggests that there is also a significant gap in diagnosis of dementia. Only between a third and a half of people with dementia ever receive a formal diagnosis, 870 (0.4%) Richmond patients were diagnosed with dementia (QOF 2011/12).

Estimates provided through the Richmond Risk Stratification Project show high levels of co-morbid mental illness (depression and dementia) and chronic physical conditions (including heart disease and diabetes). Co-morbidity increases significantly with age. For example 36% of men and 50% of women aged 65+years who have depression also have three or more other physical conditions.

More integrated approaches to detection and management of patients with depression and dementia combined with long term physical conditions can improve quality of life and achieve more effective use of resources.

Mortality rates for suicide and injury of undetermined intent are assessed (based on three-year pooled averages). Richmond has slightly lower rates than elsewhere. For Richmond, the mortality rate for suicide and undetermined injury was 7 per 100,000 population under 75 years, compared with 7.09 for London as a whole and 7.91 for England.

Some implications for improving mental health outcomes

A number of Richmond strategies for children and young people (mainly in development) have an important role in influencing future patterns of mental health. These strategies cover emotional wellbeing and mental health, ‘hidden harm’, early years, and prevention of risky behaviours. These strategies will need to achieve an effective balance of investment in prevention and early intervention through universal services (such as health visiting and early education) and more intensive targeted programmes.

Measures for promoting mental health in the workplace should be considered, in collaboration with local employers. Such measures would help reduce the cost of work-related mental ill health. Richmond Council, as one of the major local

employers, might consider how its policies promote and protect the mental health of employees.

Richmond mental health strategies for adults and older people already set out an overall framework to improve outcomes through reconfiguration of mental health services. The strategies outline the development of a more preventative, community-based and recovery orientated model of care. This needs assessment will inform the updating of these strategies.

This assessment of mental health needs demonstrates the importance of:

- Improving the detection and management of common mental health problems within primary care; and targeting those who are most vulnerable and at high risk (older people, and those with long term physical conditions, those on low income)

- Ensuring care pathways are in place for the effective assessment and management of those with serious mental health problems, and delivery through collaboration between primary health care and specialist mental health services.

- Strengthening early intervention in psychosis, and crisis intervention and home treatment to prevent inappropriate hospital admission.

- Improving the early detection and diagnosis of dementia within primary care in conjunction with the new memory assessment service.

- Strengthening community based services and approaches that promote independence and social engagement and help prevent depression and other mental disorders among vulnerable groups, particularly older people,

- Strengthening integrated approaches to prevention and management of co-morbid mental health and physical health conditions.

Richmond needs to prepare a joint policy on prevention of self harm and suicide that identifies the range of measures that could improve outcomes, to contribute to the national suicide prevention strategy.

Profiles of mental health and wellbeing

1. Purpose

This paper is part of the assessment of need for mental health and wellbeing in Richmond among the adult and older populations in Richmond.

The paper sets out:

- the main factors (risks and protective factors) that determine patterns of mental health and wellbeing
- the impact of these factors on mental health and wellbeing
- estimates of levels of mental health conditions
- some implications for changes and development of services to improve mental health and wellbeing.

A previous paper considered evidence-based frameworks. A further paper will assess profiles current services in addressing mental health needs and planned changes planned to improve outcomes.

Related needs assessment work cover the emotional wellbeing and mental health of children and young people (CAMHS), early years, risky behaviours and substance misuse (drugs and alcohol).

2. Determinants of mental health and wellbeing

The mental health and wellbeing of the populations is determined by a complex range of factors. The main factors determining mental health are known through research. These factors can act to protect mental health and wellbeing or increase risks of mental illness. Table 1 below summarises many of the risks and protective factors which operate at individual, family and community level.

Table 1: Risk and protective factors of for mental health and wellbeing

	Individual	Family	Community
Risks	Low self esteem Developmental delay Low educational attainment Physical illness Learning disability Experience of bullying/abuse	Parental conflict Family break down Parental mental illness Parental substance misuse Criminality Bereavement Living alone/ social isolation Low income, financial insecurity, debt Unemployment	Socio economic disadvantage Inadequate housing/homelessness Discrimination Insecure, low control/high demand job Poor educational provision Inadequate health and community services
Protective factors	Feeling safe Not bullied Self esteem, sense of self identity & self efficacy Educational attainment Interpersonal skills Resilience & coping skills Engagement in positive activities	Sound parental attachment Family bonds Social support / networks Learning & development environment Financial security	Access to leisure & recreational /open spaces Community safety/ low crime levels Schools with strong academic and non academic opportunities Job security, effort/reward balance Occupational opportunities Appropriate health and community services

These factors operate cumulatively over the life course. The factors interact through the stages of life and generations. Most mental health begins before adulthood and often continues through life (Royal College of Psychiatry 2010).

Childhood is a critical period. Adverse social circumstances significantly increase the risk of emotional and behavioural problems in childhood but also later life (Allen 2011). For example experience of poor parenting and/ or exposure to parental substance misuse or domestic abuse increases significantly a child's risk of behaviour problems and conduct disorder.

Half of all lifetime mental illness begin by age 14 and three quarters of lifetime mental illness arise by mid twenties (Kessler et al 2007, Meltzer et al 2003).

Most protective factors at an individual level (shown in table 1) are identical to positive social and emotional wellbeing. The active promotion of social and emotional wellbeing strengthens resilience and ability to cope with adverse circumstances and helps prevent mental health problems.

The impact of the main determinants of mental health and wellbeing in Richmond borough are examined below.

3. Risks and protective factors in Richmond borough

3.1. Demographics

The level of mental health need is determined in part by the overall size and structure of the Richmond population. The risks of mental illness vary by age, sex and ethnicity.

National surveys show that women are more likely to experience common mental health problems than men (19.7% of women and 12.5% of men) (McManus et al 2009). The risk of depression increases with age; 40% of those over 85 years of age are affected. Dementia is more prevalent in older adults. It affects 5% of people over 65 and 20% of those over 80 (Knapp & Prince 2007).

The resident population of Richmond upon Thames was estimated to be around 190,900 in 2010 (51% women and 49% men) (ONS mid 2010 population estimates).

Table 2 below shows population estimates for SW London boroughs (ONS mid 2010 population estimates). It shows estimates for total populations and for the main age groups.

22% of the Richmond population was aged under 18 years (41, 800). The needs assessment for emotional wellbeing and mental health (CAMHS needs assessment 2012) provides further details of the child and adolescent population.

In 2010, 12.7% of the Richmond borough population was aged 65 years and above. This was the second highest older population (as a proportion of the total population) across the SW London boroughs. Richmond had the highest proportion of population 75 years and above (7%).

Around 200,500 patients (all ages) are registered with NHS Richmond GPs (49.9% males and 50.1% females) (Primary care support services 2012).

Table 2: Population estimates : SW London boroughs (mid 2010 population estimates)							
Borough	**total population**	**population aged 18-64 yrs**	**% population aged 18-64 yrs**	**population aged 65+ yrs**	**% population aged 65+yrs**	**population aged 75+yrs**	**% population aged 75+yrs**
Richmond	190900	124800	65.37	24300	12.7	12000	7.06
Kingston	169000	114900	67.99	20100	11.89	10100	5.97
Wandsworth	289600	211100	72.89	26400	9.11	13400	4.63
Sutton	194200	123500	63.59	26800	13.8	13400	6.9
Merton	208800	141800	67.91	24000	11.49	12300	5.89
Total	1052500	716100	68.04	121600	11.55	61200	5.81

Source: ONS Mid-2010 Population Estimates

Population projections

The total population of the borough of Richmond is projected to increase, by 4% in 2015 (to 204,200) and by 9% in 2020 (to 215,300).

Table 3: Population projections: SW London boroughs						
Borough	18-64 years			Total		
	2012	2015	2020	2012	2015	2020
Richmond	127,300	130,000	135,800	196,700	204,200	215,300
Kingston	120,200	125,000	132,200	177,200	186,500	199,600
Wandsworth	219,100	227,400	238,000	300,400	313,000	329,300
Sutton	127,300	131,500	138,800	200,600	208,700	222,000
Merton	146,600	153,300	162,800	216,200	227,400	243,500

Source: PANSI. Figures from ONS sub national population projections

The older population living in the boroughs of SW London is projected to increase significantly over the decade (table 4). The greatest increase in the older population as a proportion of the total population is expected in Richmond and Sutton. In 2020 14.7% of the population (around 31600) will be aged 65 years and over. There will be associated increases in levels of mental illness.

Table 4: Population projections 2012-20 : aged 65 and over (and as a proportion of the total population) for SW London boroughs						
	2012	**% of pop 65+**	**2015**	**% of pop 65+**	**2020**	**% of pop 65+**
Kingston	21,200	11.96%	22,900	12.28%	25,700	12.88%
Merton	24,800	11.47%	26,300	11.57%	28,300	11.62%
Richmond	25,900	13.17%	28,400	13.91%	31,600	14.68%
Sutton	28,100	14.01%	29,600	14.18%	31,800	14.32%
Wandsworth	26,600	8.85%	27,300	8.72%	28,100	8.53%

Source: POPPI. Figures from ONS sub national population projections available March 2012 based on ONS mid 2010 population estimates.

Ethnicity

Prevalence rates of common and severe mental health problems appear to vary by ethnic group although there is no consensus on this pattern in the research.

People from black and minority ethnic backgrounds experience disproportionately factors relating to deprivation that are linked to poor mental health (eg Cooper et al 2008). These include discrimination, poverty, poorer housing and education.

Evidence indicates that people from black and minority ethnic groups are often reluctant to seek help from mental health services. Delay in accessing support can result in higher rates of hospital admission and more complex and intrusive interventions, including compulsory detention and seclusion (SCIE 2008). The *2009 Count Me In Census* showed that some black and ethnic minority groups are more likely to be diagnosed with schizophrenia and detained and treated compulsorily under the Mental Health Act (Commission for Healthcare Audit and Inspection 2009).

The Richmond borough black and ethnic minority population comprises 11.5% of the total population. This is similar to the national average but substantially lower than London (35%). People of Indian origin are the largest ethnic minority group (2.5%). A further 12% have a non white British background. This is higher than England and slightly higher than Greater London (11%). This population is diverse. Irish is the largest proportion of this group (2.8%) (ONS population estimates by ethnic groups).

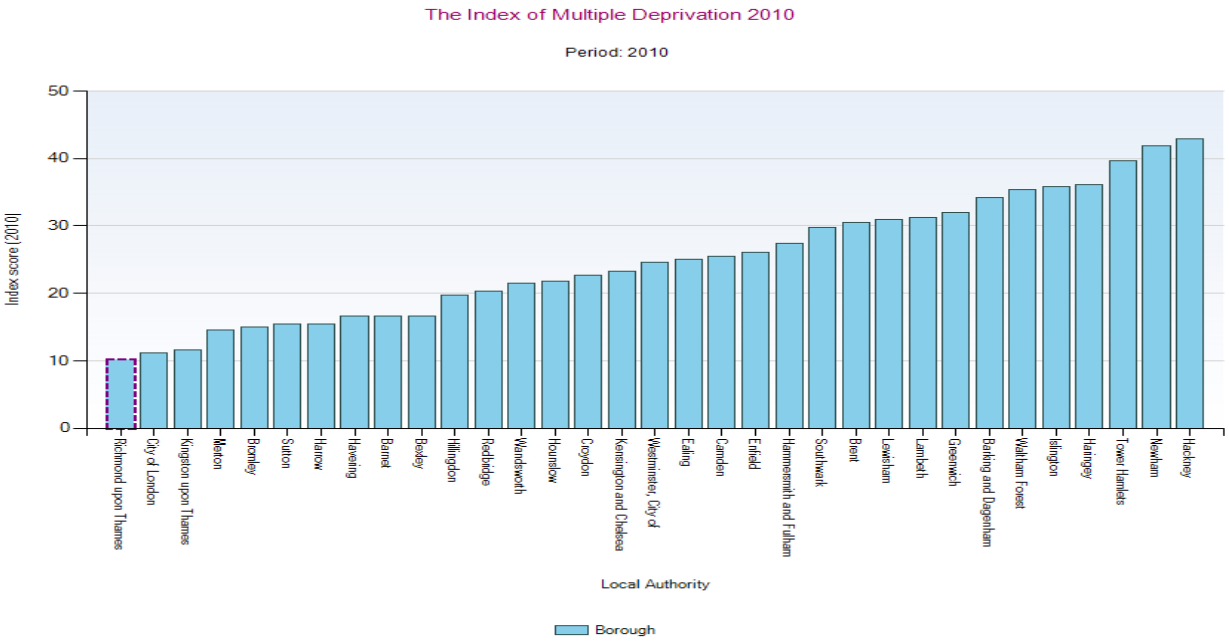
This pattern of ethnicity is an important factor influencing both the risk of experiencing mental illness and also level of access and outcomes of mental health services.

3.2. Deprivation

There is a strong relationship between deprivation and experience of mental health problems. The relationship is marked with respect to depression and psychotic disorders. The National Psychiatric Morbidity Survey reported that people living in households with the lowest levels of income were more likely to have a common mental health disorder than those living in the highest income households (McManus et al 2009).

Richmond borough is one of the most affluent areas in the country. It is the least deprived borough within London (as measured by the Index of Multiple Deprivation) (Figure 1 below).

Figure 1: Deprivation: Local authorities in London



Source: Index of multiple deprivation 2010

However there are marked variations in levels of affluence within the borough of Richmond, with clear pockets of deprivation in certain areas.

Figure 2:

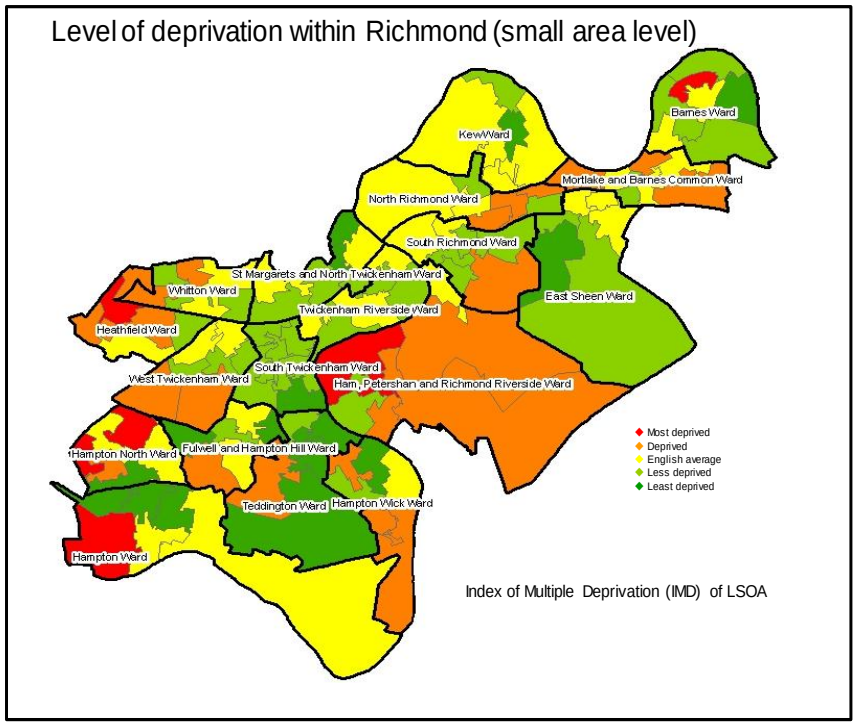


Figure 2 above shows that pockets of high deprivation exist within Heathfield, Whitton, Barnes, Mortlake, Barnes Common, Ham Petersham and Richmond Riverside, West Twickenham, Hampton North and Hampton wards (Richmond JSNA

2012). Many of these wards also contain areas of great affluence. The level of need for mental health and related services is likely to be higher in these more deprived areas compared with more affluent areas.

3.3. Community social cohesion and mental wellbeing

'Social cohesion' refers to the strength of community relationships and levels of participation in community activities and public affairs. It also refers to social contacts and networks (with family, friends and relatives) and social support and a sense of belonging. Evidence shows that higher levels of 'social cohesion' are associated with better levels of health including mental health and wellbeing, as well as other social and economic benefits (Wilkinson 1996). For example residents' perceptions of the safety and friendliness influence levels of anxiety and depression.

The Place Survey conducted in 2008 in Richmond borough provides information on different dimensions of social cohesion (Ipsos Mori 2009). Table 5 below summarises some of the main findings. These findings suggest that overall Richmond scores highly on measures of social cohesion compared to other parts of London.

Table 5: Richmond Borough Results of Place Survey 2008/09: Social cohesion

Indicators	**% of population** responding positively to statements (figures in brackets show scores for five most deprived areas in Richmond)		
	Richmond	Outer London	London
believe people from different backgrounds get on well together in local area	87.6 (76.6)	75	76.3
feel they belong to their neighbourhood	64.1 (59.1)	53	52
civil participation in local area	17.7	15	17
feel they can influence decisions in locality	31	34	35
general satisfaction with the area as a place to live	92.2 (85.2)	73	74
participation in regular volunteering	24.3	21	20.8
perceptions of anti-social behaviour as a problem	9.9	26	26.5
perception of drunk and rowdy behaviour as a problem	24.1	35	35.5
perception of drug use or drug dealing or drug dealing as a problem	10.3	35	36.5
self reported measure of people's overall health /wellbeing	85.4 (73.4)	78	79.4
satisfaction with people over 65 with both home and neighbourhood	88.9 (82)	75	77.1
extent to which older people receive support needed to live independently	20.1	23	23.3
fair treatment by local services	75.4	66	67.2

Source: Results of the Place survey 2008/09 : London Borough of Richmond (Ipsos Mori 2009)

For example the vast majority of residents (92%) were satisfied with Richmond as an area, compared with the average for London (74.9%). Most residents (87.6%) felt people from different backgrounds got on well together in their local area (compared to the average for London of 76.2%). However there were also concerns. Around 10% of residents reported being concerned with antisocial behaviour. Almost a

quarter of residents (24.1%) perceived alcohol to be a problem, and 10.3% perceived drug use or dealing as a problem. However, these figures are considerably lower than other areas of London.

The survey compared the scores for selected indicators for the five most deprived areas (Ham, Mortlake, Heathfield, Hampton and Castelnau) with the borough as a whole. The scores for the five most deprived areas are shown in the brackets in the table. The scores show clearly that these deprived areas have lower levels of social cohesion. For example a significant gap exists between proportion reporting satisfaction of people age 65+ with both home and neighbourhood (82% and 88.9% respectively). The scores for the deprived areas are nearer to the average for London. It is important to note that residents in the deprived areas reported lower levels of health and wellbeing than the average for London.

3.4. Childhood experiences

Childhood experiences are known to have a critical influence on future physical and mental health as well as opportunities in later life (see for example Allen 2011).

A child's social and emotional wellbeing provides the building blocks for healthy behaviours and capacity for learning and educational attainment. Good social and emotional health acts as a source of resilience against adverse experiences (such as poverty and family violence) (NICE 2009, 2012).

Evidence shows that poor social and emotional health predicts a range of negative outcomes in adolescence and adulthood including anti-social behaviour, mental health problems, involvement in crime and violence, drug and alcohol misuse and teenage pregnancy (Farrington et al 2006, Waldfogel and Washbrook 2008).

Those children who are at risk of, or more likely to be experiencing social and emotional problems are living in situations of deprivation. Children who are exposed to parental drug and alcohol problems, parental mental health problems, family relationship problems, or criminality are at particular risk. Children at risk may also include those who are in a single parent family or who were born to mothers aged under 18, with a low educational attainment, or who are (or were as children) looked after.

The recent detailed needs assessment of the emotional wellbeing and mental health of children in Richmond shows overall a positive set of indicators relating to risks and outcomes compared to other areas in England (CAMHS needs assessment 2012). However there are marked variations in children's experiences within Richmond borough. In Richmond around 11% children live in income deprived household (around 4,000 children). There are groups of children who are more vulnerable to emotional, behavioural and mental health problems.

This variation is also evidenced by the more recent Richmond Young People's Survey (2012). This survey included a range of indicators that help assess the emotional wellbeing and mental health. The survey was undertaken by the School Health Education Unit in conjunction with Richmond children's services. A total of 4216 primary and secondary school pupils took part.

While overall children report positive measures, a minority of children are clearly more vulnerable and at greater risk of experiencing emotional and behavioural problems. Table 6 below highlights concerns relating to bullying, self esteem, attitudes towards weight and dieting and use of drugs and alcohol.

Table 6: Richmond Young people's survey 2012: Emotional wellbeing & mental health

- 20% of pupils aged 10-12 years said that they had experienced bullying type behaviour often or every day. Among 12-15 year olds 21% said that they had experienced bullying type behaviour often or every day.
- Certain groups have lower levels of self esteem. 18% of year 6 girls and 25% of year 7 girls recorded medium-low self esteem.
- Girls in particular are concerned about their weight at an early age. 42% of girls aged 11-12 years said they would like to lose weight. 59% of girls aged 14-15 years said they would like to lose weight.
- 4% of pupils aged 9-10yrs said that they have had an alcoholic drink in the past 7 days. 20% of pupils aged 12-15yrs said that they have had an alcoholic drink in the last 7 days (14% of 15 year olds). This is slightly higher than the 18% reported in wider survey sample. 9% of pupils 12-15 years said they got drunk on at least one day in the last week. This is the same figure in the wider sample.
- 30% of pupils aged 12-15 years have been offered illegal drugs. 14% of pupils say they have ever taken some form of illegal drug (7% reported taking an illegal drug in the last month). Cannabis is the drug used most often.
- 45% of year 14-15 year olds have been offered drugs but on 23% report taking drugs. This compares to 15% of pupils who report taking drugs in the wider sample.

3.5. Employment in adult life

Work has an important role in promoting and protecting mental wellbeing. It is an important determinant of self-esteem and identity. It can provide a sense of fulfilment and opportunities for social interaction. For most people, work provides their main source of income (Black 2009, NICE 2010).

Work can also have negative effects on mental health, particularly in the form of stress. Prolonged stress is linked to psychological conditions such as anxiety and depression as well as physical conditions such as heart disease, back pain and headache. Working in environments that are insecure, low paid and stressful is associated with increased risks of poor physical and mental health (NICE 2010).

The costs of mental ill health to employers (including lost productivity, sickness absence and staff turnover and recruitment) are significant (McCrone 2008). The proportion of sickness absence attributable to mental ill health is between 37.5% and 44%. The annual cost of mental ill health to an organisation with 1,000 employees is estimated to be £835,355 (2009 pay levels) (NICE 2010). Improving the management of mental health in the workplace, including prevention and early identification of problems, could enable employers to save at least 30% of these costs - with increased productivity, reduced staff absenteeism and improved staff retention (Sainsbury Centre for Mental Health 2007).

Unemployment significantly increases risks of mental illness. Anxiety and depression are two to three times more common amongst unemployed people (Meltzer et al 2004).

Figure 3

Figure 3 above shows trends in unemployment rates 2005 -2012 for Richmond borough, compared to SW London, London and England. The impact of the economic recession from 2008 is clearly evident. Richmond has maintained lower unemployment rates. However there was a marked increase in unemployment rates during 2009, in line with increases in SW London, England and London.

Table 7: Levels of unemployment and JSA claimants : July 2011 to June 2012

	Unemployment		Claimant JSA	
	Total 16-64	Rate (%)	Total JSA 16-64	Proportion (%)
UK	2547386	8.1	1596758	4.0
London	381066	9.2	233620	4.3
Wandsworth	12000	6.5	6521	3.0
Kingston	5000	5.9	2009	1.7
Merton	8000	7.1	3984	2.7
Richmond	5000	4.3	2003	1.6
Sutton	7000	7	3537	2.8

Source: ONS Labour market statistics Local Area Data Oct 2012

Table 7 above gives the most recent figures on unemployment and job seeker allowance claimants. Around 5000 Richmond residents are unemployed. This 4.3% unemployment rate is lower than the rate for other SW London boroughs. There about 2,000 Richmond residents claiming job seekers allowance (JSA). These represent 1.6% of the resident working age population. This JSA rate is lower than that for London (4.3%) and other boroughs in SW London (ONS 2012).

For adults with mental health problems (including those with schizophrenia and psychosis), evidence shows employment leads to better health outcomes, recovery and rehabilitation, reduced risk of long term incapacity, reduced poverty and improved quality of life and well being. People are far more likely to recover from mental illness if they are in employment than if they are not (Waddell & Burton 2006).

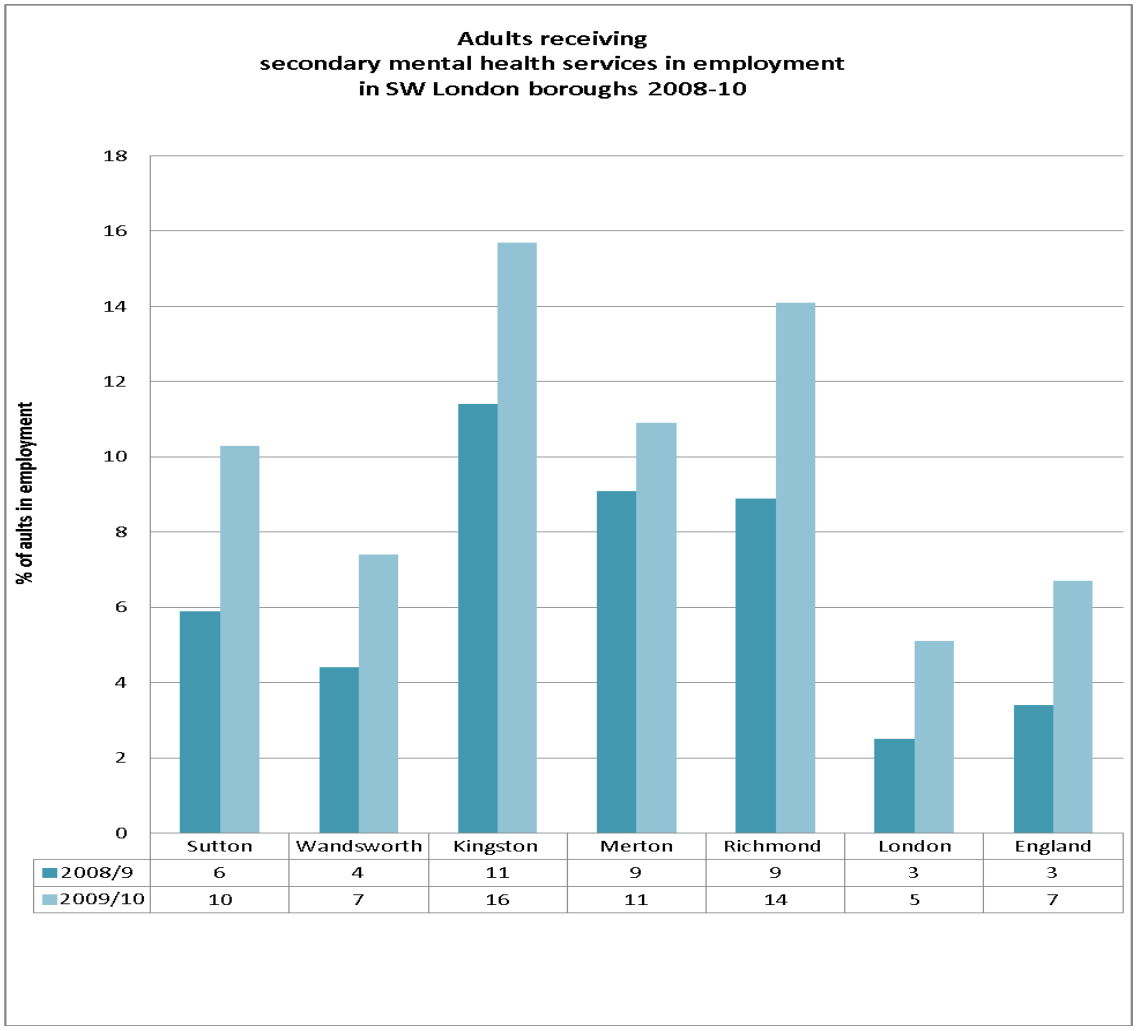


Figure 4

For those registered as disabled due to mental health conditions, there are particular barriers for gaining employment (Sainsbury Centre for Mental Health).Trends show that employment rates for disabled people with depression or anxiety and those with specific learning disabilities have been significantly lower than the employment rates for disabled people with most other types of impairment (Office for Disability 2012).

Figure 4 above shows levels of employment of adults who are receiving mental health services (as a proportion of all adults in contact with mental health services). It shows the proportion of users of mental services in employment has increased in all SW London boroughs over the two years 2008-10. Richmond has the second highest proportion of service users in employment (11%) in SW London. This compares to 5% for London as a whole and 7% for England.

3.6. Social isolation and social support in later life

Social relationships with family, friends and relatives, and social support are important determinants of both physical and mental health in later life. It can have a protective effect in preventing illness, as it can help older people cope with the stress of negative life events such as bereavement and the onset of a chronic illness (McMunn et al 2006). Social engagement (for example accessing local amenities) has been shown to have a direct effect in maintaining cognitive function in older age.

The most recent findings (table 8) of the English Longitudinal Study of Aging demonstrate the strong link between social engagement and mental health and wellbeing, as well as other factors (Banks et al 2010).

Table 8: Social engagement and mental health : Findings of English Longitudinal Study of Aging 2010

- Depressive symptoms and loneliness rise with age, particularly among women, while quality of life decreases. Women aged 75 and older have particularly poor wellbeing, with high rates of depressive symptom, low life satisfaction, poor quality of life and high levels of loneliness.
- Wealth was associated with all aspects of wellbeing. More affluent individuals have few depressive symptoms, greater life satisfaction, better quality of life and lower levels of loneliness.
- The proportion of people with depressive symptoms decreased, while mean life satisfaction and quality of life increased with an increasing number of close relationships. The likelihood of having persistent depressive symptoms decreased with the number of close personal relationships.
- On average older people with two or more cardiovascular diseases reported almost double the rate of increased depressive symptoms of older people who were free of cardiovascular disease.

Figure 5 shows that in the borough of Richmond the number of older people (65-74yrs and 75+ yrs) living alone, and those older people living alone with limiting long standing illness.

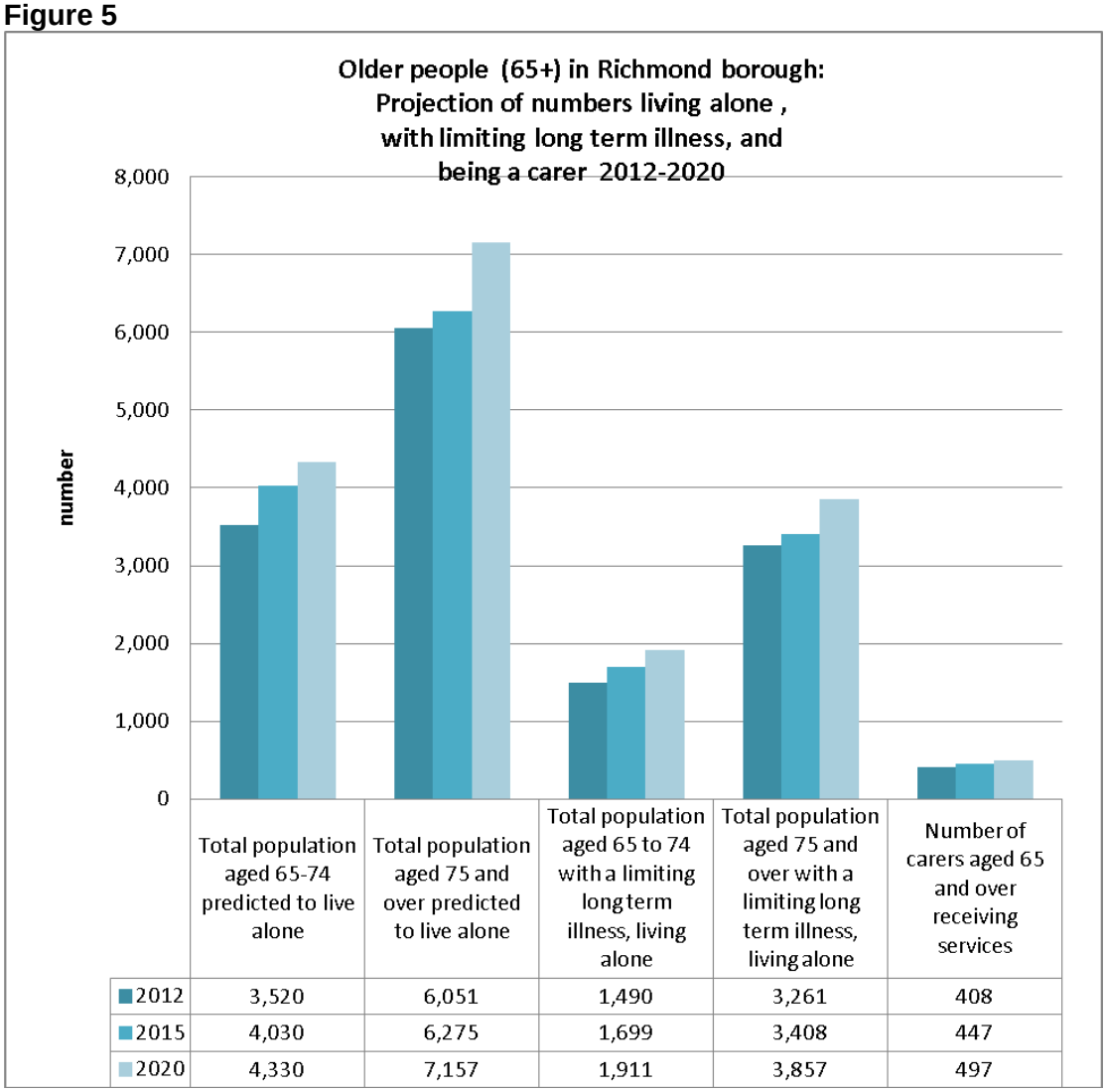
The number of 65-74 year olds living alone is estimated to increase from 3,500 in 2012 to 4,300 in 2020 (an increase of 23%). The number of those 75 years and over living alone is projected to increase from 6,000 in 2012 to 7,100 in 2020 (an 18% increase). These growing numbers of older people will be at increased risk of depression and dementia. Those with limiting long term illness will be particularly vulnerable.

Many people assume caring roles in midlife and older age. Stress associated with providing care, particularly for someone with dementia, can result in high levels of psychological distress (McMunn et al 2006). Being a carer has a strong influence on

ability to participate in social activities (as well as paid employment) with consequences for physical and mental health.

The number of carers aged 65 years and over in Richmond and receiving services is estimated to increase from 400 to around 500, an increase of 25%. This group are particularly vulnerable to mental health problems.

Figure 5



	Total population aged 65-74 predicted to live alone	Total population aged 75 and over predicted to live alone	Total population aged 65 to 74 with a limiting long term illness, living alone	Total population aged 75 and over with a limiting long term illness, living alone	Number of carers aged 65 and over receiving services
2012	3,520	6,051	1,490	3,261	408
2015	4,030	6,275	1,699	3,408	447
2020	4,330	7,157	1,911	3,857	497

Source: POPPI (Projecting older people population information)

4. Mental health disorders

4.1. Prevalence estimates: Richmond and SW London

The ONS Adult Psychiatric Morbidity Survey (2007) provides data on the prevalence of both treated and untreated psychiatric disorders in the English adult population (aged 16 and over) (McManus et al 2009).

The survey showed that in 2007 nearly one person in four (23.0 per cent) in England had at least one psychiatric disorder and 7.2 per cent had two or more disorders.

There are about 35 people with a common mental disorder for each person with psychosis.

The ONS report (McManus et al 2009) makes the point that although common mental health disorders are usually less disabling than major psychiatric disorders such as psychosis, their greater prevalence means that the cumulative cost to society is vast.

4.2. Levels of mental health conditions among the adult population

Figure 6 below sets out estimates of the number of people with mental health conditions in each of the boroughs in SW London. Common mental disorders are the most prevalent mental health conditions. Differences in numbers of cases across the boroughs reflect in the main the differences in absolute size of the populations.

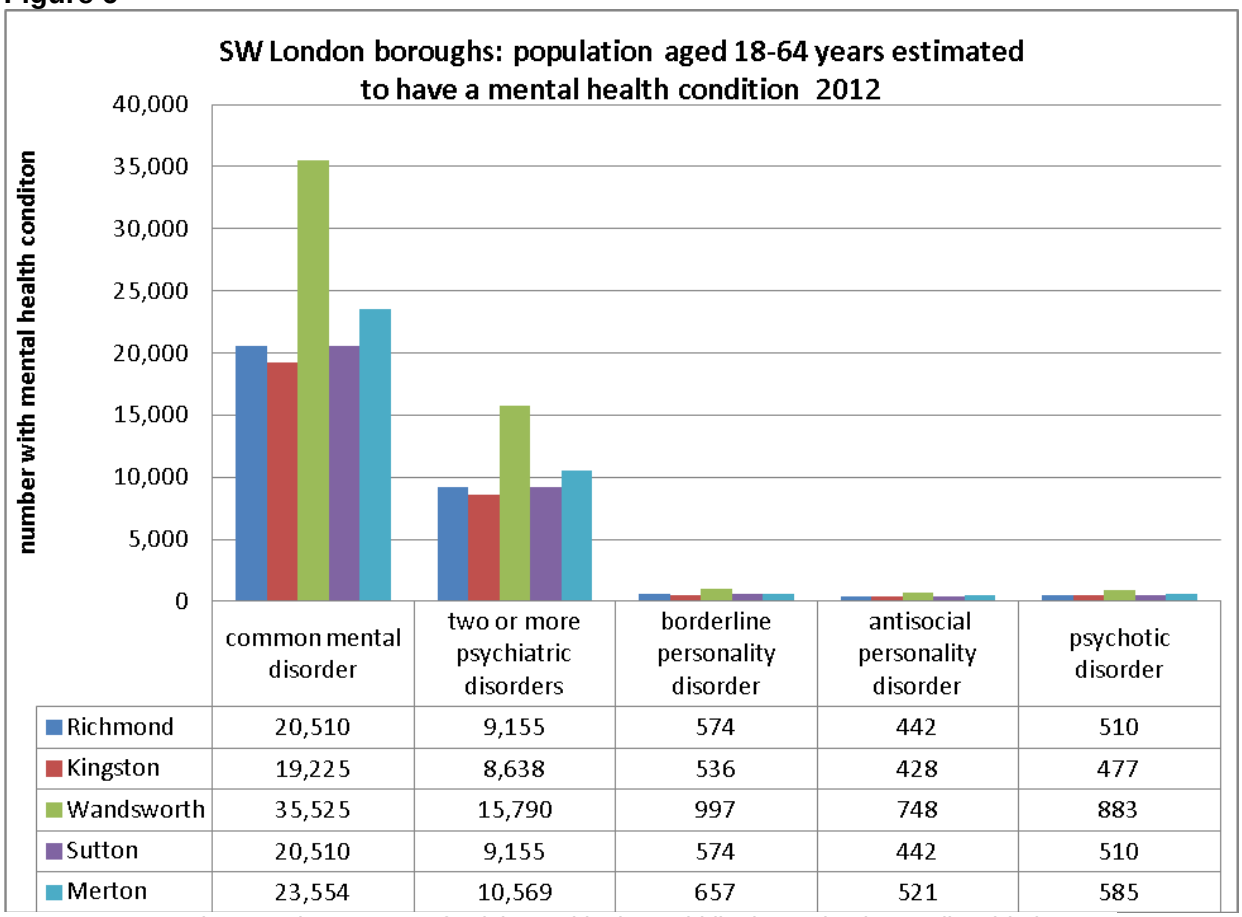
Estimated numbers of people with serious mental illness in Richmond borough are: 574 borderline personality disorder, 442 anti-social personality disorder, 510 psychotic disorder.

People with severe mental health problems tend to experience their first episodes in late adolescence to early adulthood. Evidence indicates that intervention in the early stages of psychosis can change the pathway of the illness and improve long term outcomes. The first 3-5 years are a critical period (NICE 2008).

Figure 6 also indicates high levels of co-morbidity of psychiatric conditions. There are many combinations of conditions. Depressive episodes tend to be associated with other common mental disorders but also less common conditions including anti social personality disorder. Dual diagnosis of substance misuse and psychiatric illness is frequent.

Evidence also shows that people with schizophrenia and bipolar disorder die between 10-25 yrs earlier than their counterparts without mental illness. Cardiovascular disease and associated behavioural risk factors are the main cause of this.

Figure 6



	common mental disorder	two or more psychiatric disorders	borderline personality disorder	antisocial personality disorder	psychotic disorder
Richmond	20,510	9,155	574	442	510
Kingston	19,225	8,638	536	428	477
Wandsworth	35,525	15,790	997	748	883
Sutton	20,510	9,155	574	442	510
Merton	23,554	10,569	657	521	585

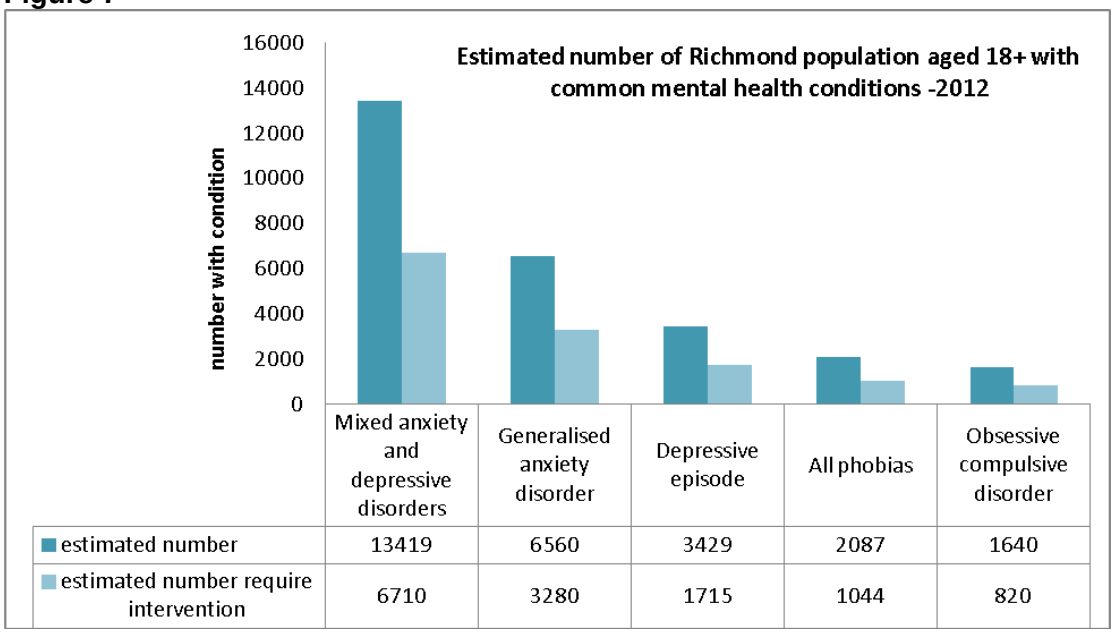
Source: PANSI. The prevalence rates of Adult psychiatric morbidity in England 2007 listed below are applied to ONS 18-64 population projections.

	% males	% females
Common mental disorder	12.5	19.7
Borderline personality disorder	0.3	0.6
Antisocial personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5
Two or more psychiatric disorders	6.9	7.5

Figure 7 below sets out the estimated number of Richmond residents with different categories of common mental health disorders. About 50% of those with common mental health problems may require some form of treatment (Meltzer et al 2000). For example around 6,700 adults with mixed anxiety and depressive disorders are estimated to require treatment. However it is likely that not all of these individuals will be detected or will present to primary care (discussed below).

The national programme of IAPT is designed to provide a cost effective response to high prevalence of common mental health problems (based on NICE guidelines). A range of population groups have been identified as having particular needs and barriers to access (including black and minority ethnic communities, older people, lesbian, gay, bisexual and transgender community, new mothers, offenders and people with learning disabilities (DH 2008)).

Figure 7



Source: Prevalence rates of Adult psychiatric morbidity in England 2007 applied to ONS Mid 2010 population estimates 18 years and over.

4.3. Mental health indices and local need

The above estimates of numbers of Richmond residents with mental health conditions are based on application of psychiatric prevalence rates for England. However it is important to take account of the particular character of Richmond (lower levels of deprivation) that influence levels of mental illness.

A number of indices have been developed to describe the level of mental health need among the adult population within a given area that takes account of certain factors relating to deprivation (Mental Health Observatory) [1].

The scores for indices for the five SW London boroughs are shown below.

Table 9: Mental health indices: Scores for SW London boroughs

Borough	Richmond	Kingston	Wandsworth	Sutton	Merton
common mental health (NPMSCIR12)	**1.115**	1.112	1.329	1.090	1.155
Severe mental health (MINI2K)	**0.628**	0.629	1.451	0.818	0.697

Source: Mental health observatory

[1] These indices use the proportion of people rated as having a mental health disorder in general population surveys and hospital admissions rates as their basis. These are then correlated with a range of population characteristics associated with mental health problems eg deprivation, unemployment and social isolation.
The National Psychiatric Morbidity Survey Index relates to common mental disorders that do not normally referred to specialist services (NPMSCIR12).
The Mental Illness Needs Index 2000 (MINI2K) relates specifically to the more severe mental disorders that require secondary mental health services.
The indices give a score for each local authority area, which shows how the area relates to the standard score of 100 for England. A score of less than 100 indicates mental health needs are likely to be lower than expected for England as a whole and greater than 100 indicates a higher need.

The Richmond common mental health score (1.115) suggests a slightly higher level of need in Richmond than would be predicted if national prevalence rates apply.

The Richmond score for severe mental health (0.6) suggests that the borough has a lower (40% less) mental health need with respect to severe mental health disorders than England as a whole.

The mental health indices were originally developed using now rather dated information. The prevalence estimates for Richmond therefore **have not been adjusted using these scores.**

Nevertheless the Richmond scores show that national prevalence rates can only provide broad estimates.

4.4. Levels of mental health conditions among the older population (aged 65 years and over).

The main mental health conditions affecting older people include:

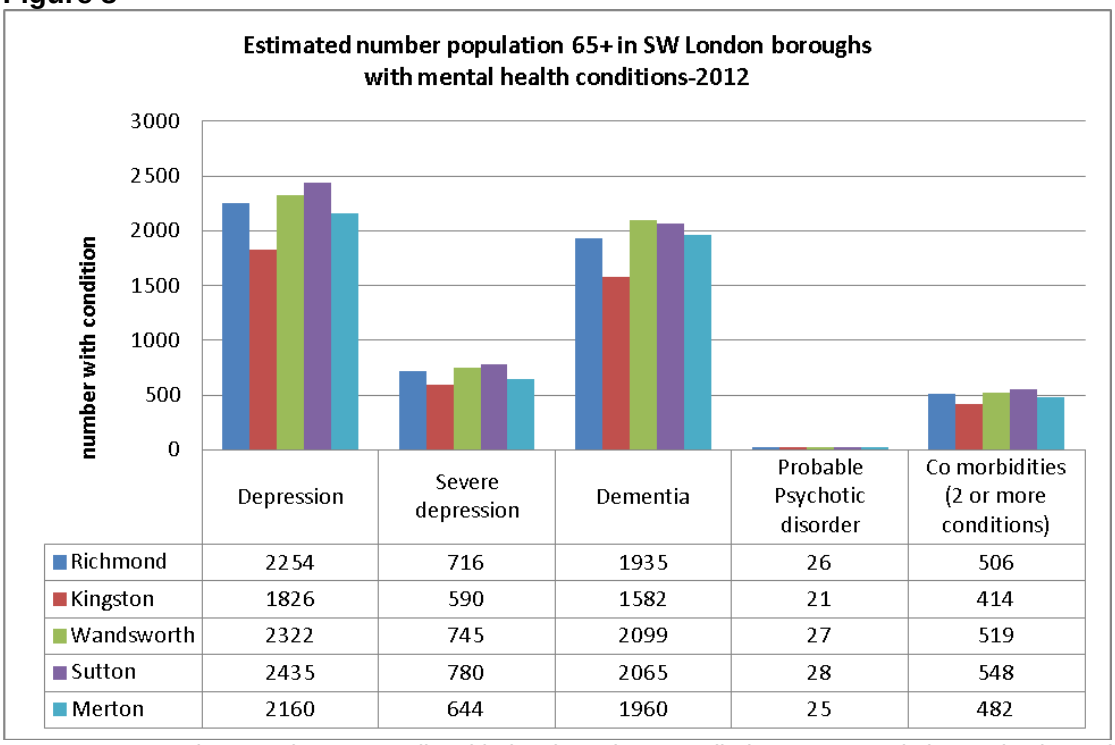
- Depression
- Dementia
- Psychotic disorders

The estimates of local prevalence of these main categories of conditions for each SW London borough are shown in figure below. These estimates are based on using national survey data and or prevalence data from specific research studies applied to local population figures for 2010 (Projecting Older People Population Information-POPPI). Overall the patterns in level of mental health conditions among older people across the boroughs reflect the differences in the absolute size of older people in each borough.

Depression is the most common mental health problem in older people.

Estimates show Richmond has high absolute levels of depression (around 2,300 older people) and severe depression (around 700 older people); with Sutton and Wandsworth experiencing slightly higher levels.

Figure 8



	Depression	Severe depression	Dementia	Probable Psychotic disorder	Co morbidities (2 or more conditions)
Richmond	2254	716	1935	26	506
Kingston	1826	590	1582	21	414
Wandsworth	2322	745	2099	27	519
Sutton	2435	780	2065	28	548
Merton	2160	644	1960	25	482

Source: POPPI. The prevalence rates listed below have been applied to ONS population projections of the 65 and over population to predict numbers with depression and severe depression to 2020. [2]

	Depression		Severe depression
Age range	% males	% females	% people
65-69	5.8	10.9	2.5
70-74	6.9	9.5	1.6
75-79	5.9	10.7	3.5
80-84	9.7	9.2	3.0
85+	5.1	11.1	3.9

The most recent relevant source of UK data is Dementia UK[3] . The prevalence rates have been applied to ONS population projections of the 65 and over population predicted 2020: Source POPPI.

Rates for men and women with dementia are as follows:

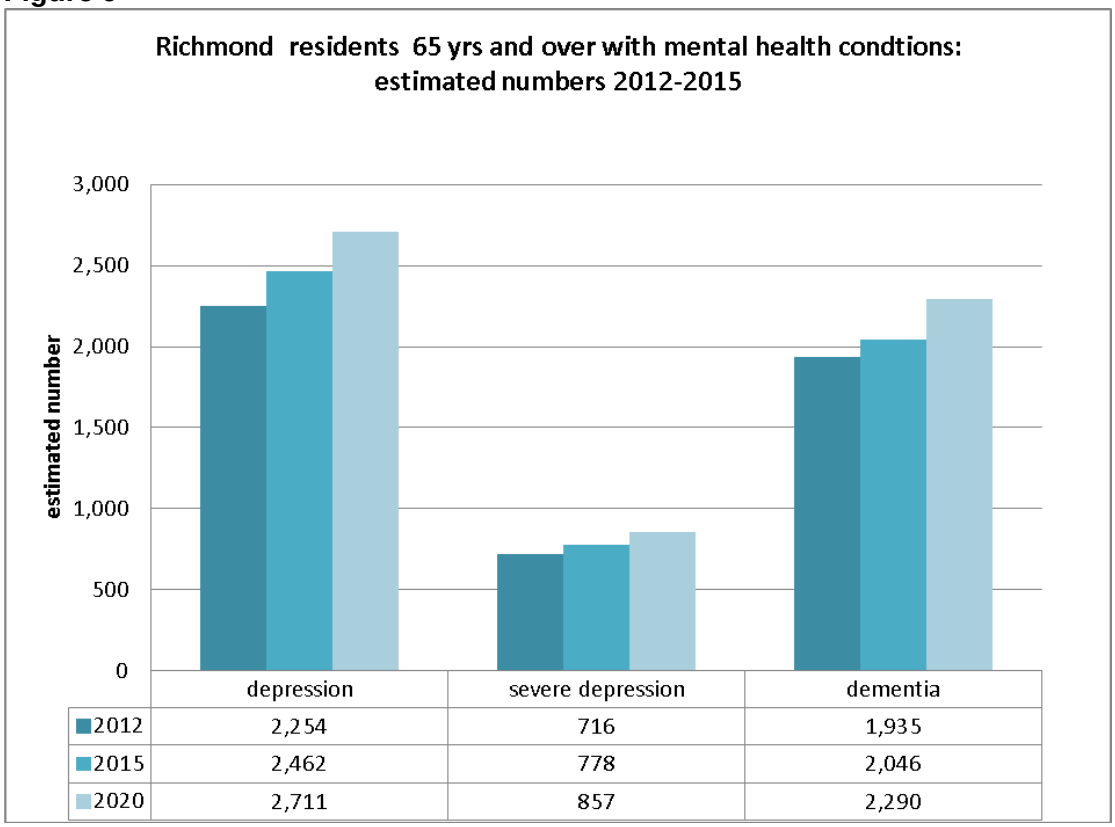
Age range	% males	% females
65-69	1.5	1.0
70-74	3.1	2.4
75-79	5.1	6.5
80-85	10.2	13.3
85-89	16.7	22.2
90+	27.9	30.7

[2] Prevalence rates based on Figures are taken from McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787–1795.

[3] A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.

Estimates future levels of mental health conditions among Richmond older residents

Figure 9



	depression	severe depression	dementia
2012	2,254	716	1,935
2015	2,462	778	2,046
2020	2,711	857	2,290

The number of older people living in Richmond with depression and severe depression is projected to increase by 20% and 19% respectively from 2012 to 2020.

The number of older people with dementia in Richmond is projected to increase from around 2,000 in 2012 to 2,300 in 2020 –an increase of 18%.

Social isolation and lack of social support networks, together with poor physical health, are important risk factors for depression among older people. The increasing numbers of older people in Richmond living alone, and with long term physical conditions contribute to the projected increase in mental illness among older people.

There are different types of dementia

- Alzheimer's disease (accounting for 60% of all cases in people aged over 65)
- Vascular dementia (15-20% of all cases of cases aged over 65)
- Dementia with Lewy bodies (15-20% of call cases of people over 65)
- Frontotemporal dementia (more common among younger people).

People with learning disabilities are at higher risk of dementia. People with Down's syndrome have an increased genetic risk. (SCIE 2008).

Two thirds of the estimated numbers of people with dementia are likely to live in the community-cared for family, neighbours and mainstream primary and social services The remaining third are likely to be living in care homes (probably with more advanced illness) (Knapp & Prince 2007).

4.5. General practice based prevalence estimates of mental health conditions in Richmond

Evidence indicates that a high proportion of people with common mental health problems do not present to services. The ONS national survey reported that a total of 38% of people with a common mental health disorder said they had contacted their GP (McManus et al 2009).

Patients have reported that the most common reasons for reluctance to contact the GP include: did not think anyone could help (28%); a problem one should be able to cope with (28%); did not think it was necessary to contact a doctor (17%); thought problem would get better by itself (15%); too embarrassed to discuss it with anyone (13%); and afraid of the consequences (for example treatment, tests, hospitalisation or being sectioned under the Mental Health Act; 10%) (Meltzer et al 2000).

Poorer access to care has been found to be associated with lower socio-economic group, geographical location, ethnic minority groups, age and gender (older people or younger men) the presence of other impairments, and learning difficulties.

There is a similar significant diagnosis gap with respect to dementia. Only between a third and a half of people with dementia ever receive a formal diagnosis, although early diagnosis and intervention in dementia is cost-effective (NICE 2010, NAO 2007).

Table 10 below shows the prevalence in Richmond of depression, dementia and serious mental illness as measured by the number of people diagnosed in general practice i.e. on disease specific registers (QOF indicators 2011/12).

General practice based prevalence levels of mental health conditions in Richmond are compared to levels for London and England. 5.9% of patients were diagnosed with depression in Richmond, compared to 7.8% for London and 11.2% in England. This lower figure may reflect lower levels of depression in Richmond, but also other factors such as individuals willingness to present as highlighted above, particularly those who are most vulnerable groups (including older people, and black and minority ethnic groups).

Table 10: General Practice : Prevalence of mental health disorders: QOF 2011/12

	Richmond		London	England
	number of patients diagnosed with condition	% diagnosed with condition	% diagnosed with condition	% diagnosed with condition
Depression (ages 18+)	**10497**	**6.7**	**8.1**	**11.7**
Dementia	**870**	**0.4**	**0.4**	**0.5**
Serious mental illness	**1646**	**0.8**	**1.0**	**0.8**

Source: NHS The Information Centre Quality & Outcomes Framework 2011/12

5. Co-morbidity of mental and physical health conditions

Many people have both long term physical health conditions and mental health problems (co-morbidity). This can lead to significantly reduced quality of life and much poorer health outcomes. An estimated 30% of all people with a long term condition also have a mental health problem (Naylor et al 2012).

Having a mental health problem increases the risk of physical ill health and vice versa (see table 11 below).

Table 11: Co-morbidity: Physical illness and mental illness

- Depression is two to three times more common in people with a chronic physical health problem (such as heart disease, diabetes, respiratory or neurological disorder), occurring in about 20% of this population (Hemington & Marmot).
- Those with depression and diabetes are particularly disabled as measured by self reported quality of life scales(Naylor et al 2012)
- Individuals with known serious and complex mental health problems have a higher rate of physical health problems than the general population and are more likely to die prematurely (Osborn 2012). People with schizophrenia or bipolar disorder die on average between 10-25 years earlier than their counterparts without mental health problems.
- The main cause of the gap in mortality is cardiovascular disease and modifiable risk factors (smoking, diabetes, hypertension and high cholesterol) (Osborn 2012).

It is estimated that at least £1 in every £8 spent on long term conditions is linked to mental health (Naylor et al 2012).

Co-morbidity of mental health and physical conditions in general practice- Richmond

Table 11 presents an initial analysis of level of co morbidity of mental health and physical health conditions based on six Richmond GP practices (covering an adult population of around 30,400 patients). This dataset is part of the Richmond Risk Stratification Project that is supporting identification and management of long term conditions. The analysis is conducted by the Public health intelligence service.

Table 12 shows those patients who are diagnosed with depression only and those with comorbid physical conditions.

The analysis shows a high level of co-morbidity. For example 7.9% of men and 9.6 of women aged 18-64yrs who have depression also have three or more physical conditions. Co-morbidity increases significantly with age. 35.7% of men and 49.7 % of women aged 65+years who have depression also have three or more physical conditions. These 231 patients (in total) have significant needs with associated

costs, some of which may be avoided by effective integrated management of the different conditions.

Table 12 includes prescribing data on use of anti depression medication in the analysis. This allows additional patients with depression to be identified. These results again demonstrate the high level of co-morbid depression and physical conditions.

Table 11 Depression

Number of patients diagnosed with depression	Males				Females				Total	
	18-64	65+	18-64	65+	18-64	65+	18-64	65+	18-64	65+
Only depression	55.7%	17.9%	267	10	54.8%	10.7%	512	20	779	30
Depression and one other physical condition[1]	23.2%	26.8%	111	15	23.9%	19.8%	223	37	334	52
Depression and two other physical conditions	13.2%	19.6%	63	11	11.8%	19.8%	110	37	173	48
Depression and three or more physical conditions	**7.9%**	**35.7%**	38	20	**9.6%**	**49.7%**	90	93	**128**	**113**
All patients with depression only or co morbid physical conditions	100%	100%	479	56	100%	100%	935	187	1414	243

Source: General practice data extract May 2012 and SUS APC data 1/3/2011-29/2/12

[1]Physical /neurological conditionals :heart disease (heart failure, ischemic heart disease (excl AMI), hypertension, atrial fibrillation, stroke), cancers, endocrine conditions (diabetes, osteoporosis, thyroid), respiratory disease (COPD, asthma), Joint pain ,skin disease neurological conditions (Parkinson's, multiple sclerosis, epilepsy, dementia), obesity and chronic kidney failure

Table 12: Depression & anti depression medication

Number of patients diagnosed with depression + anti depression medication	Males				Females				Total	
	18-64	65+	18-64	65+	18-64	65+	18-64	65+	18-64	65+
depression only	51.4%	14.9%	489	37	49.3%	10.0%	892	67	1381	104
depression and one other physical condition	24.9%	23.8%	237	59	25.5%	20.5%	461	138	698	197
depression + two other physical condition	15.3%	22.2%	146	55	14.0%	23.3%	254	157	400	212
depression + three other physical conditions	**8.4%**	**39.1%**	80	97	**11.2%**	**46.2%**	202	311	**282**	**408**
All patients with depression only or co morbid physical conditions	100%	100%	952	248	100%	100%	1,809	673	2761	921

Source: General practice data extract May 2012 and SUS APC data 1/3/2011-29/2/12

Table 13 shows the level of co-morbid dementia and physical conditions. The analysis shows that all patients with dementia have at least one other physical conditions. 73.4% of men aged 65+years and 60% of women aged 65+ with dementia also have three or more physical conditions (a total of 253 patients).

Table 13: Dementia

Number of patients with dementia	Males				Females				All	
	18-64	65+	18-64	65+	18-64	65+	18-64	65+	18-64	65+
Dementia only	0.0%	0.0%	0	0	0.0%	0.0%	0	0	0	0
Dementia +1 other	20.0%	8.9%	1	7	20.0%	11.6%	1	19	2	26
Dementia +2 other	20.0%	17.7%	1	14	20.0%	22.6%	1	37	2	51
Dementia + 3 or more	60.0%	73.4%	3	58	60.0%	65.9%	3	108	6	166
All patients with dementia only or comorbid physical conditions	100%	100%	5	9	100	100	5	164	10	243

Evidence shows that levels of co-morbidity are particularly high among older people in acute general hospitals, accounting for about two-thirds of occupied beds (NAO 2007).

For example in 2009/10, 1,308 Richmond PCT residents were admitted to hospital with dementia (as any diagnosis). 96% of these patients were acute trust admissions (NHS London 2011). For the 137 patients with a primary diagnosis of dementia, 71% were admitted to an acute trust (as opposed to the mental health trust).

Evidence also indicates that in care homes, around 40% of residents have depression, 50-80% some level of dementia, and 30% anxiety (Knapp et al 2008). The table below shows the number of people in care homes is expected to rise.

Table 14: Richmond borough : projection of number of older people in care homes

	2012	2015	2020
number of people 65+	747	791	890

Source: Projecting older people population information- POPPI accessed 5th November 2012)

Suicide and self harm

Self harm and suicide are important concerns, and are potentially preventable.

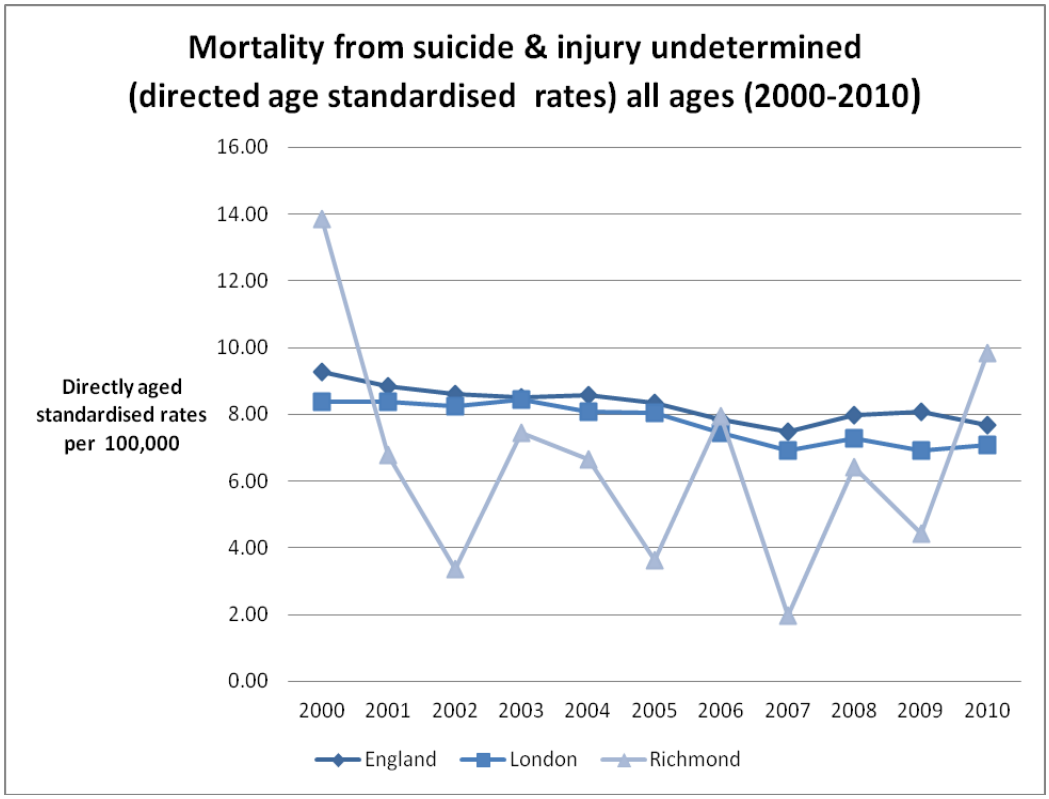
Mortality rates for suicide and injury of undetermined intent (using three-year pooled rates) are shown in the table below. For Richmond, the mortality rate for suicide and undetermined injury was 7 per 100,000 population under 75 years, compared with 7.09 for London as a whole and 7.91 for England. (The wide confidence limits for Richmond rates reflect the smaller numbers).

Richmond: Mortality from suicide and injury undetermined

Directly age-standardised rates (DSR) per 100000 under 75 yrs 2008-10 (Pooled)

	Directly standardised rates per 100,000	95% CONFIDENCE LIMITS	
		LOWER	UPPER
England	7.91	7.77	8.06
London	7.09	6.74	7.44
Richmond	7.00	4.73	9.27

Figure below shows the trends in mortality rates from suicide and injury undetermined. Mortality rates show a gradual fall over the last ten years. Richmond mortality rates are lower than the rates for London and England with exceptions for certain years. The high degree of variation for Richmond rates reflect the small number of deaths involved annually.



Suicide risk is complex and a combination of factors determine in most cases risk.

Groups at risk include:

- people with depression, particularly those undiagnosed or untreated depression
- people with a history of self harm
- people who misuse drugs or alcohol. Dual diagnosis (co-morbidity of drug and alcohol misuse and mental ill health) is associated with increased risk of suicide and suicide attempts
- people living with long-term physical health conditions;
- looked after children, care leavers and children and young people in the youth justice system
- people who are vulnerable due to social and economic circumstances including unemployment, social isolation and experienced abuse and violence
- lesbian, gay, bisexual and transgender
- Black, Asian and minority ethnic groups and asylum seekers
- Veterans.

The new national suicide prevention strategy sets out priority areas to be addressed locally.

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