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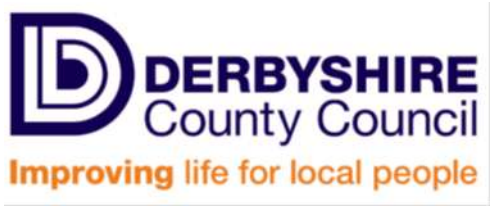

The State of Mental Health in Derbyshire

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1.0	23/09/15	Report finalised	Iain Little
1.1	02/10/15	Addition of Executive Summary and Data tables Expansion of glossary Correction to prevalence of opiate and/or crack cocaine use in section 2.2.7.4 Minor amendments made to report	Iain Little

CONTENTS

The State of Mental Health in Derbyshire

Executive Summary

This report summarises information on the current state of mental health and wellbeing in Derbyshire. Data has been collated from a range of routinely available sources, supplemented by data from local providers. It is presented as a profile report, covering children and young people and adults, and can be used to inform priority setting and the planning of mental health services.

The data included in the report explores the following aspects of mental health and wellbeing in Derbyshire:

- populations at higher risk of mental illness,
- the prevalence of the wider determinants of good and poor mental health,
- the prevalence of mental illness,
- the use of mental health services,
- service quality and outcome indicators, and
- spend on mental health services

For a number of indicators, Derbyshire appears statistically significantly different from England. The report has not attempted to conclude whether this variation is appropriate or not, rather we would encourage stakeholders to review the data and determine whether the reasons for the variation are known, or if further investigation is required to understand them.

The following is a summary of findings, which are provided in more detail in the report. Variation between Derbyshire and England, and within Derbyshire, is highlighted in the data tables in Appendix 1.

Wider determinants of mental health

The wide range of factors that can influence an individual's mental health are not distributed evenly throughout the population. There are certain population groups that are at increased risk of poor mental health.

- Derbyshire has an older population compared to England, with a higher proportion of the population with a disability or long-term health condition.
- There is variation across Derbyshire in both the proportion of the population living in areas with the highest rates of deprivation, and in the proportion of children living in poverty. For both indicators, rates are highest in Bolsover and Chesterfield, and lowest in Derbyshire Dales.
- A higher proportion of children in Derbyshire have a good level of development at the end of Reception compared to England, but GCSE achievement rates are lower in Derbyshire. Derbyshire Dales is the only district in Derbyshire where achievement is higher than England.
- Derbyshire has a lower long-term unemployment rate compared to England, but there are higher rates of unemployment in Bolsover and Chesterfield.
- There is a higher proportion of households occupied by a single person aged 65 years and over in Derbyshire compared to England.

- The rate of smoking in Derbyshire is similar to England, but a higher proportion of mothers smoke at the time of delivery in Derbyshire.
- There is variation in the rate of admissions for alcohol-specific conditions, with admissions higher in men than women, and higher in Amber Valley and Chesterfield.
- Health-related quality of life among older people is lower in Bolsover, Chesterfield and Erewash compared to England, but higher in Derbyshire Dales.

Prevalence of mental illness

- Self-reported wellbeing in Derbyshire is similar to England, but potentially 128,000 adults in Derbyshire report feeling very anxious.
- One in ten young people have a diagnosable mental health condition, equating to 10,100 young people in Derbyshire.
- Estimates suggest that the prevalence of common mental health problems is lower in Derbyshire compared to England, with the highest rates in Chesterfield. Self-reported rates of anxiety or depression are higher in Hardwick and Southern Derbyshire CCGs compared to England.
- Estimates suggest there are approximately 3,400 individuals with psychosis in Derbyshire.
- There is wide variation in the recording of depression and serious mental illness within GP practices, reflecting varying levels of need, but also differences in ascertainment and recording rates.
- Based on national estimates, there are approximately 15,700 to 19,600 young people aged 10 to 24 years in Derbyshire who self-harm, with a higher admission rate for self-harm amongst young people in Derbyshire compared to England.
- In 2013 there were 48 suicides in Derbyshire, a rate lower than the national rate. Provisional data for 2014 suggests there has been a recent increase in the number of suicides.
- The under-75 mortality rate amongst people with a serious mental illness is three times higher than in people without a serious mental illness.

Use of mental health services

- There is little comparable data on access to, and outcomes from CAMHS services, a fact recognised nationally.
- Access to IAPT services in Derbyshire is higher across Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs compared to England, although a recent Health Equity Audit highlighted a number of population groups with lower than expected access to services. The recovery rate of individuals from local IAPT services is significantly higher in Southern Derbyshire CCG compared to England, and similar in Erewash, Hardwick and North Derbyshire CCGs.
- In general, the waiting times to access IAPT treatment are good in Erewash, Hardwick and North Derbyshire CCGs with the vast majority of individuals waiting less than 28 days for treatment, but worse in Southern Derbyshire CCG.
- There is a lower rate of new social care assessments for individuals with a mental illness in Derbyshire compared to England, and also in the rate of individuals receiving social care services.

- Hardwick CCG have a significantly higher rate of A&E attendances for a psychiatric condition compared to England, with Erewash, North Derbyshire and Southern Derbyshire CCGs having a significantly lower rate.
- There is a higher use of specialist mental health services in Hardwick and North Derbyshire CCGs compared to England, despite the prevalence of mental illness being similar.
- The rate of detentions under the Mental Health Act is significantly higher in Hardwick and Southern Derbyshire CCGs, but lower in North Derbyshire compared to England. There has recently been an increased use of Section 136 suites to assess individuals compared to police stations. Over 40% of individuals detained under Section 136 for an assessment in Derbyshire are discharged with no follow-up.
- There is variation between GP practices in the achievement of the quality indicators that accompany the depression and serious mental illness Quality and Outcomes Framework registers.

Spend

- Approximately 6% of NHS spend on mental health services in Derbyshire is allocated to children's services.
- For Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs, mental health is the disease category with the highest level of spend. North Derbyshire has a higher proportion of its overall spend on mental health compared to the other CCGs.

The wide range of indicators included in the report highlights the need to take a whole-systems approach to improve the mental health of the population of Derbyshire. This includes provision of NHS and social care services for individuals with a diagnosed mental illness, but also includes promotion of positive mental health, prevention of mental illness and early identification of individuals in need of support and treatment. This report should be considered alongside, and inform the actions identified within the *Derbyshire County Joint Vision and Strategic Direction of Travel for Adult Mental Health 2014-19*.

It is recommended that the report is used by stakeholders for three main purposes:

- to inform discussions about the planning of mental health services
- to identify population groups or conditions where a more detailed assessment of current service provision, including obtaining the views of key stakeholders, would be beneficial to inform commissioning and delivery of services
- to identify key indicators that can be monitored over time to know whether the mental health of the population of Derbyshire is improving

The State of Mental Health in Derbyshire

1 Introduction

Mental illness is the single largest cause of disability and morbidity in England, contributing almost a quarter of the overall burden of disease. But being mentally healthy isn't just the absence of a mental illness. Having good mental health leads to numerous positive health outcomes, such as lower levels of mental and physical illness, reduced mortality and reduced health risk behaviours. It also allows us to have healthy relationships, to cope with life's ups and downs and to fulfil our potential.

The aim of this report is to summarise information on the current state of mental health and wellbeing in Derbyshire. It is presented as a profile report that can be used to inform priority setting and the planning of mental health services.

The data included in the report explores the wider determinants of good and poor mental health, the prevalence of mental illness, access and outcomes from services, and spend. Data has been collated from a range of routinely available sources, supplemented by some data from local providers. Throughout the report, the commentary highlights where there is variation between Derbyshire and national data, and also where there is variation by CCG or district within Derbyshire.

The report includes information relating to the mental health and wellbeing of children and adults, but does not include information on dementia, learning disabilities or autism.

2 Populations at higher risk, and risk and protective factors for mental ill health

There are a wide range of personal, social, economic and environmental conditions that can influence an individual's mental health. These factors are not distributed evenly throughout the population, and therefore there are certain population groups at increased risk of poor mental health. This section highlights some of the groups, and quantifies the size of the potential population at risk within Derbyshire.

2.1 Populations at higher risk

2.1.1 Age and gender

Rates of mental ill health vary by age and gender. Women experience significantly higher rates of common mental health problems and eating disorders than men. Rates of anti-social personality disorder appear to be more common in men, but the latest Adult Psychiatric Morbidity Survey reported that there was no significant difference in prevalence between men and women, although this may be due to the small numbers identified within the national survey.

Table 1: Prevalence of mental health conditions by gender, aged 16+

	Prevalence of condition (%)		
	Male	**Female**	**Persons**
Common mental disorders	12.5	19.7	16.2
Post-traumatic stress disorder	2.6	3.3	3.0
Psychosis	0.3	0.5	0.4
Anti-social personality disorder	0.6	0.1	0.3
Borderline personality disorder	0.3	0.6	0.4
Eating disorders	3.5	9.2	6.4
Psychiatric comorbidity	6.9	7.5	7.2

Source: National Psychiatric Morbidity Survey, 2007

In general, prevalence of mental illness peaks among either younger adults (for personality disorders and eating disorders) or those aged 35-54 years (for common mental health problems and psychosis). For all conditions, older adults have lower prevalence.

Table 2: Prevalence of mental health conditions by age

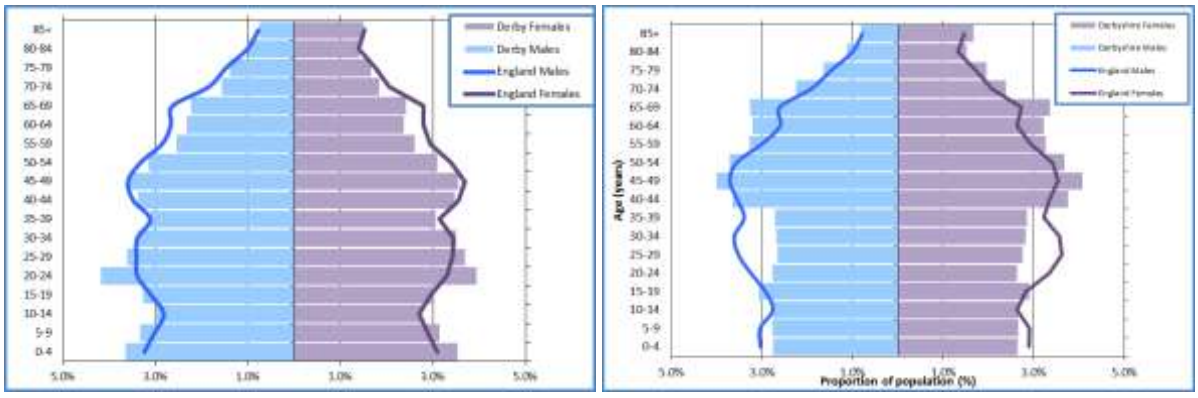
	Prevalence by age group (%)						
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**
Common mental disorders							
Male	13.0	14.6	15.0	14.5	10.6	7.5	6.3
Female	22.2	23.0	19.5	25.2	17.6	13.4	12.2
Post-traumatic stress disorder							
Male	5.1	3.6	3.0	1.9	1.9	0.7	0.2
Female	4.2	3.7	3.5	5.8	1.9	1.5	0.8
Psychosis							
Male	-	0.6	0.7	0.1	-	-	-
Female	0.4	0.2	1.1	0.8	0.6	-	-
Eating disorder							
Male	6.1	5.1	3.3	3.7	2.0	1.5	0.5
Female	20.3	12.6	10.0	9.9	3.9	2.4	0.9
Psychiatric comorbidity							
Male	12.2	11.0	7.9	5.5	3.6	1.9	1.0
Female	12.6	9.1	8.4	10.1	4.6	2.7	1.7

	16-34	**35-54**	**55-74**	**75+**
Antisocial personality disorder				
Male	1.7	0.2	-	-
Female	0.4	-	-	-
Borderline personality disorder				
Male	0.3	0.2	0.4	-
Female	1.4	0.5	-	-

Source: National Psychiatric Morbidity Survey, 2007

Derby City has a higher proportion of children and young adults in its population than England. Derbyshire County has a higher proportion of adults aged 45 years and older, with fewer younger adults. Estimates of the prevalence of conditions in Derbyshire are provided in section 3.3.

Figure 1: Population structure of Derby City and Derbyshire County, 2013



Source: ONS mid-year population estimates

2.1.2 Ethnicity

There are differences in the prevalence of mental illness between different ethnic groups.

Rates of common mental health problems are significantly higher amongst South Asian women (34.3%) than amongst other ethnic groups (White 19.3%, Black 21.0% and Mixed ethnic/Chinese 20.6%). There is little variation in the rates of common mental health problems between men from different ethnic groups.

Rates of psychosis are significantly higher among Black men (3.0%) compared to White men (0.2%). There were no reported differences in rates between women from ethnic groups. Rates of post-traumatic stress disorder are three times as high amongst Black men (7.4%) compared to White men (2.5%), with no significant difference reported by ethnic groups amongst women.

According to the 2011 census, there were 32,652 individuals from BME groups living within Derbyshire, comprising 4.2% of the population. This is significantly lower than the England and Wales proportion, where BME groups comprise 19.5% of the population. The largest BME groups within Derbyshire are White Other, Indian, White and Black Caribbean and White Irish. The highest rates of BME groups are located in Chesterfield, Long Eaton and the communities adjacent to Derby City. However, there are areas with higher rates of BME population within the majority of urban areas in Derbyshire.

2.1.3 Looked after children

Looked after children have a higher level of mental health problems than their peers, with 72% having a mental health or behavioural problem. Rates of mental illness are highest amongst children and young people in residential care.

As at August 2015, there were 619 looked after children in Derbyshire. Chesterfield and Erewash had the highest rates of children in care. Approximately one in twenty of looked after children are in secure units, children's homes and hostels, with the highest proportion in Erewash. Approximately one in three children taken into care is due to abuse, neglect and family dysfunction.

There is no comparable England data for the same time period. However for the latest period that comparable data is available (2013/14), Derbyshire had a significantly lower rate of looked after children compared to England.

Table 3: Information on looked after children in Derbyshire, August 2015

	Number of looked after children	Rate of looked after children (per 10,000 population aged under-18)	% of looked after children in secure units, children's homes and hostels	% of children in need due to abuse, neglect or family dysfunction
Derbyshire	619	40.2	5.1	35.3
Amber Valley	80	33.3	5.4	39.2
Bolsover	62	39.6	2.6	44.0
Chesterfield	125	61.5	5.9	35.0
Derbyshire Dales	37	28.5	4.6	28.4
Erewash	142	61.7	10.4	47.0
High Peak	61	33.4	4.4	28.2
North East Derbyshire	47	25.7	3.3	23.5
South Derbyshire	65	30.2	2.8	25.2

Source: CAYA, DCC

2.1.4 Carers

Carers play a vital, yet often unrecognised role, in supporting the health and social care system to care for people experiencing ill health.

Young people with a caring responsibility often miss out on 'being a child' and can become isolated. They often express feelings of anxiety, frustration, guilt and resentment and can show high levels of stress levels. Achievement and attendance at school can be affected by their caring responsibilities, and aspirations for future careers can be low. Adult carers report a lower quality of life and less social contact than they would like, combining to increase the prevalence of mental ill health among carers.

There are a reported 1.1% of children aged under-15 years who provide unpaid care in Derbyshire, and this is similar to the England rate (1.1%). However, this is likely to be an under-estimate of the true prevalence as not all young carers will be known to services and others may not identify themselves as a carer.

In Derbyshire (including Derby City) there are 12,500 carers registered with Derbyshire Carers Association. There was a considerably higher number of individuals who self-reported having caring responsibilities in the 2011 Census – in Derby City there were 25,584 carers and 92,761 carers in Derbyshire County. There were higher proportions of the populations of Bolsover, Derbyshire Dales and North East Derbyshire with caring responsibilities compared to England. This data also suggests that a significant proportion of carers is not known to services and therefore may not be having their needs assessed and met.

According to the 2011 census, the majority of carers in Derbyshire are women (57%), and there was a higher proportion of older carers aged over 65 years compared to those aged under 24 years (23% and 6% respectively).

Table 4: Carers in Derbyshire, 2011

	Number of carers in population	Proportion of population that are carers (%)
England	5,400,000	10.4
Derby City	25,584	10.3
Derbyshire	92,761	12.1
Amber Valley	14,607	11.9
Bolsover	9,624	12.7
Chesterfield	13,034	12.6
Derbyshire Dales	9,003	12.7
Erewash	12,562	11.2
High Peak	10,314	11.3
North East Derbyshire	13,135	13.3
South Derbyshire	10,482	11.1

Source: ONS

2.1.5 Disability and long term conditions

The impact of living with a long term health problem or disability can have a significant impact on the mental wellbeing of individuals, carers and family members. There is an increased risk of developing depression, stress or anxiety, although good management of the condition or disability can reduce the risk of developing mental illness.

Derbyshire has a significantly higher rate of people who state that their daily activities are limited by their health or a disability compared to England, equating to 157,000 individuals. The higher rate is most likely due to the older population of Derbyshire. All districts also have a higher rate than England with the exception of South Derbyshire which has a similar rate to the national figure. Approximately two thirds of those with a long term condition or disability in Derbyshire report feeling sufficiently supported to manage their condition, a proportion similar to the national figure.

Table 5: Proportion of population self-reporting a long term health problem or disability, 2011 and those supported to manage their condition, 2013/14

	% of those with a long term health problems or disability who say their day-to-day activities are limited	% patients with long term condition who feel supported to manage their conditions
England	17.6%	65.1%
Derby City	18.7%	63.4%
Derbyshire	20.4%	67.7%
Amber Valley	20.3%	-
Bolsover	24.7%	-
Chesterfield	23.1%	-
Derbyshire Dales	18.5%	-
Erewash	19.3%	-
High Peak	18.1%	-
North East Derbyshire	22.0%	-
South Derbyshire	17.5%	-

Source: Census and GP Patient Survey.

2.2 Risk and protective factors for mental ill health

2.2.1 Deprivation and poverty

Socio-economic deprivation measures the disadvantage experienced by an individual or community relative to society, and considers factors such as income, employment, access to services, health and the living environment. An area itself is not deprived, it's the circumstances and lifestyles of the population that affects its deprivation score. Not everyone living in a deprived area will be deprived and similarly not everyone experiencing deprivation will live in a deprived area.

Areas with higher levels of socio-economic deprivation are associated with higher levels of mental illness. Both, individual and neighbourhood deprivation increases the risk of poor mental health.

People with mental illness are more likely to experience socio-economic deprivation. Studies have shown a decline in social position and financial circumstances over time in people who were depressed. In addition, self-reported poorer mental health in men is associated with a downward socio-economic trajectory over the life course.

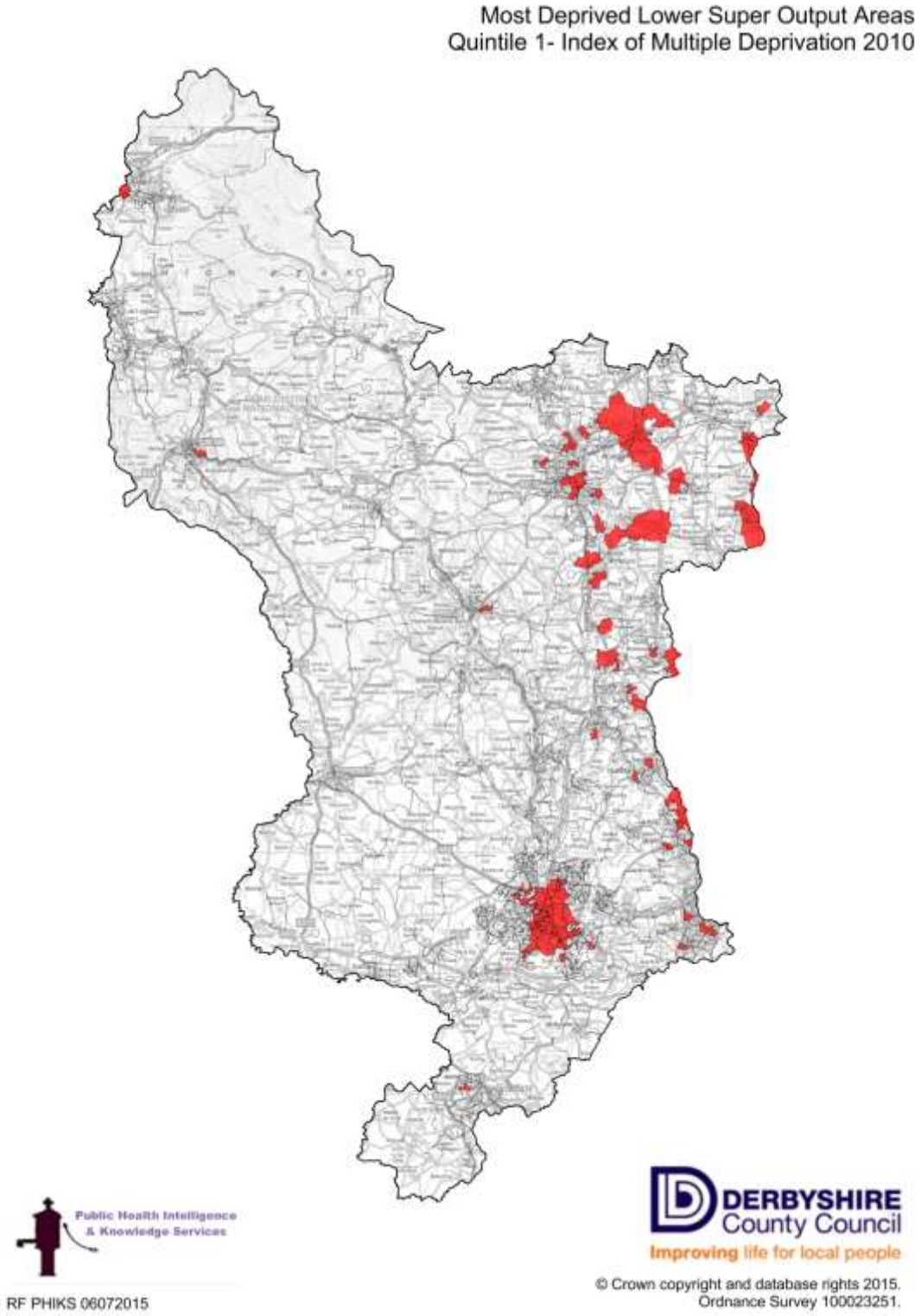
Derbyshire County has lower levels of deprivation than the national average, but one in eight residents live in an area classed as being in the 20% most socio-economically deprived areas of England. The population of these most-deprived areas is approximately 95,000 individuals. The proportion living in the most deprived communities varies by district from over one in four individuals in Chesterfield and Bolsover to less than 1 in 50 in South Derbyshire. Figure 2 shows that the most socio-economically deprived areas in Derbyshire are located primarily in Chesterfield, Derby City and towards the eastern side of the county. However, there are also communities with high levels of socio-economic deprivation in Glossop, Buxton, Matlock and Swadlincote and therefore these communities are likely to have higher prevalence of mental illness.

Table 6: Proportion of population living in national most deprived 20% of areas, by district

District	Number living in national most deprived 20% areas	Proportion of population (%)
Derby City	72,901	29.0
Derbyshire	95,046	12.3
Amber Valley	11,042	8.9
Bolsover	21,033	27.4
Chesterfield	26,985	25.9
Derbyshire Dales	1,598	2.2
Erewash	18,367	16.2
High Peak	4,171	4.2
North East Derbyshire	10,201	10.3
South Derbyshire	1,649	1.7

Source: Office for National Statistics

Figure 2: Areas within Derbyshire classified as within the most 20% socio-economically deprived communities in England



The definition of poverty is a household living on an income less than 60% of the national average. This means that some households may find themselves in poverty one year and not the next, despite having no change in their income. Poverty does not only affect the unemployed – two thirds of children growing up in poverty live in working households. Persistent poverty is when a household experiences relative income poverty for at least three years out of a four-year window.

Living in poverty can have a significant impact on a child's life. Poor children are four times more likely to become poor adults than other children. Children who experience persistent poverty at the age of three are more likely to have emotional and behavioural problems. This link between poverty and mental health problems continues throughout adolescence, with young people in poverty being nearly three times more likely to suffer mental health problems than their peers living in more affluent households.

In 2012, 16.3% of under-16s in Derbyshire were living in poverty, lower than the England average of 19.2%. There are however, an estimated 21,860 children experiencing poverty within Derbyshire. The districts with the highest proportion of children living in poverty are Bolsover and Chesterfield, which have rates of child poverty higher than England. Erewash has a rate similar to England, and all other districts have a significantly lower proportion of children living in poverty compared to England.

Table 7: Proportion of children living in poverty in Derbyshire in 2012, by district

District	Estimated number of children living in poverty	% of children living in poverty
Derby City	12,095	23.8
Derbyshire	21, 860	16.3
Amber Valley	3,560	16.9
Bolsover	2,955	21.5
Chesterfield	3,745	21.0
Derbyshire Dales	1,045	9.3
Erewash	3,735	18.9
High Peak	2,105	13.1
North East Derbyshire	2,355	14.8
South Derbyshire	2,360	13.0
England	-	19.2

Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)

2.2.2 Crime

2.2.2.1 Victims of crime

Being a victim of crime, being fearful of personal safety or living in an environment where crime is more common are factors that can contribute towards social isolation, decreased quality of life and result in higher levels of mental ill health.

Rates of depression and anxiety have been reported as being between two and nearly five times higher amongst individuals experiencing abuse, compared to individuals that had not experienced abuse. Rates of mental health conditions are highest in individuals who have experienced extensive physical and sexual abuse, with individuals who have experienced abuse approximately five to fifteen times more likely to attempt suicide. In addition, more than half of individuals who have experienced abuse report self-harm, compared to 10% of those with no experience of abuse.

Children and young people who live in households where abuse occurs may witness it, or become victims of abuse themselves. This can lead to immediate behavioural problems and emotional trauma, social development problems, poor educational attainment and mental health difficulties in adult life.

Derbyshire has a higher rate of reported incidents of domestic abuse compared to England and the East Midlands. It is not possible to determine whether the rate in Derbyshire is significantly different from the England rate, as the reporting and recording of domestic abuse varies by police force. Since 2007/08 the rate of domestic abuse incidents reported in Derbyshire has significantly increased, from 21.0 per 1,000 to 21.9 per 1,000 in 2012/13. Both England and the East Midlands have experienced much more significant increases, although this may be influenced by improvements in reporting and recording practices within police force areas.

Table 8: Incidents of domestic abuse, 2013/14

	Reported incidents of domestic abuse (per 1,000 adults)
Derbyshire (including Derby City)	21.9
East Midlands	20.2
England	18.8

Source: Public Health England

Within Derbyshire, one quarter of children referred to social care have domestic abuse highlighted as a concern. The proportion is highest in Chesterfield.

Table 9: Proportion of referrals of children and young people to social care where domestic abuse is flagged as a cause for concern, 2013/14

	% of child referrals where domestic abuse is flagged as a cause for concern
Derbyshire	25.3
Amber Valley	26.3
Bolsover/North East Derbyshire	25.5
Chesterfield	33.8
Derbyshire Dales/High Peak	22.9
Derbyshire Dales/South Derbyshire	19.3
Erewash	26.2

Source: Department for Education

Derbyshire has a lower rate of violent crime than England. It is not possible to determine whether the rate in Derbyshire is significantly lower than England, as differences may be due to reporting and recording of violent crime across the country. Rates in each district are all lower than England, with the exception of Derby City which has a higher rate.

Table 10: Violent crime in Derbyshire, 2013/14

	Incidents of violent crime (including sexual violence)	Rate of violence offences (per 1,000 population)
England	593,830	11.1
Derby City	3,545	14.1
Derbyshire	5,632	7.3
Amber Valley	812	6.6
Bolsover	583	7.6
Chesterfield	1,090	10.5
Derbyshire Dales	381	5.3
Erewash	1,031	9.1
High Peak	700	7.7
North East Derbyshire	411	4.1
South Derbyshire	624	6.5

Source: Public Health England

2.2.2.2 Offender mental health

Mental health issues are much more common in prisoners than in the general population. As many as 90% of prisoners report having a mental illness, with 26% of female prisoners and 16% of male prisoners said they had received treatment for a mental health problem in the year before custody. The suicide rate in offenders is almost fifteen times higher than in the general population. It is

estimated that 95%of imprisoned young offenders have a mental health disorder and many have more than one disorder.

There is very limited routine information available on the number of offenders within Derbyshire. In 2014, Derbyshire had a lower rate of first time entrants to the Youth Justice System than England (279 and 409 per 100,000 population respectively).

2.2.3 Education

2.2.3.1 School readiness

Starting school ready and able to learn has an impact on school achievement and mental wellbeing throughout the school years. Children's wellbeing is linked to later academic achievement, with children who have better emotional wellbeing at age 7 having a higher progress score at the end of primary school compared to their peers with lower emotional wellbeing.

A higher proportion of children in Derbyshire have a good level of development at the end of Reception compared to England. The proportion between districts varies from 57% in Chesterfield to 67% in Derbyshire Dales.

Table 11 School readiness, by district, 2013-14

	Number of children achieving a good level of development at end of Reception	Proportion achieving a good level of development at the end of Reception (%)
England	387,086	60.4
Derby City	1,710	51.3
Derbyshire	5,152	61.5
Amber Valley	1,248	63
Bolsover	848	59
Chesterfield	1,126	57
Derbyshire Dales	657	67
Erewash	1,267	61
High Peak	1,013	62
North East Derbyshire	953	64
South Derbyshire	1,170	59

Source: Department for Education (DfE), EYFS Profile: EYFS Profile statistical series

2.2.3.2 School exclusions

Permanently excluded children are three times more likely to leave school with no qualifications and are more likely to be unemployed. Secondary school pupils who are living in poverty are more likely to be excluded which then compounds their risks of long term unemployment and intergenerational poverty. Derbyshire has a significantly higher rate of exclusions from primary schools, and a similar rate of exclusions from secondary schools compared to the England average. Approximately 1 in 15 young people at a secondary school in Derbyshire have a fixed period exclusion.

Table 12: Exclusions from school, 2012/13

	Proportion of primary school children with fixed period exclusions (%)	Proportion of secondary school children with fixed period exclusions (%)
England	0.9	6.8
Derbyshire	1.2	6.8
Derby City	0.7	7.7

Source: School Census https://www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2012-to-2013

2.2.3.3 GCSE achievement

Better wellbeing in children results in an increased ability to learn and engage with educational process which therefore has a positive impact on academic achievement. Academic success also has a strong positive impact on children's wellbeing, both in the present and as an adult.

The proportion of young people achieving 5 or more A* to C grades at GCSE in Derbyshire is significantly lower than the national achievement. There is also variation by district, with Amber Valley, Bolsover, Chesterfield, Derby City, Erewash and South Derbyshire having significantly lower achievement rates compared to England. Derbyshire Dales is the only district where achievement is significantly higher. Achievement rates are also lower amongst disadvantaged pupils in Derbyshire compared to England. The achievement rate amongst pupils with special educational needs in Derbyshire is similar to the national rate.

Table 13: GCSE achievement in Derbyshire, 2013/14

	Proportion achieving 5 or more A* to C including English and Maths (%)	Proportion achieving 5 or more A* to C (%)	Proportion of disadvantaged pupils achieving 5 or more A* to C (%)	Proportion of pupils with special educational needs achieving 5 or more A* to C (%)
England	56.8	65.8	45.1	32.0
Derby City	50.0	58.8	36.2	24.3
Derbyshire	53.7	62.9	39.3	31.7
Amber Valley	53.5	-	-	-
Bolsover	48.1	-	-	-
Chesterfield	53.6	-	-	-
Derbyshire Dales	61.6	-	-	-
Erewash	46.1	-	-	-
High Peak	57.4	-	-	-
North East Derbyshire	60.0	-	-	-
South Derbyshire	51.0	-	-	-

Source: Department for Education

2.2.3.4 Young people not in education, employment or training (NEET)

It is estimated that a third of young people who are Not in Education Employment or Training (NEET) have suffered depression. The proportion of young people aged 16-18 who are NEET in Derbyshire is significantly lower than England.

In 2013/14 national legislation was introduced to increase the age to which all young people in England are required to be in either education or training. This has led to an increase in the rates of young people in full time education particularly those seen at age 17 and concurrently a drop in the proportion of young people who are NEET. At the end of January 2015, 4.0% of 16-18 year olds in Derbyshire were classified as NEET.

Table 14: Young people not in education, employment or training, 2013/14

	Number of NEET young people	Proportion of NEET young people (%)
England	-	4.7
Derbyshire	1,040	4.0
Derby City	530	6.4

Source: Department for Education

2.2.4 Employment

Employment is directly related to many factors that positively influence mental wellbeing, including income provision, life satisfaction and independent support (not reliant on benefits or others). Conversely, unemployment may be a cause or consequence of poor mental health. Individuals with poor mental health may struggle to remain in employment, and unemployment can result in anxiety, stress, depression and decreased self-esteem. Parental unemployment has an impact on children's wellbeing through the strain it places on parents, which may lead to poor parenting practices. Children who live in households with two adults in employment are likely to experience significantly fewer emotional and behavioural problems at age three.

In 2013 there were 15 million working days lost to stress, anxiety and depression in the UK. Only musculoskeletal disorders and minor illnesses resulted in more days lost, but it is estimated some of these would have actually been due to mental illness but not reported as such due to actual or perceived stigma.

Derbyshire has a lower proportion of children living in households where one parent receives out-of-work benefits than England. Amber Valley, Derbyshire Dales, High Peak, North East Derbyshire and South Derbyshire also have lower rates, but Bolsover and Chesterfield have higher rates.

Derbyshire has a significantly lower proportion of working age population who have been unemployed for more than a year. Derbyshire has a similar proportion of working days lost to sickness absence and the proportion of employees who had a least one day off in the previous week as England.

Table 15: Employment statistics

	% of children living in households where 1 or more parent/guardian is receiving out of work benefits	Long term unemployment: % of working age population Oct 14	% of working days lost to sickness absence	% of employees who had at least 1 day off in previous week
England	18.0	0.61	1.6	2.5
Derby City	22.9	0.69	0.6	0.8
Derbyshire	16.3	0.42	1.2	2.3
Amber Valley	16.8	-	1.3	2.6
Bolsover	22.9	-	2.0	3.4
Chesterfield	21.5	-	1.1	1.8
Derbyshire Dales	8.4	-	0.7	1.9
Erewash	18.1	-	1.3	2.5
High Peak	13.5	-	1.5	2.9
North East Derbyshire	15.3	-	1.3	1.8
South Derbyshire	11.8	-	0.8	1.7

Source: DWP, NOMIS

2.2.5 Relationships

2.2.5.1 Family relationships

Adults who are married or widowed have lower rates of common mental health problems than those who are divorced or separated. Having parents go through a separation can also have a negative impact on a child's mental health. Young people who are living with parents who need care, are experiencing domestic abuse or have a substance misuse or mental health problem are particularly at risk of their circumstances negatively impacting on their mental health.

In Derbyshire the proportion of adults whose marital status is separated or divorced is 12.3% of the population, which is higher than the national average. Amber Valley, Bolsover, Chesterfield, Erewash, High Peak and South Derbyshire have significantly higher proportions, and Derbyshire Dales a significantly lower proportion. It is not known what proportion of those that are separated or divorced will also have dependent children.

Table 16: Relationship status of adults, 2011

	Number of adults whose current marital status is separated or divorced	% adults whose current marital status is separated or divorced
England	-	11.6
Derby City	23,075	11.6
Derbyshire	77,715	12.3
Amber Valley	12,475	12.4
Bolsover	7,840	12.6
Chesterfield	11,493	13.4
Derbyshire Dales	6,565	11.1
Erewash	11,675	12.7
High Peak	9,188	12.3
North East Derbyshire	9,447	11.4
South Derbyshire	9,032	11.9

Source: ONS Census 2011

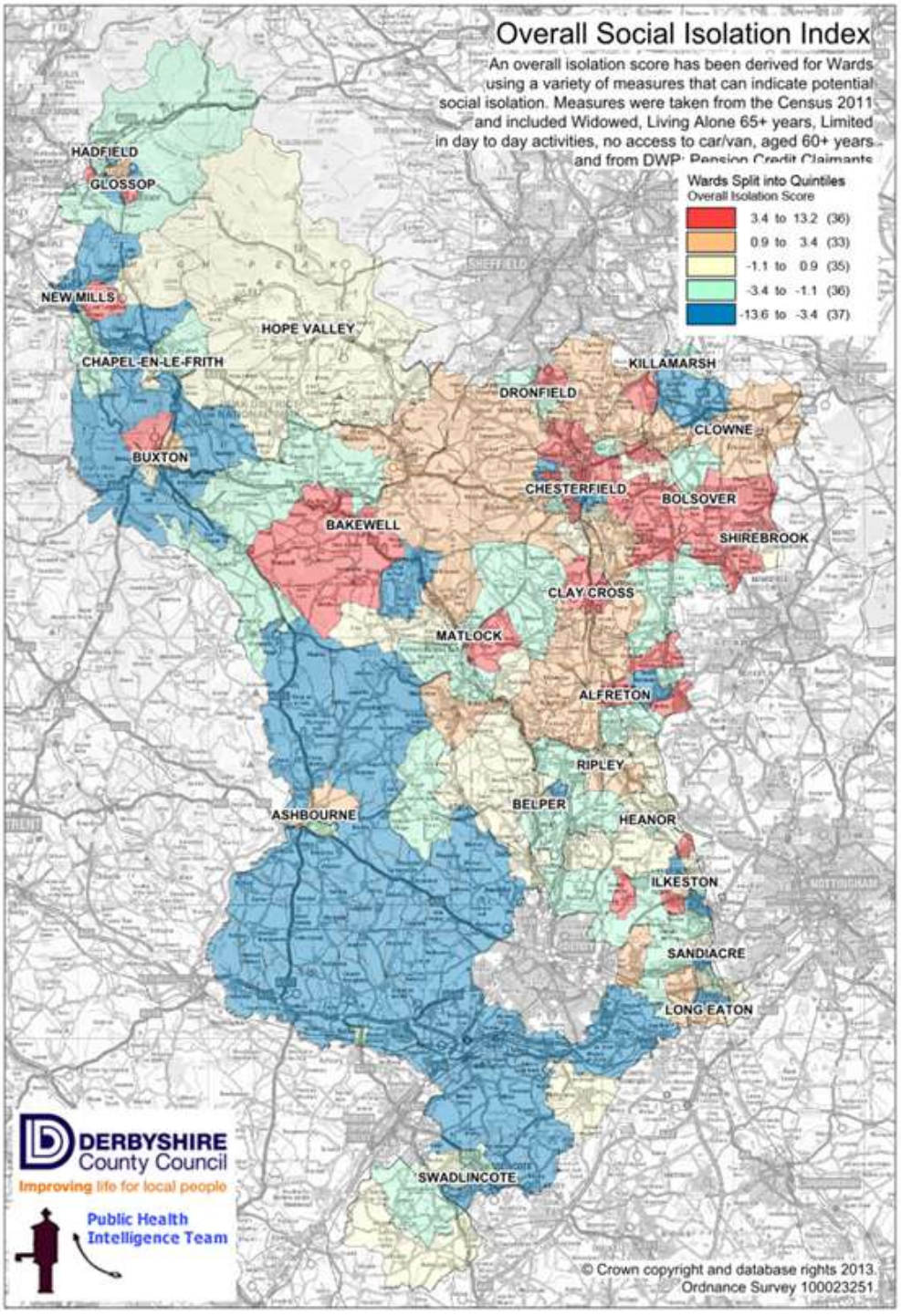
2.2.5.2 Social relationships

Having a network of support is an essential component of positive mental wellbeing. Community networks, such as family, neighbours and social networks, support individual resilience through helping individuals cope with challenges and adverse events.

Being socially isolated is linked to increased risk of mental ill health. The rural nature of parts of Derbyshire will result in greater social isolation, but there are factors that increase the likelihood of social isolation in urban areas, such as living alone, disability, crime, transport/vehicle ownership and age.

A social isolation index has been developed within the Public Health team at Derbyshire County Council. Due to the indicators used (which include living alone aged 65 years and over, widowed, presence of a disability and no access to car) the index will mainly highlight social isolation amongst the older population. The index highlights pockets of rural isolation, but also areas with high levels of social isolation amongst older adults living in Chesterfield, North East Derbyshire and Bolsover.

Figure 3: Overall social isolation in Derbyshire (where a higher positive score indicates a greater level of social isolation)



Living alone can be a significant factor leading to an individual feeling socially isolated. In 2011, there were 31,578 households in Derby and 96,233 in Derbyshire that were occupied by a single person. The proportion of households in Derby that are recorded as one person households is similar to the England figure, and the proportion in Derbyshire is significantly lower. In addition, there were 12,432 households in Derby and 43,270 households in Derbyshire that were occupied by a single person aged over 65 years. The proportion of households occupied by single, older adults is significantly lower in Derby compared to England, but significantly higher in Derbyshire.

Table 17: Proportion of single person households, 2011

	Proportion of all households occupied by a single person (%)	**Proportion of households occupied by a single person aged 65 years and over (%)**
England	12.8	5.2
Derby City	12.9	5.1
Derbyshire County	12.6	5.7

Source: ONS

2.2.6 Housing and homelessness

Living in a safe and affordable home is a protective factor for good mental wellbeing. Conversely, living in poor housing or being homeless increases the likelihood of developing a mental health problem. Lack of adequate space, unsafe, cold and poorly designed housing, homelessness and instability, are known to impact on mental health, particularly contributing to anxiety and depression. Poor housing can also described at a community level in terms of a lack of community facilities, higher crime levels, lower employment and absence of social support networks.

2.2.6.1 Poor quality housing

Derbyshire has a similar proportion of households experiencing fuel poverty compared to England. Bolsover, Chesterfield, North East Derbyshire and South Derbyshire have significantly fewer households living in fuel poverty compared to England. Derbyshire Dales has a significantly higher proportion, and this may be due to the higher proportion of households that do not receive a mains fuel supply.

There are a lower proportion of households experiencing overcrowding in Derbyshire and all constituent districts compared to England. There are approximately 7,300 overcrowded households in Derbyshire.

Table 18: Proportion of households experiencing fuel poverty and overcrowding

	Proportion of households experiencing fuel poverty (%)	Proportion of households experiencing overcrowding (%)
England	10.4	4.8
Derby City	12.8	5.2
Derbyshire	10.0	2.2
Amber Valley	10.3	2.3
Bolsover	9.8	2.5
Chesterfield	10.0	2.5
Derbyshire Dales	11.3	1.7
Erewash	10.4	2.3
High Peak	10.5	2.7
North East Derbyshire	9.0	2.0
South Derbyshire	9.0	1.8

Source: ONS, Census 2011

2.2.6.2 Homelessness

Homelessness is associated with increased likelihood of mental illness, with 80% of homeless people having a mental health issue.

In Derbyshire there are fewer households in temporary accommodation than the national average. There are 16,837 households on local authority housing waiting lists, with the most being in High Peak.

Table 19: Households in temporary accommodation and on housing waiting lists, by district, 2013/14

	Households in temporary accommodation per 1,000 households (number)	Number of households on local authority housing waiting list
England	2.6 (58,440)	1,368,312
Derby City	0.3 (27)	3,868
Derbyshire	0.2 (80)	16,837
Amber Valley	0.4 (23)	2,914
Bolsover	0.0 (0)	1,578
Chesterfield	0.3 (16)	1,699
Derbyshire Dales	0.4 (14)	1,137
Erewash	0.2 (9)	2,320
High Peak	0.1 (5)	3,589
North East Derbyshire	0.3 (12)	1,673
South Derbyshire	0.1 (<5)	1,927

Source: Department of Communities and Local Government

2.2.7 Lifestyle factors

2.2.7.1 Smoking

Despite many smokers believing that their habit reduces stress and anxiety, smoking has been shown to increase anxiety. In addition, there is also an association between smoking and depression, although whether smoking causes depression or vice versa is unclear. Smoking rates in adults with depression are approximately twice as high compared to people without depression.

Smoking rates amongst people with a mental health disorder are significantly higher than in the general population. It is estimated that of the 10 million smokers in the UK, about 3 million have a mental disorder. The high smoking rates among people with a mental illness is a significant contributory factor towards the high premature mortality observed in this population group.

In 2013, there were an estimated 1,695 smokers in Derbyshire, with a similar prevalence to England. There is variation between the districts, with Derby City having a significantly higher smoking prevalence, and Amber Valley and Derbyshire Dales having significantly lower smoking prevalence compared to England.

Smoking whilst pregnant not only increases the risk of physical health problems in new-borns, but is also a risk factor for the development of mental health problems in childhood. The proportion of women smoking at the time of delivery is higher in Derbyshire than England. In 2013/14 there were 1,224 mothers who reported smoking at the time of delivery..

Table 20: Smoking prevalence in Derbyshire, 2013 and smoking at the time of delivery, 2013/14

	Smoking prevalence (%)	Smoking status at time of delivery (%)
England	18.4	12.0
Derby City	22.1	15.1
Derbyshire	17.5	16.3
Amber Valley	12.3	-
Bolsover	23.0	-
Chesterfield	20.3	-
Derbyshire Dales	10.0	-
Erewash	19.6	-
High Peak	21.2	-
North East Derbyshire	18.9	-
South Derbyshire	14.8	-

Source: Integrated Household Survey, PHE. HSCIC (SSATOD)

2.2.7.2 Physical activity

Being physically active is a protective factor against mental ill health and can also help in recovery from a mental illness. For mild depression, partaking in physical activity can be as effective as antidepressants or Cognitive Behavioral Therapy.

Physical inactivity is defined as undertaking less than 30 minutes of moderate intensity exercise per week. Derbyshire has a similar proportion of the population being inactive as England, but there is variability within the county. Bolsover has significantly higher rates of physical inactivity, and Derbyshire Dales and South Derbyshire significantly lower rates compared to England.

An alternative measure to review levels of physical activity is to estimate the proportion of the population that utilise outdoor spaces. Although Derbyshire contains significant amounts of outdoor space, utilisation of this space is below the national average.

Table 21: Indicators of levels of physical activity

	Proportion of adult population classified as inactive (%)	Estimated proportion of population that uses outdoor space for exercise/ health (%)
England	28.9	17.1
Derby City	28.6	11.1
Derbyshire	29.7	13.3
Amber Valley	29.4	-
Bolsover	36.0	-
Chesterfield	32.9	-
Derbyshire Dales	24.5	-
Erewash	29.9	-
High Peak	28.8	-
North East Derbyshire	30.9	-
South Derbyshire	24.7	-

Source: Active People Survey, Sport England.

2.2.7.3 Alcohol misuse

Drinking excess alcohol leads to serious physical and mental illnesses, with people who consume high amounts of alcohol having a higher prevalence of mental ill health. In addition, alcohol problems are more common among people with more severe mental health problems.

Hospital admissions due to alcohol specific conditions in children aged under-18 are similar to the national average, but High Peak has a significantly higher rate. Overall, there has been a reduction in the rate of alcohol-related admissions in young people in Derbyshire recently.

Among the total population, the rate of alcohol-related admissions to hospital in Derbyshire is similar to the national rate, however, there is considerable variability between districts and also between genders. Amber Valley and Chesterfield have significantly higher rates of alcohol-related

admissions, with South Derbyshire significantly lower. For all districts, the rate of hospital admissions is higher amongst males than females.

*Table 22: Alcohol admissions to hospital, 2013/14**

	Admissions for alcohol-specific conditions (per 100,000 population aged 0-17)	Alcohol-related admissions to hospital:		
		per 100,000 total population	per 100,000 male population	per 100,000 female population
England	44.9	637	829	465
Derby City	45.1	742	969	539
Derbyshire	44.1	650	820	498
Amber Valley	42.1	684	886	502
Bolsover	51.0	663	852	493
Chesterfield	43.2	798	983	633
Derbyshire Dales	36.9	602	724	505
Erewash	31.8	651	830	492
High Peak	63.7	615	806	442
North East Derbyshire	47.9	591	730	464
South Derbyshire	39.3	583	715	469

Source: Public Health England calculated using HES and ONS population.

*The data presented is the narrow definition: admissions to hospital where the primary diagnosis is an alcohol related condition or secondary diagnosis is an alcohol related external cause

2.2.7.4 Drug misuse

Drug misuse can make the symptoms of mental illness worse, or can mask the presence of mental illness. There are also possible associations between the use of certain drugs and the development of a mental illness, for example cannabis use and schizophrenia.

Derbyshire has a similar estimated prevalence of opiate and/or crack cocaine use compared to England (7.4 and 8.4 per 1,000 population aged 15-64 years respectively).

2.2.8 Teenage conceptions

Teenage mothers have a rate of post-natal depression three times higher than older mothers and also have a higher risk of poor mental health for three years after the birth. There are also strong links between being a teenage mother and living in poverty, not continuing in education, employment or training and being at high risk of social exclusion. All of these factors increase the risk of long-term stress, depression and anxiety.

The outcomes for children of teenage parents can be poor, including higher rates of infant mortality, accidents and behavioural problems. They are more likely to have a lower educational attainment and a higher risk of economic inactivity and social disadvantage as adults. Daughters of teenage mothers are more likely to become teenage mothers themselves, continuing the cycle of early parenthood and social exclusion.

The rate of teenage conceptions in Derbyshire is significantly lower than the national average and has fallen over the last fifteen years. The rates of teenage conceptions vary by district, ranging from 11.0 to 27.7 conceptions per 1,000 females aged 15-17 in Derbyshire Dales and High Peak respectively.

Table 23: Teenage conceptions in Derbyshire, 2011-13

District	Rate of conceptions per 1,000 females aged 15-17
Amber Valley	19.5
Bolsover	25.9
Chesterfield	26.7
Derbyshire Dales	11.0
Erewash	24.9
High Peak	27.7
North East Derbyshire	18.2
South Derbyshire	24.6

Source: ONS

2.2.9 Falls

The impact of a fall can significantly affect an individual's quality of life. A subsequent loss of independence and chronic pain experienced by many of those who have fallen can lead to development of depression and anxiety.

Derbyshire has a similar rate of injuries due to falls compared to England, but the local trend is increasing. Chesterfield has a significantly higher rate and Derbyshire Dales a significantly lower rate of falls compared to England.

Table 24: Emergency hospital admissions due to falls in those aged 65 years and over, 2013/14

	Rate of injuries due to falls (per 100,000 population aged 65 and over)
England	2,064
Derby City	2,221
Derbyshire	2,207
Amber Valley	2,075
Bolsover	2,365
Chesterfield	2,528
Derbyshire Dales	2,145
Erewash	2,160
High Peak	1,868
North East Derbyshire	2,292
South Derbyshire	2,228

Source: Calculated by WM PHE KIT using HES and ONS population

2.2.10 Quality of life

A variety of factors contribute to an individual's quality of life, including presence of a long term condition, being a carer, living in poverty, having relationship difficulties, having financial stress or living in a poor quality environment. A decrease, or a perceived decrease, in quality of life can lead to decreased mental wellbeing and increased mental distress.

The EQ-5D tool can be used to assess health-related quality of life, with a higher score indicating a better quality of life. Average health related quality of life for older people is significantly lower in Bolsover, Chesterfield and Erewash compared to England, with Derbyshire Dales significantly higher.

Health related quality of life in certain population groups varies by CCG. Quality of life among carers in North Derbyshire CCG is significantly worse than England, with carers in Southern Derbyshire CCG having a similar quality of life. Among those with a long term condition, quality of life is worse in Hardwick CCG compared to England, and similar in Erewash, North Derbyshire and Southern Derbyshire CCGs.

Table 25: Health related quality of life scores, 2013/14

	Average health related quality of life score for older people (EQ-5D score)	Average health related quality of life score for carers aged 18 and above (EQ-5D score)	Average health related quality of life score for people with long term conditions (EQ-5D score)
England	0.73	0.80	0.74
Derby City	0.71	-	-
Derbyshire	0.72	-	-
Amber Valley	0.72	-	-
Bolsover	0.66	-	-
Chesterfield	0.69	-	-
Derbyshire Dales	0.77	-	-
Erewash	0.70	-	-
High Peak	0.74	-	-
North East Derbyshire	0.72	-	-
South Derbyshire	0.74	-	-
Erewash CCG	-	no data	0.75
Hardwick CCG	-	no data	0.68
North Derbyshire CCG	-	0.79	0.73
Southern Derbyshire CCG	-	0.81	0.74

Source: NHS and PH Outcomes Framework

3 Prevalence of mental wellbeing and mental illness in the population

3.1 Mental wellbeing

Psychological characteristics such as low self-esteem or feeling worthless are linked to depression and suicide risk.

Self-reported wellbeing in Derbyshire and Derby City is similar to the national average for all four measures, with the exception of the proportion of people with a high anxiety score in Derby City. The proportions reported for Derbyshire are based on a relatively small number of respondents, and therefore may not be representative of the whole population. One in twenty of the respondents in Derbyshire reported low satisfaction with their life, one in ten reported low happiness and one in five reported high levels of anxiety. If the Derbyshire sample were representative of the adult population, this would mean that approximately 22,000 adults have a low worthwhile score, and 128,000 have a high anxiety score.

Table 26: Prevalence of poor mental wellbeing, 2013/14

	% of people with a low satisfaction score	% of people with a low worthwhile score	% of people with a low happiness score	% of people with a high anxiety score
England	5.6	4.2	9.7	20.0
Derby City	7.6	5.7	11.4	24.5
Derbyshire County	5.1	3.5	10.1	20.0

Source: ONS, Annual Population Survey

3.2 Prevalence of mental illness in children and young people

3.2.1 Perinatal and infant mental health

The 1,001 'critical days' from conception to age 2 are key in influencing health outcomes later on in life. As well as the direct impact on the mother, perinatal mental health problems (commonly known as postnatal depression, and consisting of pregnancy and the year after birth) can also affect the attachment between mother and baby, and the mental health of the child and wider family.

An estimated 12% of women will require support for perinatal mental health problems. Extrapolating this to the number of births in Derby and Derbyshire provides estimates of 446 women in Derby and 993 women in Derbyshire having perinatal mental health needs.

A baby's brain develops significantly in the first 18 months, and even the earliest experiences can have an impact on emotional health throughout life. There is strong evidence that a baby's social and emotional development is strongly affected by the quality of their attachment with their caregiver. Poor attachment can lead to children being more likely to suffer from aggression and hyperactivity. The Brazelton Neonatal Assessment Scale (BNAS) is one method of measuring attachment and will be universally used across Derbyshire from April 2016. This will allow early problems with attachment to be identified.

3.2.2 Children and young people

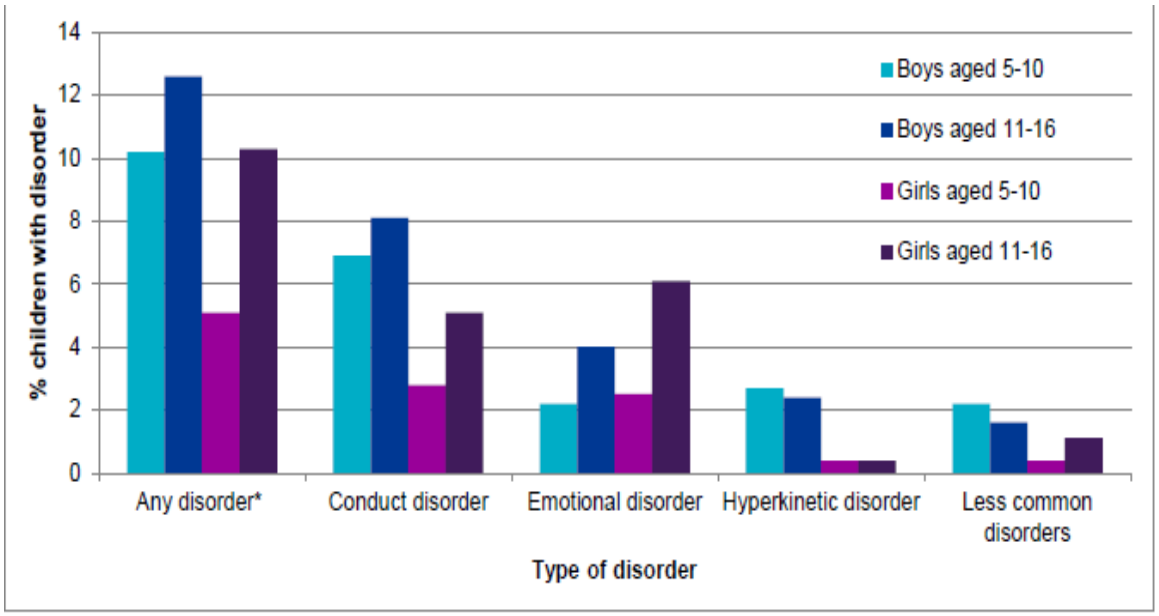
Half of all adults with a mental health problem are first diagnosed between the ages of 11 and 15 years. There is also a strong association between conduct disorder and social exclusion, offending and unstable employment. Eating disorders, although affecting relatively small numbers of young people, can have a significant impact on an individual's physical health and development, which can last into adulthood.

National figures have shown that one in ten children and young people aged between 5 and 16 years have a diagnosable mental health disorder. The most common diagnostic categories are conduct disorders, anxiety, depression and hyperkinetic disorders. Prevalence of mental health disorders in young people have been increasing over the past decades, with rates of anxiety and depression increasing by 70% in the last 25 years. Although less common than amongst adults, rates of depression are often higher in adolescence, compared to younger children.

Conduct disorder and hyperkinetic disorders are more prevalent in males and emotional disorders more prevalent in females. In general for all disorders there is a higher prevalence of mental health disorders as age increases. One in five children with a mental health disorder has multiple conditions, and this can cause problems for assessment, diagnosis and treatment. The most common combinations are conduct and emotional disorder, and conduct and hyperkinetic disorder.

The national prevalence data is based on a 2004 survey, but remains the most recent, comprehensive national survey of prevalence of mental health conditions in children and young people. If prevalence has changed in the last decade then the estimates will be under or over-estimates of the true prevalence depending on the direction of the trend.

Figure 4: Prevalence of mental health disorders in children in UK 2004



Source: ONS

Applying the national estimates to the local population provides an approximation of the number of children and young people in Derbyshire with a mental health disorder. There are an estimated 10,100 children aged between 5 and 16 years with a mental health disorder in Derbyshire. Prevalence is higher amongst boys, and is higher among 11 to 16 year olds compared to 5 to 10 year olds.

Table 27: Estimated prevalence of mental health disorders amongst young people aged 5-16

	Estimated proportion of population aged 5-16 with any mental health disorder (%)	Estimated proportion of population aged 5-16 with conduct disorder (%)	Estimated proportion of population aged 5-16 with emotional disorder (%)	Estimated proportion of population aged 5-16 with hyperkinetic disorder (%)
England	9.6	5.8	3.7	1.5
Derbyshire	9.3	5.6	3.7	1.5

Source: PHE estimated from 2004 ONS Survey, using 2013 population data

Table 28: Estimated number of children in Derbyshire with a mental health disorder, 2011

	Estimated number aged 5-10 yrs with mental health disorder		Estimated number aged 11-16 yrs with mental health disorder		Estimated number aged 5-16 yrs with mental health disorder	
	Boys	Girls	Boys	Girls	Boys	Girls
Derby City	951	441	1,200	927	2,151	1,368
Derbyshire	2,570	1,233	3,538	2,748	6,108	3,981
Amber Valley	410	190	549	445	959	635
Bolsover	249	124	343	276	592	400
Chesterfield	328	157	479	367	807	524
Derbyshire Dales	239	112	328	243	567	355
Erewash	371	179	504	391	875	570
High Peak	312	150	428	338	740	488
North East Derbyshire	300	154	428	334	728	488
South Derbyshire	361	167	479	354	840	521

Source: National Child and Maternal Health Intelligence Network using prevalence estimates by Green (et al) 2004.
NB Numbers will differ in combined age groups as rates are different.

3.2.2.1 Emotional Health Survey among Year 8 students

An online, anonymous survey was conducted with year 8 pupils in Derbyshire between May and July 2015. A total of 2,234 young people from twenty one schools completed the survey, representing 27% of the year 8 population in Derbyshire.

Of the respondents, 41% reported feeling happy on most days, 50% feeling OK on most days and 9% reported feeling sad on most days. In addition, 12% of respondents reported experiencing strong

feelings of anger every day, and 26% of respondents reported that they never or rarely felt optimistic about their future.

The survey also highlighted societal pressures experienced by young people, with a quarter of respondents reporting that they are not happy with their appearance, and nearly one in three having felt pressure to look a certain way.

3.3 Prevalence of mental illness in adults

3.3.1 Common mental health problems

There are an estimated 96,000 adults aged 16-74 in Derbyshire with a common mental health disorder. Prevalence varies by CCG, with the estimated prevalence in Erewash, Hardwick and North Derbyshire CCGs in the lowest national quartile, and Southern Derbyshire CCG in the second lowest quartile.

The modelling on which these estimates are based is now a number of years old. No update to the model has been undertaken and therefore these estimates do not take account of any recent change in socio-demographic factors that would impact on the prevalence of depression and anxiety disorders within a locality.

Table 29: Estimated prevalence of common mental health problems, aged 16-74, by CCG

	Estimated % of population aged 16-74 years with a common mental health problem (n)	National quartile (1=lowest prevalence)
England	15.6 (-)	-
Erewash CCG	12.1 (8,409)	1
Hardwick CCG	11.9 (9,553)	1
North Derbyshire CCG	12.1 (24,268)	1
Southern Derbyshire CCG	13.4 (50,376)	2
Glossop practices	12.1* (3,836)	-

* estimated prevalence of Tameside and Glossop CCG

Source: CCG estimates, Common Mental Health Disorders Tool

Applying the model used above to the district populations provides an estimated figure of 109,306 adults with a common mental health problem in Derbyshire. The district estimates include individuals aged 75 years and over and hence are higher than the CCG estimates above. The estimated prevalence of common mental health problems at a district level ranges from 10.6% in Derbyshire Dales to 15.9% in Derby City.

Table 30: Estimated prevalence of common mental health problems, by district

District	Estimated proportion of adults with a common mental health problem (n)
Amber Valley	11.8 (11,713)
Bolsover	12.4 (7,577)
Chesterfield	15.6 (12,813)
Derby City	15.9 (30,710)
Derbyshire Dales	10.6 (6,178)
Erewash	14.7 (13,144)
High Peak	13.0 (9,389)
North East Derbyshire	11.4 (9,230)
South Derbyshire	11.1 (8,552)

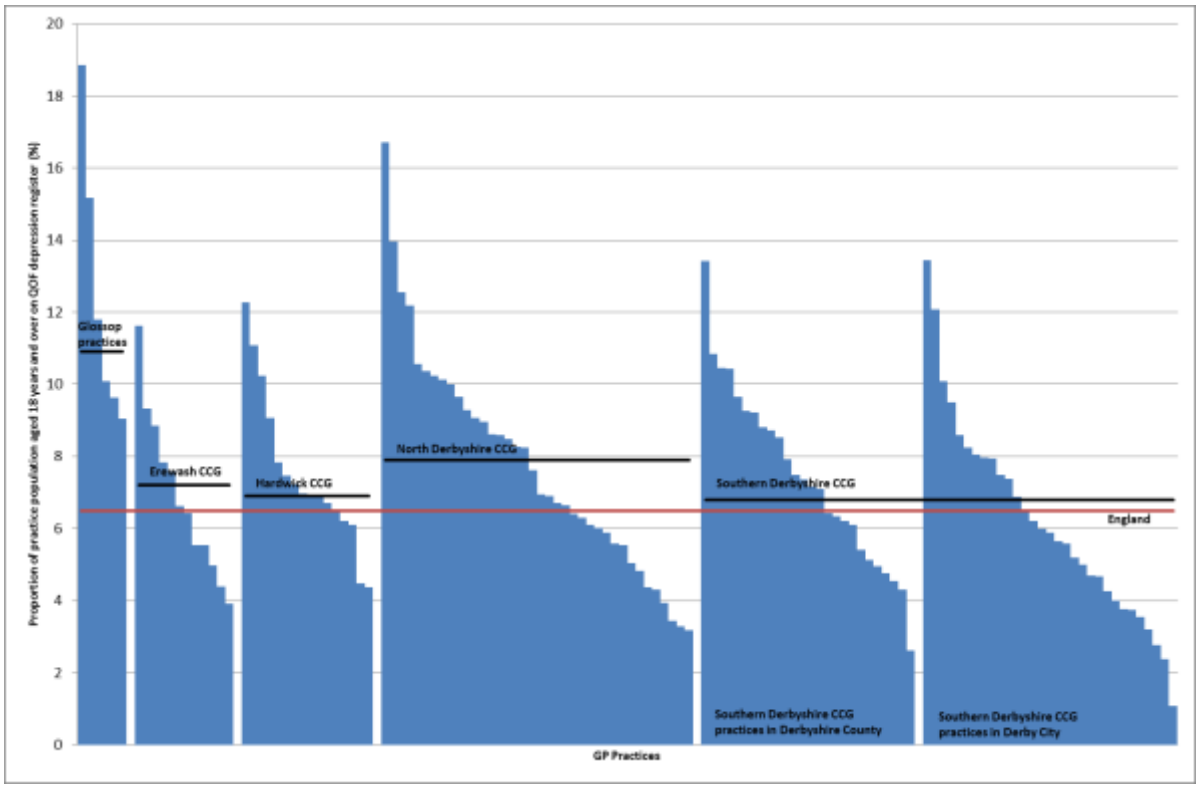
Source: Public Health England

3.3.1.1 Quality and Outcomes Framework depression register

As part of the Quality and Outcomes Framework, GP practices maintain a register of individuals with depression. In 2013/14 there were 61,552 adults aged 18+ on the registers, an overall prevalence of 7.3%. The GP practices in Glossop (10.9%), North Derbyshire (7.9%), Erewash (7.2%), Hardwick (6.9%) and Southern Derbyshire CCGs (6.8%) had a significantly higher prevalence of patients on the depression register compared to England (6.5%).

There is variation between GP practices in the proportion on the depression register, ranging from 2.4 to 18.9% of the practice population. Some of this variation will be due to higher prevalence, but will also reflect varying levels of ascertainment and recording between practices.

Figure 5: Proportion of practice population on depression register, 2013/14



Source: Quality and Outcomes Framework

3.3.1.2 Annual patient survey

The annual GP patient survey is sent annually to over 1 million people across the UK, and includes questions on self-reported health.

In 2012/13, 12.0% of respondents nationally self-reported experiencing moderate, severe or extreme anxiety or depression. Hardwick and Southern Derbyshire CCGs had a significantly higher proportion, and Erewash and North Derbyshire CCGs had a similar proportion of respondents reporting being anxious and depressed compared to England.

The difference between the proportion of patients on the QOF depression prevalence and the self-report prevalence from the GP survey is probably due to patients with long term conditions (for whom there is an increased prevalence of depression and anxiety) being more likely to respond to the GP patient survey, and an under-recording of depression in general practice

Table 31: Self-reported prevalence of moderate, severe and extreme depression and anxiety and QOF depression prevalence by CCG, 2013/14

	Self-reported prevalence in GP patient survey (%)	Range by GP practice (%)	Proportion of practice population on QOF depression register (%)	Range by GP practice (%)
England	12.0	-	6.5	-
Erewash CCG	12.4	8-20	7.2	3.9-11.6
Hardwick CCG	14.6	8-19	6.9	4.5-12.3
North Derbyshire CCG	12.3	5-22	7.9	3.2-16.7
Southern Derbyshire CCG	12.8	4-24	6.8	2.4-13.4
Glossop practices	13.8	5-16	10.9	9.6-18.9

Sources: Quality and Outcomes Framework (QOF), GP Patient Survey

3.3.2 Psychosis

The prevalence of psychosis amongst those aged 16 years and over in England is estimated to be 0.4%. Applying this prevalence to the local population equates to an estimated 3,408 adults with a psychotic disorder in Derbyshire. Prevalence varies by CCG, being lowest in North Derbyshire CCG, and highest in Southern Derbyshire CCG.

As part of the Quality and Outcomes Framework, GP practices maintain a register of individuals with schizophrenia, bipolar affective disorder and other psychoses. In Derbyshire in 2013/14 there were 8,446 individuals recorded on the registers. The prevalence in Erewash and Southern Derbyshire CCGs was significantly lower than England and Hardwick and North Derbyshire CCGs had a similar prevalence to England. There was a range in the recorded prevalence across GP practices in Derbyshire, from 0.32 to 1.81%. Some of the variation will be explained by differences in the true prevalence of serious mental illness between practices, but under-indentifying and under-recording will also contribute towards the observed variation.

The reasons for the difference between the modelled estimates and recorded prevalence at GP practices is not clear, but may be due to the modelled data being an estimate of those experiencing psychosis in the previous year, whilst the QOF register provides an estimate of the lifetime prevalence of psychosis.

Table 32: Estimated and recorded prevalence of psychosis in Derbyshire, by CCG

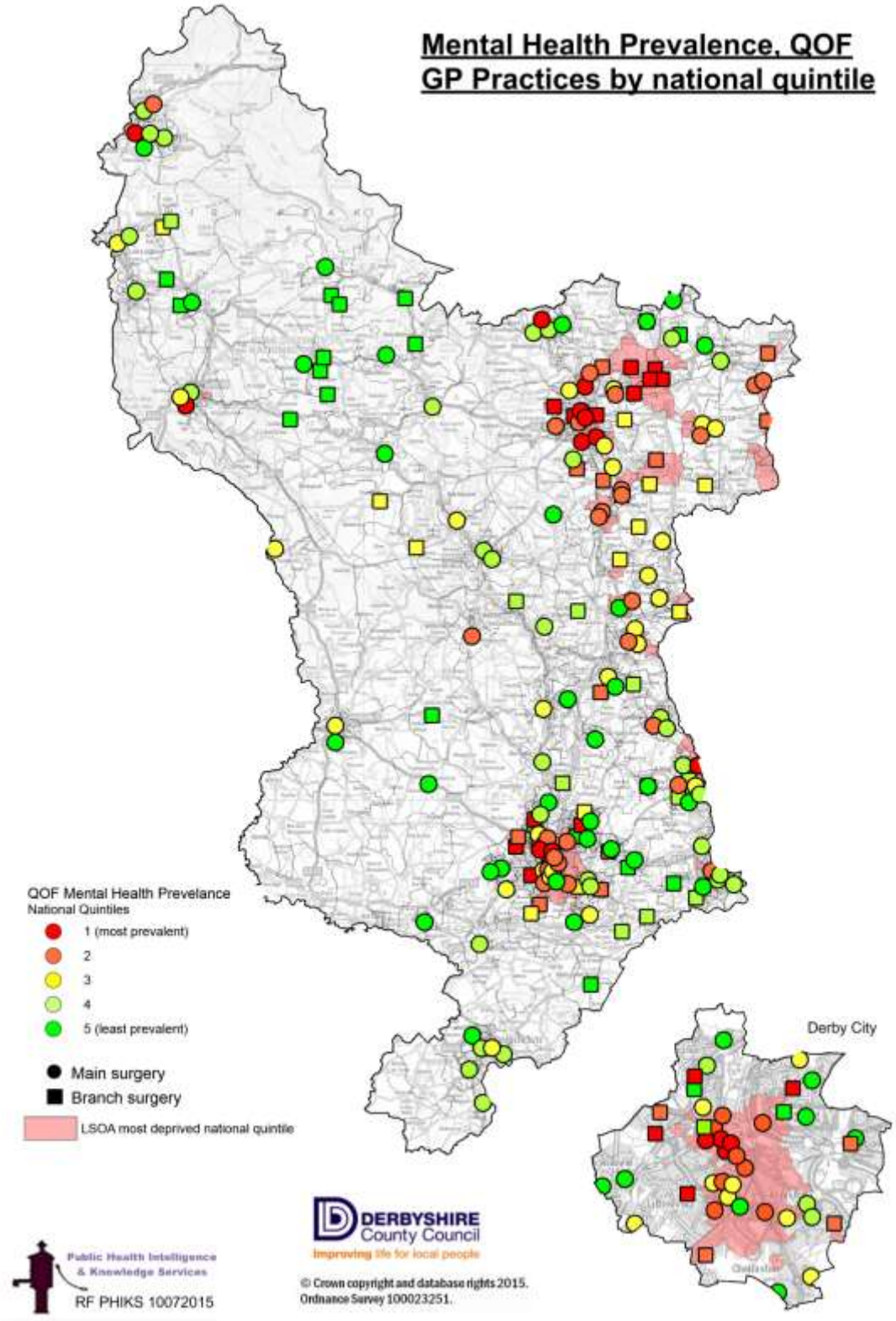
	Estimated proportion (%) of population aged 16 years and over with a psychotic disorder (n)	National quartile (1=lowest prev.)	Proportion (%) of practice population on QOF SMI register (n)	QOF SMI register prevalence range by practice (%)
England	0.40 (-)	-	0.86 (-)	-
Erewash CCG	0.41 (317)	3	0.73 (712)	0.40 – 1.46
Hardwick CCG	0.38 (339)	2	0.87 (889)	0.66 – 1.13
North Derbyshire CCG	0.35 (798)	2	0.88 (2,559)	0.33 – 1.71
Southern Derbyshire CCG	0.47 (1,954)	4	0.76 (4,071)	0.32 – 1.81
Glossop practices	0.45* (143)	3*	0.68 (215)	0.33 – 1.43

* estimated prevalence of Tameside and Glossop CCG

Sources: Quality and Outcomes Framework and PHE

There is an association between higher prevalence of serious mental illness and areas with the highest levels of socio-economic deprivation. Figure 6 shows that GP practices with the highest prevelance of serious mental illness are generally found in areas with higher socio-economic deprivation. This association may be due to a causative link between serious mental illness and deprivation, or because having a serious mental illness can lead to reduced social and economic opportunities.

Figure 6: Prevalence of serious mental illness as defined by Quality and outcomes Framework by GP practice, 2013/14



[NB Prevalence is aggregated for the total practice population, and therefore it is not possible to determine prevalence for patients registered at a branch surgery. The prevalence of branch surgeries as indicated on the map are therefore indicative of the prevalence of the total patient population for both the main and branch surgeries.]

Within Derbyshire, there are an estimated 81 individuals who have a first episode of psychosis each year. This incidence is significantly lower than England. Due to small numbers of individuals with a first episode of psychosis at a district level, all districts in Derbyshire have an incidence similar to the national figure, with the highest incidence being in Derby City and Chesterfield.

Table 33: First episodes of psychosis, by district, 2011

	Incidence per 100,000 population aged 16-64 years	Number of first episodes of psychosis
England	24.2	-
Derby City	25.7	41
Derbyshire County	16.6	81*
Amber Valley	12.5	16
Bolsover	17.6	9
Chesterfield	18.1	12
Derbyshire Dales	14.7	6
Erewash	17.3	12
High Peak	16.1	9
North East Derbyshire	15.7	10
South Derbyshire	16.5	10

* not sum of district counts due to rounding

Source: www.psymaptic.org

3.3.3 Personality disorders

The prevalence of antisocial personality disorder and borderline personality disorder among adults aged 16 to 74 years in England is estimated to be 0.3% and 0.4% respectively. Applying the national prevalence figures to the population of Derbyshire provides an estimated local count of 1,712 adults with antisocial personality disorder and 2,283 adults with borderline personality disorder.

3.3.4 Eating disorders

The national prevalence of adults aged 16 years and over screening positive for an eating disorder is 6.4%. Applying this rate to the Derbyshire population, without adjustment for differing needs in the local population, provides an estimated local count of 38,179 adults with an eating disorder.

3.3.5 Post-traumatic Stress Disorder

The overall prevalence of Post-traumatic Stress Disorder (PTSD) in the adult population of England is 3.0%. Applying this rate to the Derbyshire population, without adjustment for differing needs in the local population, provides an estimated local count of 17,576 adults with PTSD.

3.3.6 Co-existing substance misuse and mental health issues

Robust estimates on the numbers of individuals with concurrent mental health and substance misuse problems are not available.

3.4 Self-harm

Self-harm can be a way of coping with, or expressing mental or emotional distress. There is also a clear association between self-harm and suicide, with half of all people who die by suicide having a history of self-harm. However not all incidents of self-harm is an indication of a wish to die.

Between 1 in every 12 and 15 individuals aged 10-24 self-harm, equating to between 6,087 and 7,608 individuals in Derby City, and 15,662 and 19,577 in Derbyshire. Among adults, the prevalence of self-harm is estimated to be between 3 and 5%. There is significant variation by age, with young women aged 16 to 24 years having an estimated prevalence of 17.6%

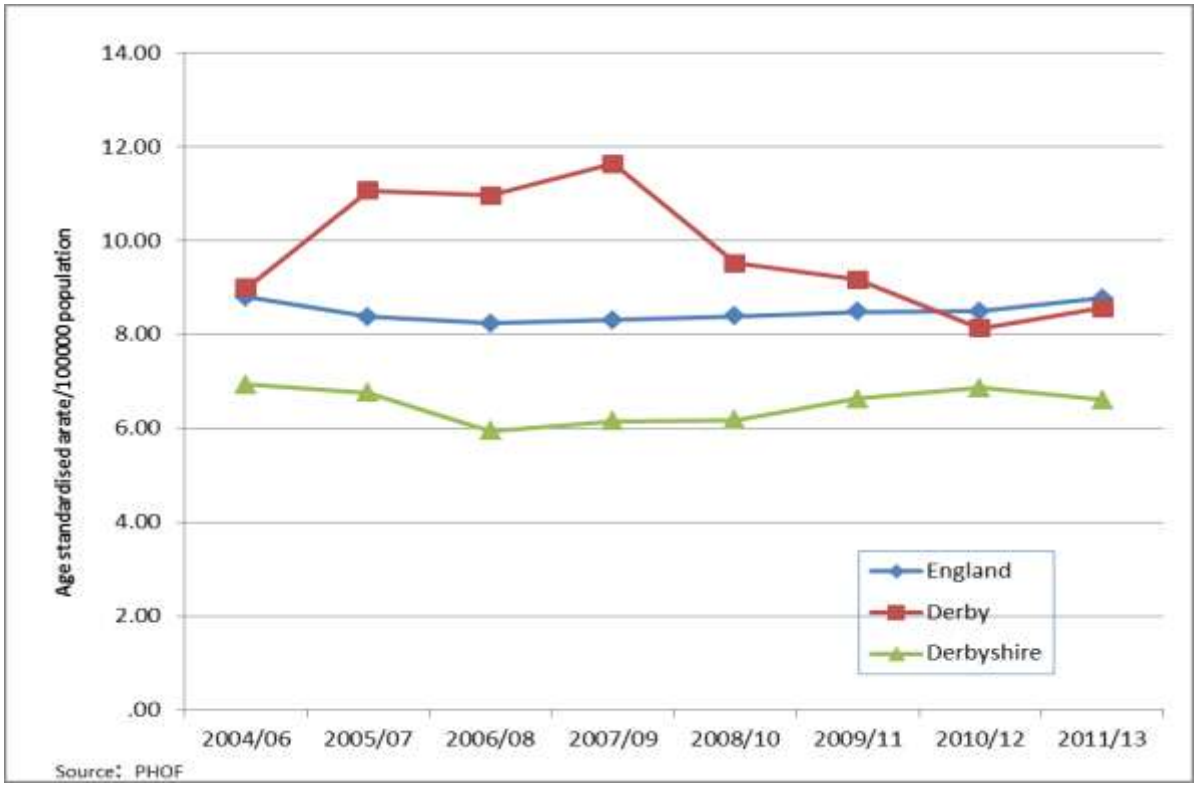
3.5 Suicide

The technical definition of a suicide differs between young people and adults. Amongst adults, data includes deaths from "injury of undetermined intent, whether accidentally or purposely inflicted", therefore including deaths where there is insufficient evidence to prove that the deceased deliberately intended to end their life. However, amongst under-15's the data only includes deaths where there is sufficient evidence of suicidal intent. The published statistics on suicides amongst young people may therefore appear to be lower than local intelligence would indicate. Verdicts of suicide are not returned for children under the age of 10 years.

A detailed analysis of all suicides in Derbyshire and Derby City in 2013 is available here, http://observatory.derbyshire.gov.uk/IAS/Custom/Resources/HealthandWellbeing/Health_Equity_Audits/Suicides_Derby_Derbyshire_2013_update.pdf. Derbyshire had a significantly lower rate of suicides compared to England, and Derby City a similar rate. There were 68 suicides in 2013, with 48 in Derbyshire County and 20 in Derby City. Three quarters of the completed suicides were males, and the highest proportions occurred in the 40 to 60 age groups. Provisional data for 2014 suggests that there has been an increase in the number of suicides across Derby City and Derbyshire, with a larger increase observed in Derbyshire.

The numbers of suicides reported in young people is very small. Between 2009 and 2013, there were nine suicides in males and four in females aged 11 to 17 years old across the East Midlands. Between 2010 and 2013 there were four deaths from suicide in Derbyshire (excluding Glossop for which data is not known) amongst 10 to 19 year olds.

Figure 7: Age standardised rate of suicide and injury undetermined



3.6 Premature mortality of adults with a serious mental illness

There is extensive published evidence that individuals with serious mental illness die approximately 20 years earlier than the general population. Information relating to premature mortality in people with a serious mental illness is expressed as an indirectly standardised ratio that compares the under-75 mortality rate amongst those who have been in contact with secondary mental health services in the previous three years with those who have not. A value greater than 100 demonstrates higher mortality in that population group.

The national data suggests that the premature mortality rate of individuals with a serious mental illness is approximately three and a half times higher amongst people with a serious mental illness. The figure for Derbyshire suggests that the premature mortality rate of individuals with a serious mental illness is approximately three times higher amongst people with a serious mental illness. For technical reasons, no significance comparisons can be made between the local and national values.

Table 34: Premature mortality (under 75 years) amongst individuals with a serious mental illness

	Indirectly standardised ratio (95% confidence intervals)
England	347.2 (342.6, 351.8)
Derby City	302.7 (239.7, 377.3)
Derbyshire	289.7 (257.4, 324.9)

Source: HSCIC

4 Use of Mental Health services

4.1 Children and young people's service use

A higher proportion of children and young people with anxiety or depression are not in contact with mental health services compared to adults. Among those aged 5 to 15 years, 76% with anxiety or depression are not in contact with a mental health services, compared to 35% of adults.

Barriers, such as stigma, autonomy, transport and perception of services are difficult for young people to overcome, and are often combined with a high demand for the service once they have asked for help. Accessing services can sometimes be particularly difficult for vulnerable children and young people as there can be additional barriers to prevent them from accessing the help they need.

4.1.1 Admissions in children and young people

There were 132 admissions for mental illness among young people in Derbyshire in 2013/14. The admission rate is similar in Derbyshire compared to England. The rate of admissions for self-harm is significantly higher in Derbyshire compared to England, with 1,611 admissions of individuals aged 10 to 24 years.

Nationally there has been a large increase in the number of young people being admitted to hospital because of self-harm, and over the last ten years the rate has increased by 68%. Rates of admission for self-harm are significantly higher in Chesterfield and North East Derbyshire compared to England.

Table 35: Hospital admissions amongst young people for mental illness (2013/14) and self-harm (2010/11-2012/13)

	Admissions due to mental illness (per 100,000 population aged 0-17)	Admissions for self-harm (per 100,000 population aged 10-24)
England	87.2	352.3
Derby	60.5	527.1
Derbyshire	85.3	410.7
Amber Valley	-	355.5
Bolsover	-	408.5
Chesterfield	-	617.9
Derbyshire Dales	-	340.1
Erewash	-	344.7
High Peak	-	182.4*
North East Derbyshire	-	494.4
South Derbyshire	-	343.6

* this data does not include self-harm admissions from the Glossop area and will therefore under-estimate admissions in High Peak
Source: HES data for high level areas, SUS data for local districts for self-harm admissions

4.1.2 Access to Children and Adolescent Mental Health Services (CAMHS)

Since the publication of *Together We Stand* report in 1995, CAMHS have been arranged in a tiered system. Each part of the tier is commissioned by a different organisation or jointly commissioned by different organisations.

Tier 1 (Universal services): these are not 'mental health services' but universal provision that work with young people, including GPs, health visitors, schools, early years' provision and others. Universal services are commissioned by CCGs and Local Authorities and schools themselves, and may be provided by a range of agencies. There is no information on access to or outcomes from Tier 1 services.

Tier 2 (Targeted services): includes support for children and young people with milder problems and may be delivered by professionals who are based in schools or in children's centres. Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing mental health problems (e.g. youth offending teams and looked after children's teams, paediatric psychologists based in acute care settings, primary mental health workers, educational psychologists and counselling provided by schools/voluntary sector). Targeted services are commissioned by CCGs, Local Authorities and schools, and are provided by a range of organisations.

Tier 3 (Specialist services): these are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. Access to the team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral. These services are commissioned by CCGs although there may be a contribution from Local Authorities.

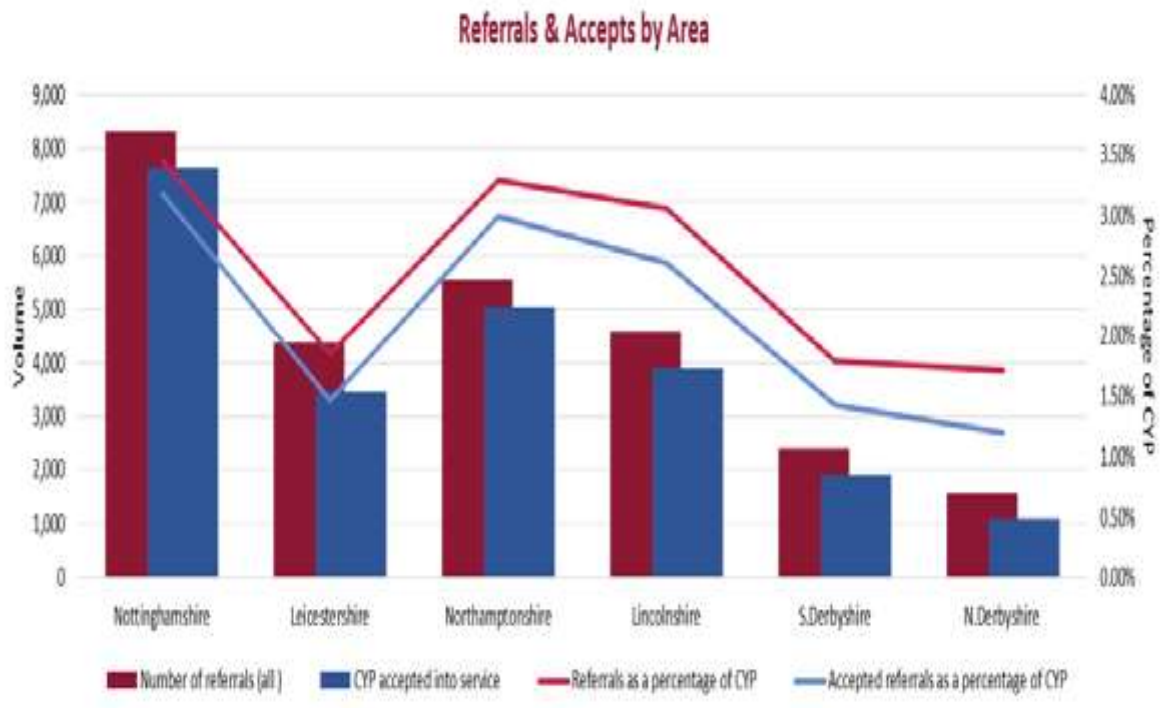
Tier 4 (Specialised CAMHS): these include day and inpatient services and some highly specialist outpatient services including children and young people with gender dysphoria, children and young people who are deaf, highly specialised autism spectrum disorder (ASD) services, and highly specialised obsessive compulsive disorder services. These services are commissioned directly by NHS England.

4.1.2.1 Access to tier 2 and 3 services

It has been recognised nationally that there is an issue with the quality of CAMHS data. Differing data systems, the type of data collected and recorded, and variations in service requirements have made comparisons of services difficult. The Health and Social Care Information Centre is developing a new Mental Health Services data set (MHSDS) that will incorporate CAMHS data as well as data sets relating to Children and Young People's Improving Access to Psychological Therapies (CYP IAPT). This will begin in February 2016.

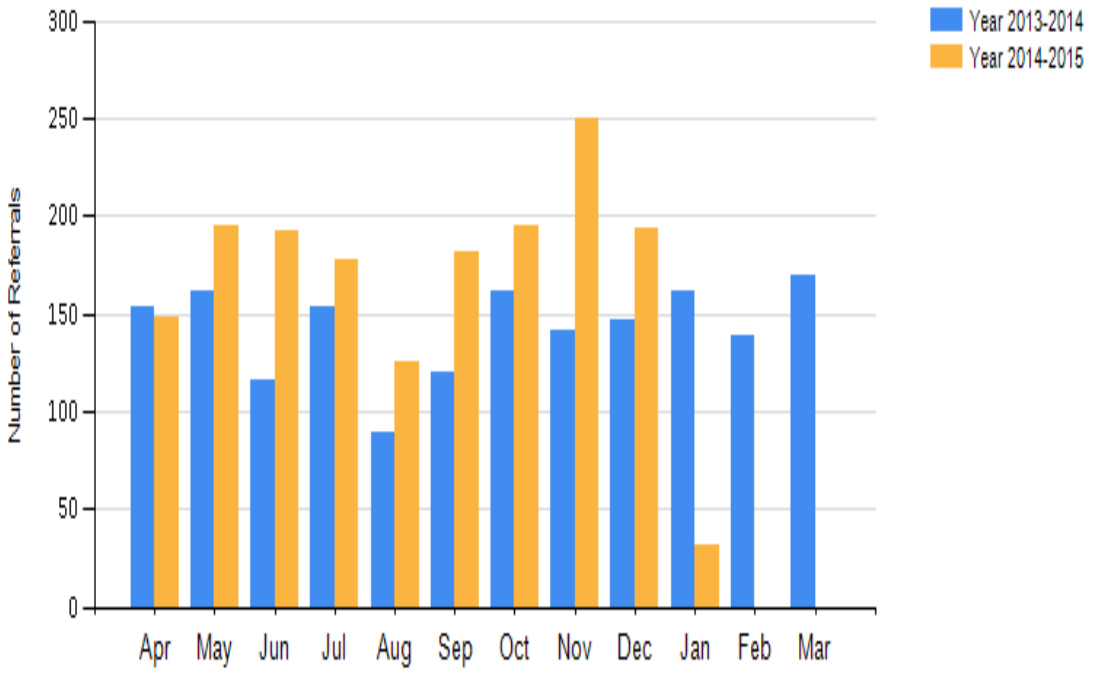
There is therefore very limited information available at the moment that allows for CAMHS services locally to be compared against national or other benchmarks. Compared to other areas in the East Midlands, Derbyshire has a lower volume of referrals to CAMHS, with approximately 2% of children and young people referred. The reasons for the differences are not clear, but contributing factors may include differences in need, differences in Tier 1 provision or differences in referral criteria.

Figure 8: Referrals and Acceptance into tiers 2 and 3 CAMHS Services across the East Midlands, 2014



Between April and December 2014, there were 1,271 referrals to CAMHS in south Derbyshire, an increase on the previous year.

Figure 9: Referrals to tier 2 and 3 services in south Derbyshire and Derby City



Source: East Midlands Community CAMHS Mapping Project 2015

In north Derbyshire, there were 1,709 referrals to CAMHS in 2014/15, of which 1,208 (70.7%) were accepted into the service. Approximately two thirds (63.4%) of those accepted were supported by tier 3 services.

4.1.2.2 Access to tier 4 services

There are no tier 4 services within Derbyshire, which means that young people from Derbyshire in need of tier 4 services could be placed anywhere within England. It is believed that generally young people from Derbyshire will receive treatment either in Sheffield or elsewhere in the East Midlands. Implementation of a new data base in November 2015 will provide additional information, including where young people are placed and their length of stay.

In 2014/15, 83 young people from Derbyshire were admitted to Tier 4 services. There has been an increase in the numbers accessing tier 4 services over the last three years, a pattern replicated across the East Midlands. The reasons for this increase are not clear.

Table 36: Admissions to Tier 4 CAMHS services by county 2012/13 to 2014/15

	Rate of admissions (per 100,000 young people)		
	2012/2013 (n)	**2013/2014 (n)**	**2014/2015 (n)**
Derbyshire County	35.0 (26)	49.8 (37)	111.7 (83)
Leicestershire County	24.8 (18)	84.0 (61)	106.0 (77)
Lincolnshire County	127.9 (65)	159.4 (81)	169.2 (86)
Northamptonshire County	99.1 (51)	114.7 (59)	149.7 (77)
Nottinghamshire County	49.5 (38)	71.6 (55)	108.1 (83)

Source: NHS England and population estimates 2013

4.1.3 Children and Young People's Improving Access to Psychological Therapies (CY IAPT)

Derbyshire Healthcare Foundation Trust is part of the 5 year pilot programme of Children and Young People's Improving Access to Psychological Therapies (CY IAPT). The programme works to transform services, use routine outcome monitoring, empower young people and their carers and improve access to evidence based therapies.

As the programme is in the early implementation stages there is limited local and national service data. Early results show that CAMHS has seen a 12% reduction in the overall length of time of time spent in treatment as a direct result of the implementation of CY IAPT.

Currently CY IAPT is only available in the South of the County (including Derby City) although Chesterfield Royal Hospital has applied for CYIAPT status and if successful will begin workforce training in 2016.

4.1.4 Multi-systemic therapy (MST)

Multi-systemic therapy (MST) is an evidence-based, community-based, family-driven treatment for antisocial behaviour in young people of secondary school age that places them at risk of an out-of-

home placement. These young people are at increased risk of mental health problems currently and in the future.

Within Derbyshire, the team became operational in June 2013 and since implementation:

- 38 young people have received a service, with 28 completing treatment, 8 not completing and 2 not engaging with the service
- 32 young people remained at home, 29 remained in school or work and 31 were not charged with new offences

4.2 Service use by adults

4.2.1 Primary care services

4.2.1.1 Primary care prescribing

Prescribing of anti-depressants in Derbyshire is highest in Hardwick CCG and North Derbyshire CCG. No statistical significance is attached to the data and therefore it is not possible to determine whether there is any significant variation in prescribing. Hardwick and North Derbyshire CCGs are in the highest national quintile for prescribing, and Erewash and Southern Derbyshire CCGs in the third quintile.

Generic selective serotonin reuptake inhibitors (SSRI) are recommended as first-choice treatments as they are as effective as other anti-depressants and have a favourable risk–benefit ratio. Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs all had a higher proportion of anti-depressant prescription items that were first choice generic SSRIs, compared to England. No statistical significance is attached to the data and therefore it is not possible to determine whether there is any significant variation in prescribing. Hardwick and Southern Derbyshire CCGs were both in the highest national quintile, and Erewash and North Derbyshire CCGs in the second highest quintile for use of first choice anti-depressants.

There is also variation in the primary care prescribing for psychoses and related conditions. Hardwick CCG has the highest rate, and Erewash CCG the lowest. No statistical significance is attached to the data and therefore it is not possible to determine whether there is any significant variation in prescribing. This prescribing indicator is not weighted for age, and also only relates to items prescribed in primary care.

Table 37: Primary care prescribing, by CCG, (2014/14 for anti-depressant prescribing and Q2 2014/15 for items prescribed for psychosis)

	Anti-depressant prescribing (ADQs per STAR-PU)	Use of first choice anti-depressants (%)	Number of items prescribed for psychosis (per 1,000 popn)
England	1.2	63.5	45.7
Erewash CCG	1.2	66.2	36.3
Hardwick CCG	1.6	68.4	54.6
North Derbyshire CCG	1.5	65.6	49.5
Southern Derbyshire CCG	1.2	70.3	36.5

Source: Public Health England

4.2.1.2 Improving Access to Psychological Therapy (IAPT) services

Psychological therapies are effective, evidence-based interventions for a range of common mental health problems. Improving Access to Psychological Therapy (IAPT) services were established in England in 2006, and complete provision was established across Derbyshire in 2013. The vision for IAPT services is to give greater access to talking therapies for people who would benefit from them.

Between January and March 2015, 7,050 individuals were referred to IAPT services from Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs. Referral rates in Erewash, North Derbyshire and Southern Derbyshire were significantly higher than England, and Hardwick CCG had a rate similar to England. Assuming a crude estimate that 1 in 6 individuals (17%) will be experiencing a common mental health problem at any given point in time, between 4 and 5% of individuals with a common mental health problem and registered with a GP in Erewash, Hardwick, North Derbyshire or Southern Derbyshire CCGs are referred to IAPT each quarter. The local and national trend in referrals has shown a slight increase over the last year and a half.

CCGs are monitored against a requirement for 15% of their population with anxiety or depression to enter IAPT services. In March 2015, performance against this requirement ranged from 27.1% of those estimated to have anxiety or depression in Erewash CCG, to 18.2% in Hardwick CCG. Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs consistently significantly exceed national performance.

A more detailed analysis of inequities in accessing local IAPT services was recently undertaken, with the results available here
http://observatory.derbyshire.gov.uk/IAS/Custom/pages/Health/HealthEvidence/HealthEquityAudit/HEA_IAPT_Summary.pdf

Table 38: Rate of adults referred to, and entering IAPT services, March 2015

	IAPT referral rate (per 100,000 popn aged 18+ years)	IAPT entering treatment rate (per 100,000 popn aged 18+ years)	Proportion of popn with anxiety / depression entering IAPT (%)
England	839	564	17.3
Erewash CCG	982	776	27.1
Hardwick CCG	794	537	18.2
North Derbyshire CCG	890	674	26.0
Southern Derbyshire CCG	901	578	20.0

Source: HSCIC

4.2.2 Social care services

In 2013/14 there were 175 new social care assessments for individuals with mental illness in Derbyshire, with a rate significantly lower than the England average. There was also a significantly lower rate of social care clients with a mental health problem receiving services in Derbyshire. The reasons for the variation between local and national reported data requires further investigation, but may reflect differences in the model, organisation and delivery of social care support that results in higher or lower levels of reported activity. For example, Derbyshire's investment in user-led community groups may explain the lower level of day services reported, and the higher level of residential and nursing care use may be explained by the period when social care services were managed by the NHS.

Table 39: Social care service use by people with a mental health problem, 2013/14

	Rate of new social care assessments for mental health clients aged 18 to 64 years (per 100,000 population)	Rate of social care mental health clients receiving services aged 18 to 64 years (per 100,000 population)
England	265	384
Derby	16	675
Derbyshire	38	155

Source: Referrals, Assessments and Packages of Care data

Derbyshire has a significantly lower rate of mental health clients receiving home care and day care social care services compared to England, but a significantly higher rate of social care clients with a mental health problem in residential or nursing care. The rates are not age-standardised and therefore could simply reflect differences in population structure observed between Derbyshire and England.

Table 40: Receipt of social care services for individuals aged 18 to 64 years with a mental health problem, 2013/14

	Social care mental health clients aged 18 to 64 years receiving home care (per 100,000 population)	Social care mental health clients aged 18 to 64 years receiving day services (per 100,000 population)	Social care mental health clients aged 18 to 64 years in residential or nursing care (per 100,000 population)
England	42.2	34.0	31.9
Derby	64.9	3.2	42.2
Derbyshire	20.4	6.4	37.5

Source: Referrals, Assessments and Packages of Care data

4.2.3 Ambulance service attendances

In 2014/15 there were 1,952 attendances by EMAS for mental health problems in Derbyshire, a decrease from the previous year. In approximately two thirds of attendances the individual was conveyed for further assessment, and this rate has remained steady over the last three years. No data from other ambulance trusts is available for comparison.

Table 41: Attendances by ambulance services for mental health problems in Derbyshire 2012/13 to 2014/15

	2012/13	2013/14	2014/15
Attendances	1,876	2,121	1,952
Treated on scene	597	677	614
Conveyed	1,279	1,444	1,338
Proportion conveyed (%)	68.2	68.1	68.5

Source: EMAS

4.2.4 A&E attendances

In 2012/13 in Derbyshire, there were 1,238 A&E attendances for a psychiatric disorder (this figure excludes Glossop). Erewash, North Derbyshire and Southern Derbyshire CCGs have significantly lower attendance rates than England, and Hardwick CCG has a significantly higher rate. The rate in Southern Derbyshire is exceptionally low, being approximately 6 times less than the national rate and may be worth of further investigation.

Nationally, approximately 10% of A&E attendances do not have a valid code, and this may therefore underestimate the attendance rate. In addition, there is variation in data quality between providers and this may explain some of the variation observed.

Table 42: A&E attendances for a psychiatric condition, 2012/13

	Count	Rate per 100,000 population (95% confidence intervals)
England	130,278	243.5 (242.2, 244.9)
Erewash CCG	111	117.3 (96.5, 141.2)
Hardwick CCG	323	296.5 (265.1, 330.7)
North Derbyshire CCG	588	216.1 (199.0, 234.3)
Southern Derbyshire CCG	216	41.9 (36.5, 47.9)

Source: Public Health England

4.2.5 Admissions for self-harm

There were 2,175 emergency admissions to hospital as a result of self-harm in Derbyshire in 2012/13. Admission rates were significantly higher for Hardwick, North Derbyshire and Southern Derbyshire CCGs compared to England, and Erewash CCG had a similar rate.

Table 43: Emergency hospital admissions for self-harm, 2012/13

	Count	Directly standardised rate per 100,000 population (95% confidence intervals)
England	-	191.0 (189.8, 192.2)
Erewash CCG	160	166.9 (141.9, 195.0)
Hardwick CCG	270	253.0 (223.6, 285.2)
North Derbyshire CCG	574	220.5 (202.6, 239.5)
Southern Derbyshire CCG	1,171	221.3 (208.8, 234.4)

Source: Public Health England

4.2.6 Specialist mental health service use

As of September 2014, there were 19,125 people in contact with adult specialist mental health services (community and hospital-based services) across the four CCGs. The rate of contact with specialist mental health services was significantly higher for Hardwick and North Derbyshire CCGs, and significantly lower in Erewash CCG compared to England. In 2013/14, use of specialist mental

health services was higher in Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs compared to England. In the first two quarters of 2014/15 use reduced in Erewash and Southern Derbyshire CCGs to a level comparable with England, but remained significantly higher in Hardwick and North Derbyshire CCGs.

Of the four Derbyshire CCGs, Hardwick and North Derbyshire CCGs have the highest recorded prevalence of serious mental illness in primary care. However, this prevalence is similar to the national average and therefore will not explain the high service use in Hardwick and North Derbyshire CCGs. Possible explanations for this variation would include under-recording of prevalence in primary care, individuals continuing to receive specialist mental health treatment for a long period of time or a low threshold for access to specialist mental health services.

Mental health admissions to hospital also vary significantly by CCG. Erewash and Hardwick CCGs have a significantly lower rate than England, and North Derbyshire CCG has a significantly higher rate. The proportion of mental health service users who were inpatients also varies across Derbyshire. North Derbyshire CCG has a significantly lower proportion of service users as inpatients, whereas Hardwick and Southern Derbyshire CCGs have significantly higher proportions compared to England.

Table 44: Use of specialist mental health services in Derbyshire, by CCG, September 2014

	People in contact with adult mental health services (per 100,000 population)	**Mental health admissions to hospital (per 100,000 population)**	**% of mental health service users who were inpatients in a psychiatric hospital**
England	2,177	69.8	2.5
Erewash CCG	1,911	49.8	2.4
Hardwick CCG	2,600	42.9	3.7
North Derbyshire CCG	3,055	88.5	1.9
Southern Derbyshire CCG	2,213	64.7	3.0

Source: Public Health England

Under the Mental Health Act, individuals can be formally detained in hospital for their own, or other people's safety. As of September 2014, there were 335 individuals in specialist adult mental health services in Derbyshire who were subject to the Mental Health Act. The rate of detentions was significantly higher than the national rate in Hardwick and Southern Derbyshire CCGs, and significantly lower in North Derbyshire CCG. The rate in Erewash CCG was similar to the national rate.

A need for repeat detentions under the Mental Health Act would suggest poor quality care, including issues with access to crisis services. In 2012/13, the average number of detentions was just over 1, suggesting few repeat detentions were required in Derbyshire. No statistical significance is attached to the data and therefore it is not possible to determine whether there is any significant variation in repeat detentions, but the figures for Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs appear similar to England.

Table 45: Use of Mental Health Act in Derbyshire, by CCG, (September 2015 for rate of use of Mental Health Act and 2012/13 for repeat detentions)

	People subject to Mental Health Act (per 100,000 population)	Average number of detentions under Mental Health Act
England	39.7	1.16
Erewash CCG	33.2	1.08
Hardwick CCG	62.9	1.11
North Derbyshire CCG	29.5	1.17
Southern Derbyshire CCG	46.8	1.18

Source: Public Health England

4.2.6.1 Section 136 assessments

Police forces can use section 136 of the Mental Health Act to take individuals from a public place to a place of safety for assessment when they appear to be acutely mentally unwell. In Derbyshire, in 2014, there were 68 individuals detained in Derbyshire through use of Section 136 of the Mental Health Act, and 44 between January and May 2015. There was a higher proportion of men detained than women, and the highest proportion of assessments was among 41 to 65 year olds. Between 2014 and 2015 there was an increase in the proportion assessed in a Section 136 suite, and a corresponding reduction in the proportion assessed in a police station. Section 136 suites are seen as a more appropriate setting for an assessment than police custody suites.

Outcomes of the assessment were similar between 2014 and 2015 data, with the highest proportion having no follow-up.

Table 46: Use of Section 136 of Mental Health Act in Derbyshire, 2014 and 2015 to date

	Proportion of those under Section 136 in 2014 (%)	Proportion of those under Section 136, January to May 2015 (%)
Gender		
Male	67.6	58.1
Female	32.4	41.9
Age		
<18	5.7	11.6
18-25	18.6	16.2
26-40	31.4	30.2
41-65	44.3	41.9
Over 65	0	0
Place of assessment		
Section 136 suites	50.0	71.4
A&E/hospital	10.3	4.8
Police station	38.2	19.0
Other	1.5	4.8
Outcomes		
Compulsory admitted	20.6	14.7
Informally admitted	10.3	0
Follow-up by mental health services	10.3	23.5
Follow-up by other services (including substance misuse)	14.7	17.6
No follow-up	44.1	44.1

Source: Adult Social Care, Derbyshire County Council

4.2.6.2 Early Intervention and Assertive Outreach teams

Early Intervention services provide diagnosis and appropriate treatment for the first onset of a psychotic disorder, with individuals supported for approximately three years. Between July and September 2014, there were approximately 130 new cases of psychosis supported by Early Intervention teams in Derbyshire. Erewash and Southern Derbyshire CCGs had significantly lower rates of new cases compared to England. For the same time period, there were approximately 330 individuals being treated by Early Intervention services in Derbyshire. Hardwick and North Derbyshire CCGs had significantly higher rates compared to England. This conflicts with the recorded prevalence of serious mental illness in primary care, where rates in Hardwick and North Derbyshire CCGs are similar to England.

Assertive outreach teams provide intensive support for individuals with severe mental illness who find it difficult to engage with traditional services. Numbers receiving this service in Derbyshire are small, and Hardwick, North Derbyshire and Southern Derbyshire CCGs all have significantly lower

rates of use than England. As there were less than 5 individuals receiving the service in Erewash CCG, the data has not been published.

Table 47: Use of Early Intervention and Assertive Outreach services, by CCG, 2014/15, Q2

	New cases of psychosis served by Early Intervention teams (per 100,000 population)	Rate of people receiving Early Intervention services (per 100,000 population)	Rate of people receiving assertive outreach services (per 100,000 population)
England	23.9	37.5	21.5
Erewash CCG	10.6	26.5	-
Hardwick CCG	25.1	57.1	5.7
North Derbyshire CCG	20.0	49.9	2.3
Southern Derbyshire CCG	14.8	37.0	1.2

Source: Public Health England

5 Service quality and outcome indicators

5.1 Children and young people's mental health services

5.1.1 CAMHS tiers 2 and 3

The *Future in Mind* report and corresponding taskforce groups, reported that there is a need for national service quality outcomes for CAMHS services, and collection of data to monitor these. However, at the moment there is no national data available for comparison. It is acknowledged that there should be as short a time as possible between referral to a service and treatment, whilst acknowledging service capacity. This is particularly important for young people as the time waiting for treatment can affect educational attendance and achievement, which can have significant impact in adult life.

5.1.1.1 South Derbyshire CAMHS

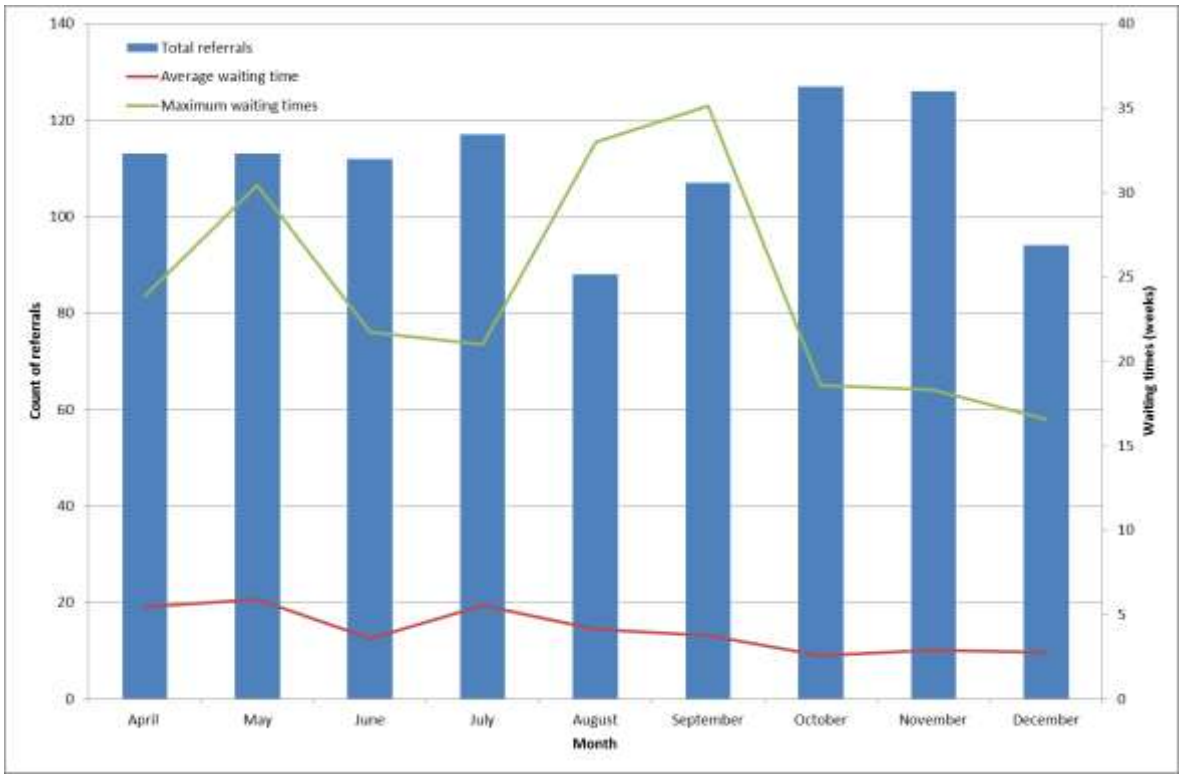
Between April and December 2014, the majority (92.5%) of young people referred to CAMHS services received their assessment within 12 weeks from referral. The mean waiting time from referral to assessment in December 2014 was 2.7 weeks, with the longest wait being 16.6 weeks. The average and longest waiting times have reduced over the nine month period between April and December 2014.

More than three-quarters (79.3%) of young people referred to CAMHS services started treatment within 12 weeks of referral. The mean waiting time from referral to treatment in December 2014 was 6.1 weeks, with the longest wait being 17.7 weeks. The average and longest waiting times have reduced over the nine month period between April and December 2014.

The majority of individuals are in treatment for less than 1 year. For the discharges between April and December 2014, approximately one in five young people were in treatment for more than twelve months, but this proportion appeared to reduce towards the end of the year.

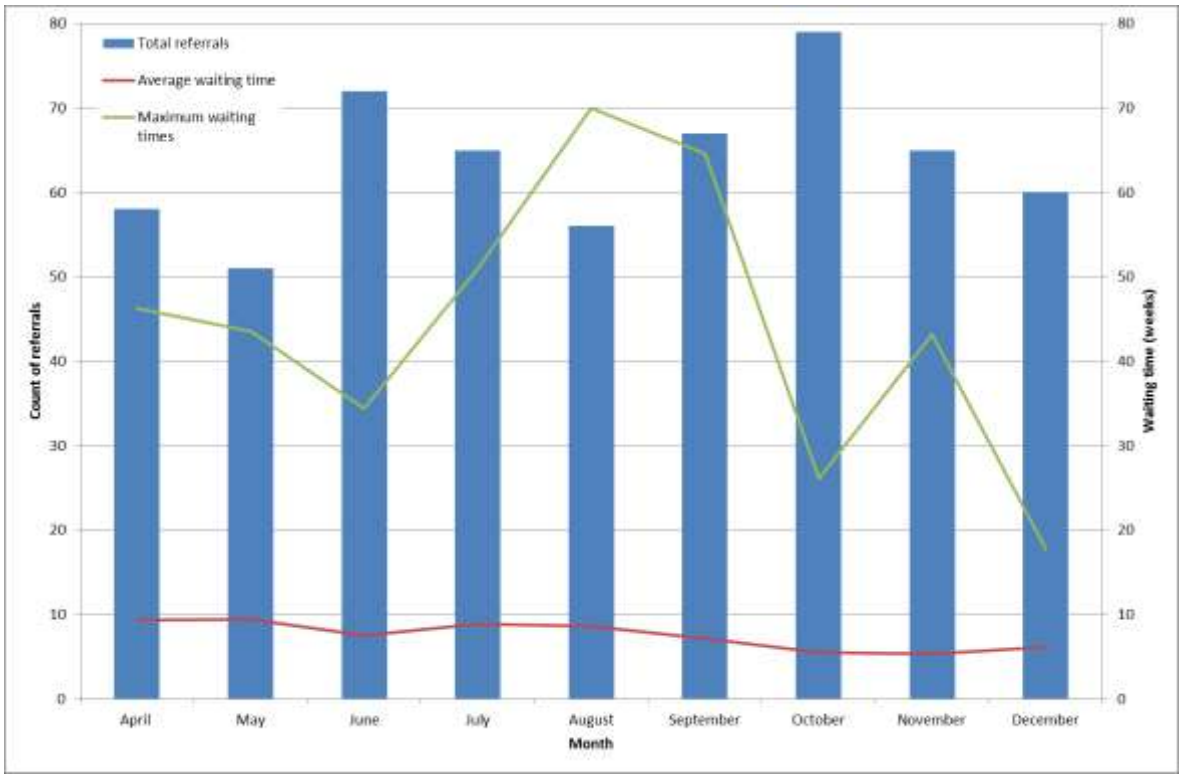
There is no data available on the outcomes from treatment.

Figure 10: Number of referrals, and average and maximum waiting times from referral to assessment for south Derbyshire CAMHS, April to December 2014



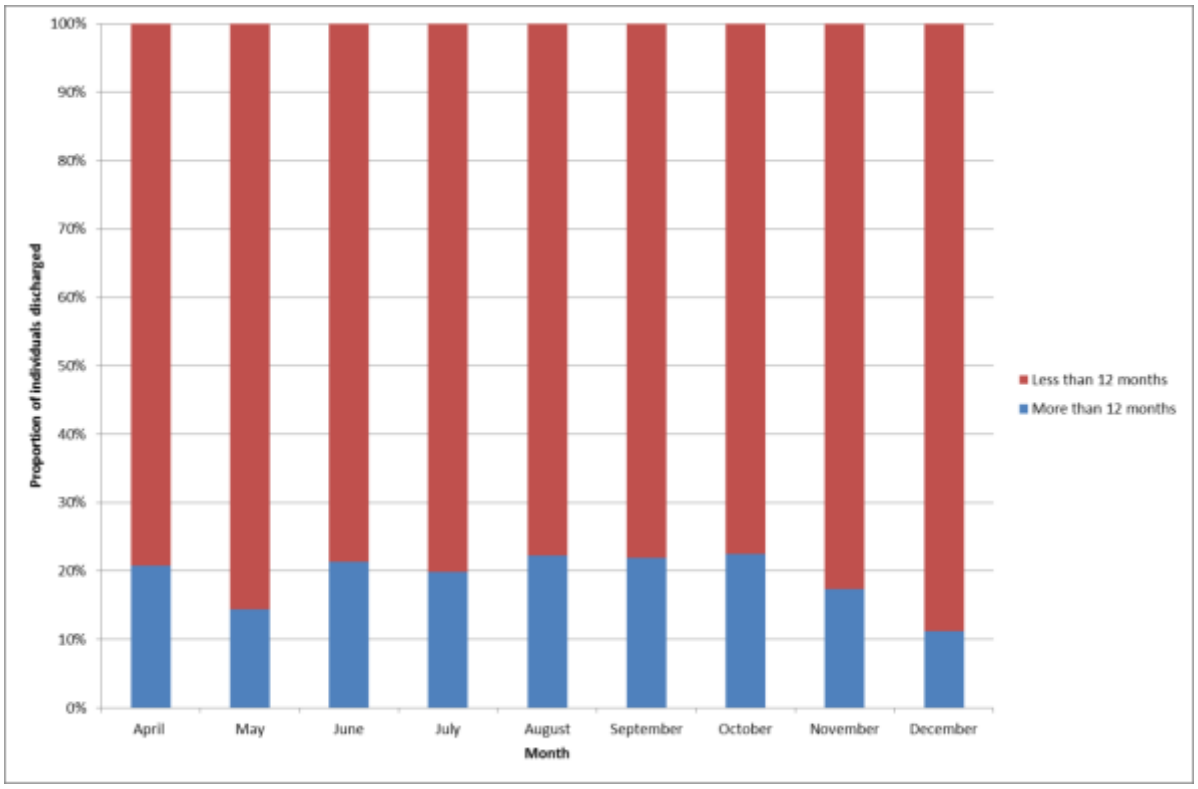
Source: DCHFT

Figure 11: Number of referrals, and average and maximum waiting times from referral to treatment for south Derbyshire CAMHS, April to December 2014



Source: DCHFT

Figure 12: Length of time in treatment for south Derbyshire CAMHS, all discharges between April and December 2014



Source: DCHFT

5.1.1.2 North Derbyshire CAMHS

There is only limited data available for the CAMHS service in north Derbyshire. In 2014/15, the average waiting time between referral and assessment was 6 weeks, and 12 weeks between referral and treatment. The average length of stay in the service was 26 weeks.

There is no information available on outcomes of treatment.

5.1.2 CAMHS tier 4

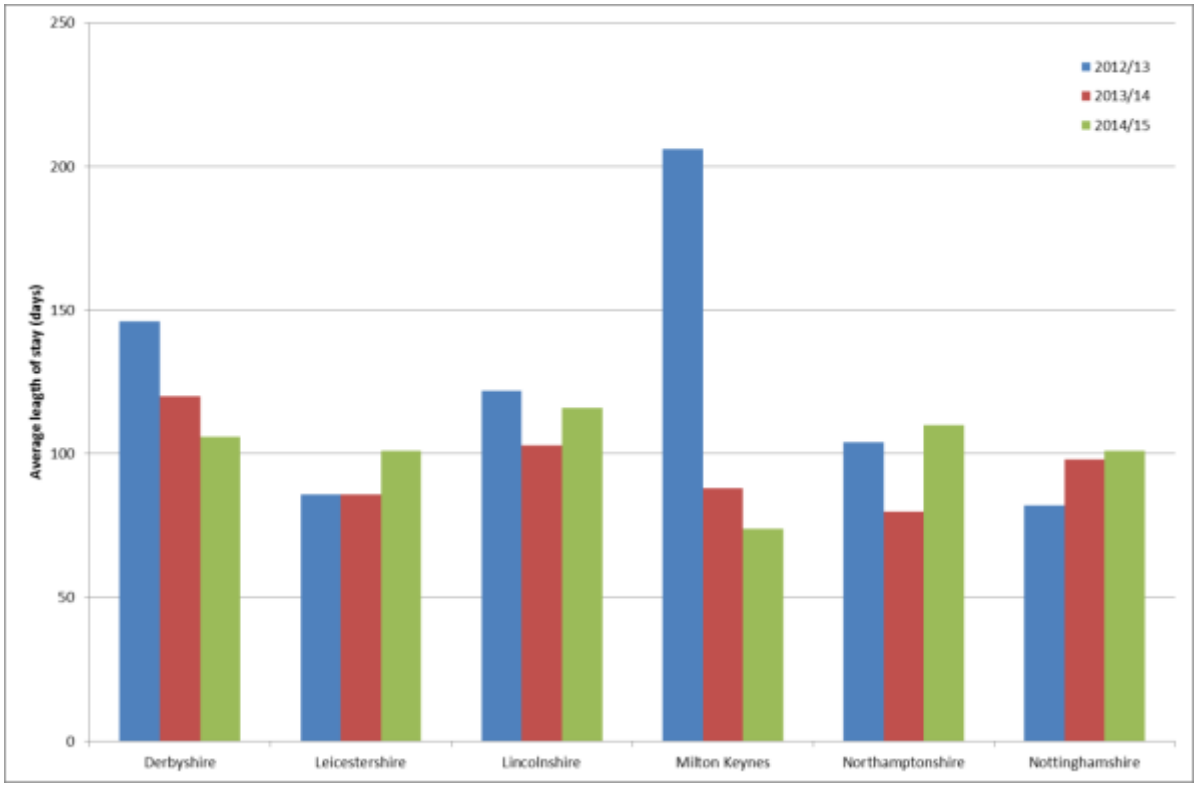
The length of stay in tier 4 services can vary considerably depending on individual diagnosis and need, and may range from a handful of days for an acute admission to eighteen months within a low secure unit or in an eating disorder unit.

There is not a complete picture for length of stay in Tier 4 services for young people registered with Derbyshire GP practices. Information for young people from North Derbyshire treated in Sheffield or Manchester is not available for this report. A national database for tier 4 services was established in November 2014 and should provide clearer and more comparable data in the future.

Due to the relatively small number of young people treated in tier 4 services, an individual with a very long stay can significantly skew the length of stay data. The average length of stay in

Derbyshire in 2014/15 was just over 100 days. There is limited comparison data available, but this figure appears similar to other localities within the region.

Figure 13: Average length of stay in Tier 4 CAMHS services, 2012/13 to 2014/15



5.1.3 Use of adult mental health beds

Since 2010, the Mental Health Act has required that young people under the age of 18 years are not accommodated in an unsuitable environment, which includes an adult ward (unless their particular needs made it absolutely necessary).

Between April and June 2014, there were no days spent on adult wards by young people from Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs. No previous data is available to determine use in previous quarters.

5.2 Adult mental health services

5.2.1 Primary care

There are a number of quality indicators that accompany the Quality and Outcomes Framework depression and serious mental illness registers. The quality indicator accompanying the depression register requires practices to assess individuals on diagnosis, and those accompanying the serious mental illness register cover use of care plans, physical health interventions and monitoring those on lithium therapy.

The Quality and Outcomes Framework allows practices to exception report to ensure that practices are not penalised if they are not able to complete the actions required by the indicator, for example if they are not able to prescribe a medication due to a contra-indication, or if the patient does not attend for a review. There is often therefore a difference between the underlying achievement of practices (which is calculated excluding those patients who have been "exception reported") and the proportion receiving the intervention (which includes all individuals on the disease register).

At a CCG–level, the achievement of assessing those diagnosed with depression was between 87 and 95%, though there was wide variation between practices in achievement and the exception rate.

Table 48: Achievement of Quality and Outcomes Framework depression indicators, 2013/14

	Underlying achievement excluding exceptions (%) (practice range)	**Exception rate (%) (practice range)**	**% of patients receiving intervention (practice range)**
DEP001: The % of patients aged 18 or over with a new diagnosis of depression in the preceding 12 months, who have had a bio-psychosocial assessment by the point of diagnosis			
Erewash CCG	86.8 (10.3-100)	18.0 (4.3-27.8)	71.7 (8.0-91.7)
Hardwick CCG	95.5 (75.0-100)	19.8 (6.5-44.2)	76.5 (51.9-90.8)
North Derbyshire CCG	94.0 (5.3-100)	22.2 (5.1-71.4)	73.0 (4.2-93.4)
Southern Derbyshire CCG	90.7 (0-100)	14.2 (0-86.7)	78.7 (0-100)
Glossop practices	89.2 (54.5-100)	9.0 (3.7-12.2)	81.1 (50.0-90.7)

Source: HSCIC

Use of a comprehensive care plan was lower in the Glossop practices compared to the other CCGs, and there was variation between practices in achievement and the exception rate. For the physical health indicators, underlying achievement for all the indicators was approximately 90% for all CCGs. However, due to the high rate of exception reporting in some practices, the overall proportion of patients who receive the intervention varied by practice and indicator. Indicators with lower implementation were recording cholesterol:hdl ratio, blood glucose and cervical screening uptake. There was a high achievement, and generally low exception reporting, for the management of patients on lithium therapy indicators.

Table 49: Achievement of Quality and Outcomes Framework serious mental illness indicators, 2013/14

	Underlying achievement net of exceptions (%) (practice range)	Exception rate (%) (practice range)	% of patients receiving intervention (practice range)
MH002: The % of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate			
Erewash CCG	91.4 (61.7-100)	16.7 (0-54.3)	76.4 (42.6-100)
Hardwick CCG	87.1 (50.0-100)	11.1 (0-29.4)	77.8 (40.0-95.7)
North Derbyshire CCG	94.1 (61.5-100)	18.1 (0-52.0)	76.8 (48.0-95.0)
Southern Derbyshire CCG	89.8 (14.9-100)	20.3 (0-56.9)	71.3 (14.3-96.9)
Glossop practices	77.3 (9.5-100)	9.3 (0-19.4)	69.2 (9.5-100)
MH003: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months			
Erewash CCG	94.6 (81.5-100)	9.3 (0-25.5)	85.7 (73.4-100)
Hardwick CCG	91.1 (62.5-100)	7.1 (0-20.0)	84.9 (50.0-100)
North Derbyshire CCG	95.6 (80.8-100)	12.8 (0-31.1)	83.2 (67.2-100)
Southern Derbyshire CCG	92.6 (67.3-100)	12.6 (0-33.3)	80.8 (64.6-100)
Glossop practices	94.8 (88.2-100)	5.3 (0-11.5)	89.6 (83.3-96.4)
MH004: The % of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months			
Erewash CCG	87.0 (57.1-100)	16.2 (0-50.0)	73.1 (45.7-100)
Hardwick CCG	89.6 (75.0-100)	14.2 (0-47.4)	76.6 (42.1-100)
North Derbyshire CCG	89.0 (57.1-100)	22.8 (0-75.0)	68.2 (25.0-87.5)
Southern Derbyshire CCG	85.1 (36.8-100)	21.2 (0-100)	66.6 (0-100)
Glossop practices	90.6 (80.0-100)	7.9 (0-25.0)	83.5 (62.5-100)
MH005: The % of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months			
Erewash CCG	91.3 (78.9-100)	13.6 (0-28.6)	78.8 (66.7-100)
Hardwick CCG	89.7 (76.2-100)	12.2 (0-38.2)	78.8 (47.1-100)
North Derbyshire CCG	91.4 (63.2-100)	16.6 (0-38.5)	76.2 (51.3-100)
Southern Derbyshire CCG	88.5 (51.4-100)	16.9 (0-47.8)	73.2 (47.8-100)
Glossop practices	94.9 (89.2-100)	8.4 (0-16.7)	86.8 (78.3-100)
MH006: The % of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months			
Erewash CCG	91.0 (76.2-100)	10.9 (0-34.5)	81.2 (50.0-100)
Hardwick CCG	87.5 (50.0-100)	7.7 (0-20.0)	81.3 (40.0-100)
North Derbyshire CCG	92.8 (73.1-100)	16.5 (0-45.9)	77.4 (50.8-93.8)
Southern Derbyshire CCG	91.1 (65.0-100)	15.6 (0-41.7)	76.7 (54.2-100)
Glossop practices	90.3 (76.2-100)	5.4 (0-11.5)	85.3 (75.0-92.9)

	Underlying achievement net of exceptions (%) (practice range)	Exception rate (%) (practice range)	% of patients receiving intervention (practice range)
MH007: The % of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months			
Erewash CCG	92.6 (73.0-100)	12.8 (0-33.0)	80.5 (65.7-100)
Hardwick CCG	87.9 (62.5-100)	9.1 (0-23.3)	80.1 (50.0-100)
North Derbyshire CCG	93.1 (76.9-100)	16.9 (0-44.3)	77.4 (49.2-95.0)
Southern Derbyshire CCG	90.0 (35.8-100)	17.4 (0-50.0)	73.9 (35.8-96.9)
Glossop practices	90.7 (75.0-100)	5.7 (0-11.5)	85.8 (66.7-100)
MH008: The % of women aged between 25 and 65 years with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years			
Erewash CCG	93.3 (60.0-100)	15.4 (0-25.0)	79.2 (50.0-100)
Hardwick CCG	90.9 (66.7-100)	15.8 (0-44.4)	76.2 (55.6-100)
North Derbyshire CCG	93.3 (50.0-100)	19.4 (0-50.0)	75.0 (33.3-100)
Southern Derbyshire CCG	94.6 (80.0-100)	20.2 (0-100.0)	75.4 (0-100)
Glossop practices	91.8 (80.0-100)	14.9 (0-25.0)	77.7 (66.7-83.3)
MH009: The % of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months			
Erewash CCG	99.2 (90.9-100)	0.4 (0-3.8)	98.8 (90.9-100)
Hardwick CCG	100 (100-100)	6.5 (0-50.0)	93.5 (50.0-100)
North Derbyshire CCG	98.2 (81.8-100)	2.6 (0-33.3)	95.6 (66.7-100)
Southern Derbyshire CCG	98.2 (81.8-100)	4.8 (0-33.3)	93.5 (66.7-100)
Glossop practices	100 (100-100)	1.1 (0-6.7)	98.9 (93.3-100)
MH010: The % of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months			
Erewash CCG	94.8 (85.7-100)	8.0 (0-20.0)	87.4 (71.4-100)
Hardwick CCG	96.3 (87.5-100)	7.2 (0-50.0)	89.4 (50.0-100)
North Derbyshire CCG	94.5 (20.0-100)	7.7 (0-33.3)	87.5 (16.7-100)
Southern Derbyshire CCG	93.1 (0-100)	11.2 (0-75.0)	82.1 (0-100)
Glossop practices	100 (100-100)	1.1 (0-6.7)	98.9 (93.3-100)

Source: HSCIC

5.2.2 Improving Access to Psychological Therapy (IAPT) services

Southern Derbyshire CCG has a significantly lower rate of individuals waiting more than 28 days for their first treatment compared to England, but Erewash, Hardwick and North Derbyshire CCGs had significantly higher rates. There has been a consistent trend since February 2014, with Southern Derbyshire significantly lower, North Derbyshire significantly higher and Hardwick and Erewash usually significantly higher or similar to the national average. North Derbyshire have a significantly lower rate of individuals waiting more than 90 days to access treatment compared to England, with Erewash and Southern Derbyshire CCGs having a similar rate. The number of cases waiting more than 90 days in Hardwick CCG is too small for a rate to be published.

The rate of the completion of treatment in IAPT services in is significantly higher amongst Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs compared to England. The proportion of IAPT service-users who move to recovery (defined as individuals who at their first appointment score 8 or more on the GAD7 scale, or 10 or more on the PHQ9 scale, and at their last appointment score 7 or less on the GAD7 scale AND 9 or less on the PHQ9 scale) is similar for Erewash, Hardwick and North Derbyshire CCGs compared to England, with the recovery rate significantly higher for Southern Derbyshire CCG.

Table 50: IAPT completion rate, recovery rate and waiting time data, recovery Q3 2014/15

	Completion of treatment rate (per 100,000 population)	Proportion of IAPT population who moved to recovery (%)	Proportion of IAPT referrals waiting <28 days for treatment (%)	Proportion of IAPT referrals waiting >90 days for treatment (%)
England	298	45.2	74.9	4.7
Erewash CCG	471	44.0	81.6	2.6
Hardwick CCG	337	45.0	82.8	-
North Derbyshire CCG	445	49.2	80.0	1.9
Southern Derbyshire CCG	425	53.9	55.3	3.5

Source: Public Health England

5.2.3 Specialist adult mental health services

5.2.3.1 Admissions

The proportion of admissions that were classified as an emergency was similar in Erewash, Hardwick and Southern Derbyshire CCGs compared to England, with the rate in North Derbyshire significantly higher.

The number of emergency re-admissions within 30 days of a previous discharge was similar in North Derbyshire and Southern Derbyshire CCGs. The numbers of emergency readmissions in Erewash and Hardwick CCGs were too small to be published.

Table 51: Emergency admissions, by CCG, Q2 2014/15

	Proportion of admissions which were an emergency (%)	Proportion of admissions which were emergency readmissions (%)
England	73.5	9.3
Erewash CCG	80.0	*
Hardwick CCG	80.0	*
North Derbyshire CCG	80.8	7.7
Southern Derbyshire CCG	77.1	8.6

* data suppressed due to the small number of cases
Source: Public Health England

5.2.3.2 Use of Care Programme Approach

The Care Programme Approach (CPA) co-ordinates the health and social care requirements for individuals in contact with specialist mental health services. It should ensure that everybody requiring CPA receives properly assessed, planned and co-ordinated care, including regular contact with a care co-ordinator.

At the end of September 2014, there were 5,820 individuals registered with Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs on CPA. For all four CCGs, the rate of individuals on CPA was significantly higher than the England rate, and the proportion of mental health service users on CPA was also significantly higher than England. Of those individuals who had been on CPA for more than a year, a significantly higher proportion of those in Erewash CCG compared to England, and a significantly lower proportion in Southern Derbyshire CCG had had a review. A very high proportion of individuals on CPA were followed up within 7 days after discharge from psychiatric inpatient care.

Table 52: Indicators relating to Care Programme Approach, by CCG, Q2 2014/15

	People on CPA per 100,000 population aged 18+ years	Proportion of mental health service users who are on CPA (%)	Proportion of people on CPA for more than 12 months who have had a review (%)	Proportion of patients on CPA followed up within 7 days after discharge (%)
England	518	23.8	80.2	97.3
Erewash CCG	617	32.3	88.0	96.6
Hardwick CCG	697	26.8	78.6	100
North Derbyshire CCG	946	31.0	80.7	97.6
Southern Derbyshire CCG	656	29.6	75.1	95.3

Source: NHS England

Ensuring that individuals on CPA are in stable accommodation and employment promotes personalisation and quality of life. It should also reduce the need to readmit individuals to hospital or residential care, as well as improving their safety and reducing their risk of social exclusion.

Within Derbyshire, a significantly higher proportion of adults on CPA from Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs are in stable accommodation compared to England. Similarly, with the exception of Hardwick CCG, there is also a significantly higher proportion of adults on CPA in employment.

Table 53: Proportion of adults on CPA in stable accommodation and employment, by CCG, Q2 2014/15

	Proportion of adults aged 18-69 years on CPA in stable accommodation (%)	Proportion of adults aged 18-69 years on CPA in employment (%)
England	58.2	6.6
Erewash CCG	87.5	12.5
Hardwick CCG	79.8	8.1
North Derbyshire CCG	87.5	12.5
Southern Derbyshire CCG	85.5	10.0

Source: NHS England

6 Spend on mental health services

Nationally, approximately 6% of total mental health spend is on children and young people's mental health services, with the proportion having reduced between 2006/7 and 2012/3. Within Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs' mental health budgets, 5.7% is allocated to children and young people's services, however, this will not include contributions from local authorities.

Within Derby City and Derbyshire, as would be expected, there is a higher than proportional spend on the small numbers of young people who require intensive tier 4 therapy. Approximately three quarters of spend is on tier 3 and 4 services, which are used by only 22% of service users.

Table 54: Proportion of CAMHS service users and spend, by tier

Tier of CAMHS service	Proportion of CAMHS service-users (%)	Proportion of spend (%)
Tier 4	0.9	18.9
Tier 3	20.7	59.5
Tier 2	78.4	21.6
Tier 1	Not included	Not included

The overall mental health budget for 2015/16 for Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs is £130 million for adults and £8 million for young people. North Derbyshire CCG has a higher budget for adult mental health services per head of population compared to the other CCGs, which all have similar budgets for adult services. There is also a similar budget per head of population on children's mental health services. It should be noted that this is the health budget only and therefore will not include local authority contributions for commissioning care for adults and children with mental health needs. There is no data available that allows these figures to be compared to other areas.

Table 55: 2015/16 health budget for mental health services, by CCG

	Adult budget (£)	Adult budget per 100,000 population (£)	Children's budget (£)	Children's budget per 100,000 population (£)
Erewash CCG	11,199,000	14,693,380	766,000	3,633,431
Hardwick CCG	12,056,000	15,007,158	764,000	3,476,994
North Derbyshire CCG	43,301,000	18,743,031	1,861,000	3,130,204
Southern Derbyshire CCG	63,979,000	15,413,358	4,547,000	3,609,274

Source: Hardwick CCG

6.1 Programme budgeting

Programme budgeting is an approach that allows comparisons to be made on spend between disease categories, and also allows spend on specific disease categories to be compared between organisations.

The latest programme budgeting data for mental health is from 2013/14. For Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs, mental health is the disease category with the highest spend. Erewash, Hardwick and Southern Derbyshire CCGs all had a similar proportion of their overall spend on mental health to the England average, with North Derbyshire CCGs having a higher spend. The average spend on mental health per 100,000 population is £14.6 million. Compared to the spend on mental health services in CCGs with similar characteristics, Erewash, Hardwick and Southern Derbyshire CCGs spend less on mental health services, and North Derbyshire CCG spend more.

It should be noted that spend data relates to mental health services commissioned by CCGs only, and does not include services commissioned by local authorities or NHS England.

Table 56: Programme budgeting information, 2013/14

	Total spend on mental health (£)	Proportion of spend (%)	Spend on mental health per 100,000 population (£)	Variance from cluster on spend per 100,000 population (£)
Erewash	13,637,506	11.7	13,092,980	-1,487895
Hardwick	15,651,440	11.8	13,715,019	-865,856
North Derbyshire	54,709,158	14.8	18,319,004	+3,738,129
Southern Derbyshire	70,462,146	11.6	12,801,599	-1,779,276

Source: NHS England, https://www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/

7 Stakeholder views

In March 2015, NHS England launched a taskforce with the aim of developing a five-year strategy to improve mental health outcomes across the NHS and across all ages. The first step was to hold a national consultation and engagement to find out what changes people wanted to see, and what they thought should be the priorities for mental health services. [1]

The three top areas for change in existing services were access to services (identified by 51.9% of respondents as a priority), choice of treatments (32.9%) and prevention (24.7%)

Access to services: areas identified by respondents as priorities within this theme included easier access to services, shorter waiting times, equitable access for all and lowering the thresholds to treatment.

Choice of treatments: areas identified by respondents as priorities within this theme included increasing the use of technology, treatment choices beyond cognitive behaviour therapy and being provided with information about the treatment options available, rather than being told what treatment they would receive.

Prevention: areas identified by respondents as priorities included the importance of primary prevention, especially early intervention and wellbeing for children and young people, and secondary prevention to avoid deterioration or relapse of an individual's condition. Tackling stigma and discrimination especially in certain population groups such as men, older people and individuals who identify as lesbian, gay, bisexual or transgender.

[1] Mental Health Taskforce in England (2015) *The five year forward view mental health taskforce: public engagement findings*

8 Summary of findings

This report presents a snapshot of mental health needs, and service provision across Derbyshire. It presents information across a broad range of indicators that cover risk and protective factors for mental health, prevalence of mental illness and access to and outcomes from mental health services. Within the report there are a number of key themes that have emerged, and these are summarised below.

The report highlights the need to take a whole-systems approach to improving the mental health of the population of Derbyshire, that includes consideration of prevention of mental illness, promotion of positive mental health, early identification of individuals in need of support and treatment, as well as provision of NHS and social care services.

Ensuring provision of universal and targeted interventions to promote positive mental health will contribute towards a reduction in the prevalence of mental illness and a subsequent need for treatment. There are some population groups at higher risk of experiencing mental illness, such as looked after children, carers, individuals with a long term condition or disability, those with limited social networks and individuals living in areas of higher socio-economic deprivation. Promotion of good mental health should be prioritised in these population groups to reduce the burden of mental ill health, and service pathways reviewed to ensure prompt access to treatment is available.

For many of the indicators included in the report, Derbyshire appears similar or better than England. However, this masks variation at a sub-county level. Variation in need is an important factor to consider when planning services, as communities will require a proportional volume of services relative to their needs. There also appears to be variation within Derbyshire in access to and outcome from mental health services. As well as planning services relative to need, it is also important to ensure that service provision is equitable between different population groups.

There are some indicators where the variation between local and national performance is large enough to warrant further investigations. Examples of this would include the use of social care services by individuals with mental health needs, and attendances at A&E departments with a psychiatric disorder. There may be artefactual reasons behind the differences, such as differences in coding or reporting of information which need to be explored to determine whether they are sufficient to explain differences.

There also appears to be significant variation in recording and provision of mental health services in GP practices. GP practices will be the point of entry into mental health treatment for the vast majority of individuals with a mental health condition, with many subsequently managed solely in primary care. It is important therefore that mental health service provision in primary care is equitable to reduce the health inequalities experienced by individuals with a mental illness. Some of the variation in recording will be justified by differences in need between practice populations, but under-indentifying and under-recording will also contribute towards the observed variation. In addition, there is variation in the provision of interventions to individuals with diagnosed mental illness. There are opportunities to share information and good practice with GP practices to reduce this variation.

The majority of mental health spend is on specialist mental health services. In general, CCGs in Derbyshire have a lower or similar prevalence of mental illness compared to England, but higher use of specialist mental health services. This appears particularly true in Hardwick and North Derbyshire CCGs. Further work is warranted to understand the reasons behind this, to understand whether services are as efficient and effective as possible, and provided in an equitable manner across the county.

Finally, there are areas where the availability of routine data is limited, which does not currently allow for meaningful benchmarking of local performance, or identify inequities in service provision within Derbyshire. An obvious example is data on children and young peoples' mental health services, but there is also very limited information on the physical health needs of people with serious mental illness, or the prevalence of individuals with a dual substance misuse and mental health diagnosis. Where routine data is not available, stakeholders have the opportunity to gather this information from local services. This will still not allow local need or performance to be compared to other areas, but will build a better picture of need within Derbyshire that can be used to inform service commissioning and planning.

Due to the "snapshot" nature of this report, it will become out-of-date as indicators are updated. For indicators that are updated on a quarterly basis, this will happen rapidly. However, data needs to be reviewed in an on-going manner to ensure that the mental health needs of the population of Derbyshire are being met. A smaller number of indicators that covers the breadth of this report should be identified and monitored on an ongoing basis to allow trends in local needs and performance to be monitored.

It is recommended that the report is used by stakeholders for three main purposes:

- to inform discussions about the planning of mental health services
- to identify population groups or conditions where a more detailed assessment of current service provision, including obtaining the views of key stakeholders, would be beneficial to inform commissioning and delivery of services
- to identify key indicators that can be monitored over time to know whether the mental health of the population of Derbyshire is improving

Glossary

ADQ per STAR-PU	ADQ per STAR-PU (Average Daily Quantity per Specific Therapeutic group Age-sex Related Prescribing Unit) is a measure of prescribing medicines units that take into account demographic factors within the population
Attention deficit hyperactivity disorder (ADHD) and Hyperkinetic disorders	Core symptoms include developmentally inappropriate levels of activity and impulsivity and an impaired ability to sustain attention. Affected children and young people have difficulty regulating their activities to conform to expected norms. They often fail to achieve their potential and many have comorbid difficulties such as developmental delays, specific learning problems and other emotional and behavioural disorders.
Cognitive Behavioural Therapy (CBT)	Cognitive Behavioural Therapy is a talking therapy that helps people manage their problems by changing the way they think and behave to help cope with them in a more positive way.
Common mental health problems	Common mental health problems cause marked emotional distress and interfere with daily function, but they don't usually affect insight or cognition. They include a range of anxiety and depressive disorders, which often co-exist. Conditions include generalised anxiety disorder, panic disorder, phobias, obsessive compulsive disorder and depression. Common mental health problems, if left untreated, can lead to increased physical morbidity and premature mortality.
Conduct disorder	This is an umbrella term referring to persistent patterns of antisocial behaviour, repeated breaking of social rules and/or causing distress to people. Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations
Eating disorders	Eating disorders includes conditions such as anorexia nervosa, bulimia nervosa and other related conditions. They generally have an onset in childhood or adolescence, and can cause acute psychological distress, as well as severe physical complications such as gastrointestinal problems and osteoporosis. Eating disorders often become chronic and can have long term impacts on employment, relationships, fertility and parenting.
Incidence	The incidence of a condition is the number of new cases of the disease in a population over a defined period of time
Perinatal mental health problems	Mental health problems diagnosed in pregnancy and the year following birth. They include mental health problems that were present before the pregnancy and those occurring during this time.
Personality disorder	Personality disorders are chronic, ingrained distortions of personality that interfere with the ability to make and sustain relationships, which may manifest in a pattern of aggressive, irresponsible or eccentric behaviour. Personality disorders often emerge in childhood or adolescence, and may be associated with mood and anxiety disorders, substance misuse and suicidal behaviours. Examples of personality disorder include antisocial personality disorder and borderline personality disorder.
Post-traumatic	Post-traumatic stress disorder (PTSD) is a disabling condition characterised by

stress disorder	flashbacks and nightmares, avoidance and numbing, and hyper-vigilance. It is different from other psychiatric disorders in that diagnosis requires that symptoms are caused by an external, traumatic event.
Poverty and persistent poverty	The definition of poverty is a household living on an income less than 60% of the national average. Persistent poverty is when a household experiences relative income poverty for at least three years out of a four-year window.
Prevalence	The prevalence of a condition is the number of individuals with that disease in a population, and is expressed as a proportion
Psychosis	Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. They include schizophrenia and affective psychosis, such as bi-polar disorder. Individuals with psychosis can make a full recovery, with the majority having repeated episodes over their lifetime. As well as having significant psychological impact, individuals with psychosis often experience poor physical health, for example individuals with schizophrenia die an average of 20 years earlier compared to the general population
School readiness	School readiness is a measure of how prepared a child is to succeed cognitively, socially and emotionally in school. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy. There is no nationally agreed definition and there can be differences in interpretation between being 'school ready' when starting reception or when starting year 1.
Self-harm	Self-Harm is an act of 'self-poisoning or self-injury, irrespective of the apparent purpose of the act'. Self-harm does not include alcohol and substance misuse, or eating disorders. The most common reason for hospital admissions are self-poisoning and cutting
Serious mental illness register	The Quality and Outcomes Framework requires practices to maintain a register of patients with schizophrenia, bipolar affective disorder and other psychoses.
Young carers	Section 96 of the Children and Families Act 2014 defines a young carer as "…a person under 18 who provides or intends to provide care for another person (of any age, except where that care is provided for payment, pursuant to a contract or as voluntary work)."

Appendix 1:

Geographical and CCG-level indicators, compared with England

Meta-data for geographical and CCG-level indicators

	Indicator	Period	England	Derbyshire	Derby	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire	Tool
	Risk factors for mental ill health - adults													
1	Socioeconomic deprivation: % of people living in 20% most deprived areas	2013	20.4%	12.3%	29%	8.9%	27.4%	25.9%	2.2%	16.2%	4.6%	10.3%	1.7%	CMHD
2	Utilisation of outdoor space for exercise/health: estimated % of population	2013/14	17.1	13.3	13.3									PHOF
3	Satisfaction with social care protection: % service users who say services have made them feel safe and secure	2013/14	79.1%	85.2%	78.3%									CMHD
4	Satisfaction with social care support: % service users extremely satisfied or very satisfied with their care and support	2013/14	64.8%	68%	65.2%									CMHD
5	% of adults in contact with secondary mental health services who live in stable and appropriate accommodation (persons)	2013/14	60.9%	87.9%	76.9%									PHOF
6	Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate	2013/14	64.8%	62.7%	63.2%									PHOF
7	The rate of complaints about noise	2013/14	7.4	4.4	3.7	3.7	5.1	5.2	3.4	4.1	4.3	4.2	4.9	PHOF
8	Percentage of active and inactive adults: inactive adults	2014	27.7	28.4	29.2	24.3	39.4	34.3	25.3	27.3	27.1	27.6	24.1	PHOF
9	Social isolation: % of adult social care users who have as much social contact as they would like	2013/14	44.5%	43.4%	45%									PHOF
10	Social isolation: % of adult carers who have as much social contact as they would like	2012/13	41.3%	44.7%	36.9%									PHOF
11	The % of employees who had at least 1 day off in the previous week	2010/12	2.5%	2.3%	0.8%	2.6%	3.4%	1.8%	1.9%	2.5%	2.9%	1.8%	1.7%	PHOF
12	The % working days lost to sickness absence	2010/12	1.6%	1.2%	0.6%	1.3%	2%	1.1%	0.7%	1.3%	1.5%	1.3%	0.8%	PHOF
13	Domestic Abuse - rate/1000 popn domestic abuse incidents recorded by police	2013/14	19.4%	22.2%	22.2%									PHOF

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	Indicator	Period	England	Derbyshire	Derby	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire	Tool
	Risk factors for mental ill health - adults/continued													
14	Violent crime (including sexual violence): violence offences per 1000 population	2013/14	11.1%	7.3%	14.1%	6.6%	7.6%	10.5%	5.3%	9.1%	7.7%	4.1%	6.5%	PHOF
15	Health related quality of life for people with long term conditions	2013/14	0.73%	0.7%	0.7%									NHSOF
16	% patients with long term conditions who feel supported to manage their conditions	2013/14	65.1%	67.7%	63.4%									NHSOF
17	Health related quality of life for carers aged 18 and above	2013/14	0.8	0.8	0.8									NHSOF
18	Social care related quality of life	2013/14	19%	18.9%	19.5%									ASCOF
19	Injuries due to falls in persons aged 65 and over (Persons), (Males and Females available too)	2013/14	2064	2207	2221	2075	2365	2528	2145	2160	1868	2292	2228	PHOF
20	Health related quality of life for older people	2012/13	0.726	0.719	0.712	0.717	0.664	0.694	0.770	0.699	0.738	0.722	0.727	PHOF
21	Long term unemployment: % of working age population	Oct-14	0.61	0.42	0.69									CMHD
22	Relationship breakup: % of adults whose current marital status is separated or divorced	2011	11.6	12.3	11.6	12.4	12.6	13.4	11.1	12.7	12.3	11.4	11.9	DfE Statistics
23	Fuel poverty	2013	10.4	10	12.8	10.3	9.8	10	11.3	10.4	10.5	9	9	PHOF
24	Household overcrowding: % households with occupancy rating for bedrooms -1 or less	2011	4.8	2.2	5.2	2.3	2.5	2.5	1.7	2.3	2.7	2	1.8	CMHD
25	Number of households on local authority waiting lists	2014	1368312	16837	3868	2914	1578	1699	1137	2320	3589	1673	1927	LT600 Housing stock data
26	Proportion all households occupied by single person	2011	12.8%	12.6%	12.9%									Census 2011
27	Proportion all households occupied by single person aged 65+	2011	5.2%	5.7%	5.1%									Census 2011
28	Smoking prevalence	2013	18.4%	17.5%	22.1%	12.3%	23%	20.3%	10%	19.6%	21.2%	18.9%	14.8%	PHOF
29	Smoking status at time of delivery	2013/14	12%	16.3%	15.1%									PHOF

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	Risk factors for mental ill health - children													
30	School readiness: % children achieving good level of development at end of Reception year	2013/14	60.4	61.5	51.3	63	59	57	67	61	62	64	59	PHOF/ CYPMHW
31	GCSEs achieved: (% A*-C including English and Maths)	2013/14	56.6	53.7	50	53.5	48.1	53.6	61.6	46.1	57.4	60	51	DfE Statistics
32	GCSEs achieved: (% A*- C, all pupils)	2013/14	65.8	62.9	58.8									DfE Statistics
33	GCSEs achieved: (% A*- C, disadvantaged children)	2013/14	45	39	36									DfE Statistics
34	GCSEs achieved: (% A*- C, pupils with special educational need but no statement)	2013/14	32	31.7	24.3									DfE Statistics
35	GCSEs achieved: % A* - C, pupils with statemented special education needs	2013/14	11.3	8	6.5									DfE Statistics
36	16-18 year olds NEET (not in education, employment or training)	2014	4.7	4.9	6.4									PHOF/ CYPMHW
	Risk and protective factors for mental health - Adults													
37	Statutory homelessness - households in temporary accommodation	2013/14	2.6	0.2	0.3	0.4	0	0.3	0.4	0.2	0.1	0.3	0.1	PHOF
38	Estimated prevalence of opiate and/or crack cocaine use	2011/12	8.4	7.4	14.5									Co-existing substance misuse etc
39	Successful completion of drug treatment: opiate users	2013	7.8	7.2	8.3									Co-existing substance misuse etc
40	Alcohol related admissions to hospital - narrow definition (persons) - males and females also available	2013/14	645	718	801	745	681	901	641	726	650	736	629	PHOF
41	Self-reported wellbeing: people with a low satisfaction score	2013/14	5.6%	5.1%	7.6%									PHOF

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	Risk and protective factors for mental health - Adults /continued													
42	Self-reported wellbeing: people with a low worthwhile score	2013/14	4.2%	3.5%	5.7%									PHOF
43	Self-reported wellbeing: people with a low happiness score	2013/14	9.7%	10.1%	11.4%									PHOF
44	Self-reported wellbeing: people with a high anxiety score	2013/14	20%	20%	24.5%									PHOF
45	Long term health problems or disability: % who say their day-to-day activities are limited by their health or disability	2011	17.6%	20.4%	18.7%	20.3%	24.7%	23.1%	18.5%	19.3%	18.1%	22.1%	17.5%	CMHD
	Risk and protective factors for mental health - children													
46	Children in poverty: (Under 16s)	2012	19.2%	16.3%	23.8%	16.9%	21.5%	21%	9.3%	18.9%	13.1%	14.8%	13%	PHOF
47	First time entrants to the Youth Justice System	2014	409	279	536									PHOF
48	Youth offenders - community order sentences	2013/14	247.3	154.2	416.9									Govt Statistics
49	Children in need due to abuse, neglect or family dysfunction: % children in need	2014	65.8%	44.3%	70.5%	47%	42.1%	41.6%	37.4%	53.2%	44.9%	36.1%	31.1%	CYPMHW
50	Children providing care: % children aged <15 who provide unpaid care	2011	1.11%	1.09%	1.13%									CYPMHW
51	Families out of work: % of dependent children where one or more parent or guardian is receiving benefits	2013	18%	16.3%	22.9%	16.8%	22.9%	21.5%	8.4%	18.1%	13.5%	15.3%	11.8%	DWP and CAYA
52	Family homelessness: Rate/1000 households	2013/14	1.7	0.7	2.3									CYPMHW
53	Looked after children: Rate/10000 <18 population	2013/14	59.8	40.7	76.9	30.2	41.4	58.8	12.9	58.7	23.3	16.8	12.9	CYPMHW
54	Looked after children in secure units, children's homes and hostels: % of looked after children	2014	9.2%	9.5%	10.1%	8.2%	10.8%	6.7%	5.9%	13.3%	11.6%	12.9%	7.7%	CYPMHW
55	Parents in alcohol treatment: Rate/100000 children aged 0-15	2011/12	147.2	118.6	276.1									CYPMHW

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	Risk and protective factors for mental health - Children /continued													
56	Parents in drug treatment: Rate/100000 children aged 0-15	2011/12	110.4	93	110.4									CYPMHW
57	Primary school fixed period exclusions: % of school pupils	2012/13	0.88%	1.22%	0.7%									CYPMHW
58	Secondary school fixed period exclusions: % of school pupils	2012/13	6.8%	6.8%	7.7%									CYPMHW
59	Pupils with special educational need: % of all school age children with special educational need	2014	17.9%	17.2%	18.6%									CYPMHW
60	Rate of conceptions: per 1000 females aged 15-17	2011/13	27.6	22.6	-	19.5	25.9	26.7	11	24.9	27.7	18.2	24.6	ONS
61	Rate of conceptions: per 1000 females aged 15-17	2013	24.3	19.4	29.3	15.1	24.8	24.3	7.8	23.8	24.7	9.5	23.5	ONS
62	% Child referrals where domestic abuse is flagged as a cause for concern. Rate/1000 children aged 0-17	2013/14		25.3%		26.3%	25.5%*	33.8%	22.9% and 19.3%*	26.2%	22.9%*	25.5%*	19.3%*	CAYA
63	***Prevalence of mental illness - Adults*** Prevalence of common mental health problems	2013/14	15.6%	17.1%	15.9%	11.8%	12.4%	15.6%	10.6%	14.7%	13%	11.4%	11.1%	PHE
64	Prevalence of Mixed anxiety and Depressive disorder: Estimated % of population aged 16-74	2012	8.92%	6.74%	8.41%									CMHD
65	Prevalence of Generalised anxiety disorder: Estimated % of population aged 16-74	2012	4.5%	3.5%	4.3%									CMHD
66	Prevalence of Depressive episode: Estimated % of population aged 16-74	2012	2.48%	1.91%	2.56%									CMHD
67	Prevalence of all phobias: Estimated % of population aged 16-74	2012	1.77%	1.24%	1.57%									CMHD
68	Prevalence of obsessive compulsive disorder: Estimated % of population aged 16-74	2012	1.1%	0.7%	0.88%									CMHD
69	Prevalence of panic disorder: Estimated % of population aged 16-74	2012	0.65%	0.36%	0.54%									CMHD

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	Prevalence of mental illness – Adults/continued													
70	Prevalence of eating disorders: Estimated % of population aged 16+	2012	6.73%	6.69%	6.58%									CMHD
71	Prevalence of post-traumatic stress disorder (PTSD): Estimated % of population aged 16+	2012	3.02%	3.08%	2.92%									CMHD
72	Perinatal mental health: Estimated number of women requiring support during pregnancy or postnatal period	2012	83045	993	446									CMHD
73	Depression and anxiety among social care users: % people who use services who report that they feel moderately or extremely anxious or depressed	2012/13	53.4%	59.1%	52.5%									CMHD
74	New cases of psychosis: Estimated incidence per 100000 aged 16-64 (mapped from LA)	2011	24.2	16.6	25.7	16	17.6	18.1	14.7	17.3	16.1	15.7	16.5	SMI
75	Prevalence of antisocial and borderline personality disorder: Estimated % of population aged 16-74	2012		0.4%										APMS 2007
76	Suicide rate (persons) (males and females available)	2011/13	8.8	6.6	8.6	7.8	*	*	*	8.9	*	*	*	PHOF
77	***Prevalence of mental illness - Children*** Estimated prevalence of any mental health disorder: % population aged 5-16	2014	9.3%	9.3%	9.8%									CYPMHW
78	Estimated prevalence of conduct disorders: % population aged 5-16	2014	5.6%	5.6%	6.1%									CYPMHW
79	Estimated prevalence of emotional disorders: % population aged 5-16	2014	3.6%	3.6%	3.8%									CYPMHW
80	Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2014	1.5%	1.5%	1.7%									CYPMHW
81	Prevalence of ADHD among young people: Estimated number of 16-24 year olds	2013	*	10898	4604									CYPMHW

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	Prevalence of mental illness – Children/continued													
82	Prevalence of potential eating disorders among young people: Estimated number of 16-24 year olds	2013	*	10284	4321									CYPMHW
83	Children who require Tier 3 CAMHS: estimated number of children <17	2012	*	2885	1065									CYPMHW
84	Children who require Tier 4 CAMHS: estimated number of children <17	2012	*	120	45									CYPMHW
	Mental Health Service use – Adults													
85	Admissions for depression: Directly standardised rate for hospital admissions for unipolar depressive disorders/100000 popn aged 15 and over	2009/10 – 2011/12	32.1	36	33									CMHD
86	Carers of mental health clients receiving of assessments during the year: Rate/100000 popn	2013/14	64.3	111	38.7									SMI
87	Social care mental health clients receiving services during the year: Rate/100000 population aged 18-64	2013/14	384	155	675									SMI
88	New social care assessments per year for mental health clients aged 18-64: rate/100000 population	2013/14	265	38	16									SMI
89	Social care mental health clients in residential or nursing care during the year: aged 18-64 rate/100000 population	2013/14	31.9	37.5	42.2									SMI
90	Social care mental health clients aged 18-64 receiving home care during the year: Rate/100000 population	2013/14	42.2	20.4	64.9									SMI
91	Social care mental health clients aged 18-64 receiving day care or day services. Rate/100000 population	2013/14	34	6.4	3.2									SMI

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	Mental Health Service use – Adults/continued													
92	Schizophrenia emergency admissions: Rate/100000 population	2009/10 - 2011/12	57	50	82									SMI
	Mental Health service use - Children													
93	Under 18s admitted to hospital with alcohol-specific conditions	2010/11 - 2012/13	44.9	44.1	45.1	42.1	51	43.2	36.9	31.8	63.7	47.9	39.3	CYPMHW
94	Young people hospital admissions due to substance misuse: rate/100000 young people aged 15-24	2011/12 - 2013/14	81.3	91.8	94.7									CYPMHW
95	Child admissions for mental health: rate/100000 population aged 0-17 years	2013/14	87.2	87.3	60.5									CYPMHW
96	Young people hospital admissions for self-harm: Rate/100000 population aged 10-24	2010/11 - 2012/13	352.3	410.7	527.1	355.5	408.5	617.9	340.1	344.7	182.4	494.4	343.6	CYPMHW
97	Hospital admissions caused by unintentional and deliberate injuries aged 15-24	2013/14	136.7	156.3	150.4	150.9	173.9	215.3	143	130.3	164.5	144.1	126.3	PHOF
98	Number of referrals to CAMHS	Apr-Sep 2014		1009	283									MHMDS local data
	Service quality and outcome - Adults													
99	CPA adults in employment: % of people aged 18-69 on CPA in employment (end of quarter snapshot)	2012/13	8.8%	15.5%	9.6%									SMI
100	CPA adults in settled accommodation: % of people aged 18-69 on CPA in settled accommodation	2012/13	58.5%	87.8%	87.5%									SMI
101	Excess under 75 mortality in adults with serious mental illness (standardised mortality ratio SMR)	2012/13	347.2	289.7	302.7									SMI

KEY:

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•	Indicator	Period	England	Derbyshire	Derby	Amber Valley	Bolsover	Chesterfield	Derbyshire Dales	Erewash	High Peak	North East Derbyshire	South Derbyshire	Tool
102	Premature (<75) mortality in adults with serious mental illness: Rate/100000 population	2012/13	1319	1248	1032									SMI
103	***Service quality and outcome - Children*** Waiting times for CAMHS - (only have overall not Tier 3) referral to treatment - average wait (weeks)	Sep-14		7.08	11.9									MHMDS local data
104	Waiting times for CAMHS - (only have overall not Tier 3) referral to treatment - maximum wait (weeks)	Sep-14		64.57	60.29									MHMDS local data

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Appendix 1 - CCG Indicators for State of Mental Health in Derbyshire compared with England

	Indicator	Period	England	NHS Erewash	NHS Hardwick	NHS North Derbyshire	NHS Southern Derbyshire	Tool
	Risk factors for mental ill health - adults							
105	Health related quality of life for people with long term conditions	2013/14	0.74	075	0.68	0.73	0.74	NHSOF
106	% patients with long term conditions who feel supported to manage their conditions	2013/14	65.1%	64.9%	68.9%	69.3%	65.2%	NHSOF
107	Health related quality of life for carers aged 18 and above	2013/14	0.80	n/a	n/a	0.79	0.81	NHSOF
	Levels of mental illness in the population - adults							
108	Depression: QOF prevalence (18+)	2013/14	6.5%	7.2%	6.9%	7.9%	6.8%	Suicide Prev Tool
109	Depression and anxiety prevalence (GP survey)	2012/13	12%	12.4%	14.6%	12.3%	12.8%	CMHP
110	Mental health problem: QOF prevalence (all ages)	2013/14	0.86	0.73	0.87	0.88	0.76	SMI
111	% reporting a long term mental health problem (GP survey)	2012/13	4.5%	4.2%	5.9%	5%	4.3%	CMHP
112	Psychotic disorder: Estimated % people aged 16+	2012	0.4%	0.41%	0.38%	0.35%	0.47%	SMI
113	Comparison of QOF and estimated prevalence: QOF register prevalence as a ratio of estimated prevalence - SMI	2013/14	2.17	1.78	2.29	2.50	1.60	SMI
	Levels of mental illness in the population - children							
114	Estimated prevalence of any mental health disorder: % GP registered popn aged 5-16	2014	9.3%	9.8%	10.2%	9.1%	9.5%	CYPMHW
115	Estimated prevalence of emotional disorders: % registered popn aged 5-16	2014	3.6%	3.8%	4%	3.5%	3.7%	CYPMHW
116	Estimated prevalence of conduct disorders: % registered popn aged 5-16	2014	5.6%	5.9%	6.3%	5.5%	5.7%	CYPMHW
117	Estimated prevalence of hyperkinetic disorders: % registered popn aged 5-16	2014	1.5%	1.6%	1.7%	1.5%	1.6%	CYPMHW

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	Indicator	Period	England	NHS Erewash	NHS Hardwick	NHS North Derbyshire	NHS Southern Derbyshire	Tool
	Service uptake - adults							
118	Antidepressant prescribing: Average daily quantities (ADQs) per STAR-PU	2013/14	1.2	1.2	1.6	1.5	1.2	CMHD
119	Use of "1st choice" antidepressants: % of prescription items that were "1st choice" generic SSRIs	2013/14	63.5%	66.2%	68.4%	65.6%	70.3%	CMHD
120	IAPT referrals: Rate (quarterly) per 100000 population aged 18+	2014/15 Q4	839	962	794	890	901	CMHD
121	Entering IAPT treatment: Rate (quarterly) beginning IAPT treatment per 100000 population aged 18+	2014/15 Q4	564	776	537	674	578	CMHD
122	People entering IAPT services (in month) as a % of those with anxiety and depression	Mar-15	17.3%	27.1%	18.2%	26%	20%	CMHD
123	Completion of IAPT treatment: Rate (quarterly) completing treatment (at least 2 appts) per 100000 popn aged 18+	2014/15 Q4	298	471	337	445	425	CMHD
124	People with a mental illness in residential or nursing care per 100000 popn aged 18-64	2012/13	32.7	32.1	32.1	32.1	41.8	CMHP
125	Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2013/14 Q3	2.4	1.8	3.0	1.4	2.6	CMHP
126	Detentions under the Mental Health Act per 100000 population	2013/14 Q1	15.5	12	10.3	8.7	14.6	CMHP
127	Attendances at A&E for a psychiatric disorder per 100000 population	2012/13	243.5	117.3	296.5	216.1	41.9	CMHP
128	Number of bed days in secondary mental health care hospitals per 100000 population	2013/14 Q1	4686	4066	8761	4198	5862	CMHP

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	Indicator	Period	England	NHS Erewash	NHS Hardwick	NHS North Derbyshire	NHS Southern Derbyshire	Tool
	Service uptake – adults/continued							
129	People in contact with mental health services per 100000 population (end of quarter snapshot)	2013/14 Q1	2160	2492	3044	3205	2350	CMHP
130	Carers of mental health clients receiving of assessments	2012/13	68.5	71.2	71.2	71.2	50.8	CMHP
131	% reporting a long term mental health problem (GP survey)	2012/13	4.5%	4.2%	5.9%	5%	4.3%	CMHP
132	GP prescribing of drugs for psychoses and related disorders: items quarterly per 1000 population	2014/15 Q2	45.7	36.3	54.6	49.5	36.5	SMI
133	People on care programme approach (CPA): Rate/100000 population (end of quarter snapshot)	2014/15 Q2	518	617	697	946	656	SMI
134	Service users on CPA: % people in contact with mental health services who are on CPA (end of quarter snapshot)	2014/15 Q2	23.8%	32.3%	26.8%	31%	29.6%	SMI
135	Use of mental health services by BME groups: % of people in contact with MH services from black and minority ethnic groups	2012/13	8.6%	2.3%	1.1%	1%	7.2%	SMI
136	New cases of psychosis served by Early Intervention teams: Rate (annual) per 100000 population	2014/15 Q2	23.9	10.6	25.1	20	14.8	SMI
137	Rate of people being treated by Early Intervention teams: Rate/100000 population (end of quarter snapshot)	2014/15 Q2	37.5	26.5	57.1	49.9	37	SMI

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	Indicator	Period	England	NHS Erewash	NHS Hardwick	NHS North Derbyshire	NHS Southern Derbyshire	Tool
	Service uptake – adults/continued							
138	Rate of people receiving assertive outreach services: Rate/100000 population (end of quarter snapshot)	2014/15 Q2	21.5	*	5.7	2.3	1.2	SMI
139	Contacts and daycare attendances: Rate per 100000 population (end of quarter snapshot)	2014/15 Q2	12490	13826	11803	14363	11114	SMI
140	People subject to the Mental Health Act: Rate per 100000 population (end of quarter snapshot)	2014/15 Q2	39.7	33.2	62.9	29.5	46.8	SMI
141	Admissions under the Mental Health Act: % of (quarterly) admissions which were MHA detentions	2014/15 Q2	25.4	20	*	15.4	34.3	SMI
142	Detentions on admission to hospital: Rate (quarterly) per 100000 population	2014/15 Q2	17.7	10	*	13.6	22.2	SMI
143	Repeat detentions under MH Act during the year: Average detentions per person	2012/13	1.16	1.08	1.11	1.17	1.18	SMI
144	Repeat short term orders under MHA during year: Average short term orders per person	2012/13	1.26	1.08	1.23	1.4	1.28	SMI
	Service quality and outcome - adults							
145	Patients with a diagnosis recorded	2013/14 Q1	17.8	18.7	14.8	7.2	13.9	CMHP
146	Patients assigned to a mental health cluster	2013/14 Q1	69	79.7	68.5	68	74.2	CMHP
147	Patients with a comprehensive care plan	2012/13	87.3%	91.1%	85.7%	88.5%	91.3%	CMHP
148	Patients with severity of depression assessed	2012/13	90.6%	95.4%	93.7%	92.5%	93.2%	CMHP
149	Access to IAPT services: People entering IAPT services (monthly) as % of those estimated to have anxiety/depression (based on GP practice code)	Mar-15	13.2%	27.1%	18.2%	26%	20%	CMHD

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	Indicator	Period	England	NHS Erewash	NHS Hardwick	NHS North Derbyshire	NHS Southern Derbyshire	Tool
150	Waiting <28 days for IAPT: % of referrals (in month) waiting <28 days for first treatment	Mar-15	74.9%	81.6%	82.8%	80%	55.3%	CMHD
151	Waiting >90 days for IAPT: % referrals (in month) waiting >90 days for first treatment	Mar-15	4.7%	2.6%	*	1.9%	3.5%	CMHD
152	IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving towards recovery"	Mar-15	45.2%	44%	45%	49.2%	53.9%	CMHD
153	IAPT DNAs: % of IAPT appointments (in quarter) where people did not attend and gave no advance warning not yet updated	2014/15 Q3	12.5%	15.4%	10.7%	10.8%	14.5%	CMHD
154	Patients finishing a course of treatment: % patients entering IAPT service who receive a course of treatment	2014/15 Q3	39.8%	1.9%	43.3%	41%	40.4%	CMHD
155	CPA adults in employment: % of people aged 18-69 on CPA in employment (end of quarter snapshot)	2014/15 Q2	6.6%	12.5%	8.1%	12.5%	10%	SMI
156	CPA adults in settled accommodation: % of people aged 18-69 on CPA in settled accommodation	2014/15 Q2	58.2%	87.5%	79.8%	87.5%	85.5%	SMI
157	CPA review: % of people on CPA for more than 12 months who had a review (end of quarter snapshot)	2014/15 Q2	80.2%	88%	78.6%	80.7%	75.1%	SMI
158	CPA users with HoNoS assessment: % of people on CPA with HoNoS recorded (end of quarter snapshot)	2014/15 Q2	82.1%	90.3%	93.4%	92.3%	89.8%	SMI
159	Delayed discharges: Days of delayed discharge in quarter as a rate/1000 bed days	2014/15 Q2	28.3	*	*	*	14.2	SMI
160	Children on adult wards: Number of bed days (in quarter) on adult mental health wards for patients aged <18	2014/15 Q1	-	*	*	*	*	SMI

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Metadata for Geographical and CCG Indicators

Indicator number	*Metadata about indicator*	*Original source*
1	Proportion of population	Office for National Statistics (ONS)
2	Proportion of relevant age population	Active People Survey, Sport England
3	Proportion service users	Personal Social Services Survey of Adult Social Care users.(ASC)
4	Proportion service users	Personal Social Services Survey of Adult Social Care users.(ASC)
5	Proportion adults in contact with secondary mental health services	Mental Health Minimum Dataset (MHMDS)
6	Proportion difference between overall employment rate and employment rate for those in contact with secondary mental health services	MHMDS and Public Health England (PHE)
7	Crude rate per 1000 relevant population	Chartered institute of Environmental Health (CIEH), DEFRA, and PHE
8	Proportion of relevant age population	Active People Survey, Sport England
9	Proportion service users	Personal Social Services Survey of Adult Social Care users.(ASC)
10	Proportion of carers of service users	Personal Social Services Survey of Carers of ASC users.(ASC)
11	Proportion employees	Labour Force Survey. ONS
12	Proportion of working days lost to sickness absence in previous week	Labour Force Survey. ONS
13	Crude rate per 1000 population domestic abuse incidents recorded by police.	Public Health England using police data
14	Rate of violence offences per 1000 population	Public Health England using police data
15	Proportion of people with long term limiting conditions who reported health related quality of life	GP Patient Survey
16	Proportion of people with long term conditions feeling supported to manage their condition	GP Patient Survey
17	Proportion of carers with health related quality of life	GP Patient Survey
18	Proportion of social care users who report quality of life	Personal Social Services Survey of Adult Social Care users.(ASC)
19	Directly age standardised rate per 100000 population aged 65 and over	HES with calculations by WMPHEKIT
20	Proportion older people reporting good health related quality of life	PHE
21	% working age population	Nomis
22	Proportion of all adults	Census
23	Proportion of all households	DECC
24	Proportion of all households	Census
25	Number of households	Local council reported housing stock
26-27	Proportion of all households	Census
28	Proportion of total population aged 18+	Integrated Household Survey PHE
29	Proportion smoking at delivery	SSATOD returns HSCIC
30	Proportion of children aged 4-5 in Reception year	Department for Education (DfE)
31-32	Proportion of all children taking GCSEs	Department for Education (DfE)
33	Proportion of all disadvantaged children	Department for Education (DfE)
34	Proportion of all children with special educational need but not statemented	Department for Education (DfE)
35	Proportion of all statemented SEN children	Department for Education (DfE)
36	Proportion all young people aged 16-18	Department for Education (DfE)
37	Crude rate per 1000 households	DCLG
38	Crude rate per 1000 population	Various sources (drug treatment, probation, police and prison data) to derive estimates
39	Proportion of all opiate users	National Drug Treatment Agency (NDTA)

Indicator number	*Metadata about indicator*	*Original source*
		calculated by PHE
40	Directly standardised rate per 100000 population	HES data calculated by PHE
41-44	Proportion population	Annual Population Survey. ONS
45	Proportion of population	Census
46	Proportion of children aged <16	HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)
47	Crude rate per 100000 population	Police National Computer
48	Crude rate per 100000 relevant population	Govt statistics Ministry of Justice
49	Proportion all children in need	Govt statistics
50	Proportion of all children <15	Census
51	Proportion of all children	Dept Work and Pensions, CAYA (local data)
52	Rate per 1000 households	P1E quarterly returns. Dept for Communities and Local Government
53	Rate per 10000 <18 population	Govt Statutory returns on looked after children and CAYA local data
54	Proportion of all looked after children	Govt statutory returns 3
55-56	Rate per 100000 children aged <15	Health & Wellbeing – Alcohol & Drugs, Public Health England
57-58	Proportion relevant school age children	School Census DfE
59	Proportion all school age population	DfE
60-61	Rate per 1000 females aged 15-17	Office for National Statistics (ONS)
62	Rate per 1000 children aged 0-17	CAYA – local data
63	Proportion general population aged 16 and over	PHE
64-69	Proportion population aged 16-74	PHE
70-71	Proportion of population aged 16+	PHE
72	Number of women of child bearing age	-
73	Proportion of adult social care users	RAP. HSCIC
74	Incidence per 100000 population aged 16-64	www.psymaptic.org
75	Proportion of population aged 16-74	APMS 2007, calculated by PHE
76	Directly standardised rate per 100000 population	ONS
77-80	Proportion of population aged 5-16	PHE estimated from ONS survey 2004
81-82	Estimated number population aged 16-24	PHE
83-84	Estimated number children <17	ONS
85	Directly standardised rate per 100000 population aged 15+	HES and PHE
86	Rate per 100000 population	RAP. HSCIC
87-91	Rate per 100000 population aged 18-64	RAP. HSCIC
92	Rate per 100000 population	HES
93	Crude rate per 100000 children <18	HES
94	Directly standardised rate per 100000 population aged 15-24	HES
95	Crude rate per 100000 population aged <17	HES
96	Directly standardised rate per 100000 population aged 10-24	Unknown
97	Crude rate per 10000 population aged 15-24	HES, calculated by PHE
98	Number of children <18	Mental Health Minimum Dataset (MHMDS) local data
99-100	Proportion population on CPA aged 18-64	MHMDS calculated by HSCIC
101	Indirectly standardised ratio	HSCIC
102	Directly standardised rate per 100000 population aged <75	HSCIC
103-104	Average wait in weeks	MHMDS local data
105	Proportion of respondents with a long term limiting illness	GP Patient Survey
106	Proportion of respondents with a long term limiting illness	GP Patient Survey
107	Proportion or respondents who are carers	GP Patient Survey
108	Proportion aged 18+ on depression register	Quality and Outcomes Framework (QOF)

Indicator number	*Metadata about indicator*	*Original source*
109	Proportion respondents with depression and anxiety	GP Patient Survey
110	Proportion on mental health register	Quality and Outcomes Framework (QOF)
111	Proportion of respondents reporting long term mental health problem (13/14)	GP Patient Survey
112	Estimated proportion aged 16+	APMS 2007
113	Ratio QOF prevalence to estimated prevalence	HSCIC
114-117	Prevalence aged 5-16	PHE estimated from ONS survey 2004
118	Crude rate ADQ per STAR-PU	NHS Business Authority (NHSBA)
119	Proportion of all prescription items for depression	NHSBA
120	Rate per 100000 population	IAPT
121	Crude rate per 100000 population	IAPT
122	Proportion of those with anxiety and depression	IAPT
123	Crude rate per 100000 population	IAPT
124	Rate/100000 people aged 18-64	Referrals, Assessments and Packages of Care (Adult Social Care)
125	Proportion mental health services users	MHMDS. HSCIC
126	Crude rate/100000 population	MHMDS. HSCIC
127	Crude rate/100000 population	HSCIC
128	Crude rate/100000 population	HSCIC
129	Crude rate/100000 population	MHMDS. HSCIC
130	Crude rate/100000 population	Referrals, Assessments and Packages of Care (Adult Social Care)
131	Proportion reporting long term mental health problem (12/13)	GP Patient Survey
132	Crude rate/1000 population	HSCIC
133	Crude rate/100000 population	HSCIC
134	Proportion people in contact with MH services	HSCIC
135	Proportion who use services who are in minority ethnic groups	MHMDS. HSCIC
136	Crude rate/100000 population	MH Community Teams Activity. HSCIC
137	Crude rate/100000 population	HSCIC
138-139	Crude rate/100000 population	HSCIC
140	Crude rate/100000 population	HSCIC
141	Proportion of admissions which were MHA detentions	HSCIC
142	Crude rate/100000 population	HSCIC
143-144	Average detentions per person. Crude rate/100000 population	HSCIC
145	Proportion patients with recorded diagnosis	MHMDS. HSCIC
146	Proportion patients assigned to mental health cluster	MHMDS. HSCIC
147	Proportion patients on register	QOF
148	Proportion patients on register	QOF
149	Proportion of those estimated to have anxiety/depression	IAPT
150-151	Proportion referrals	IAPT
152	Proportions those who have completed treatment	IAPT
153	Proportion IAPT appointments in quarter	IAPT
154	Proportion patients entering IAPT	IAPT
155-156	Proportion adults on CPA	MHMDS. HSCIC
157	Proportion on CPA for more than 12 months	MHMDS. HSCIC
158	Proportion of people on CPA with HoNoS recorded	MHMDS. HSCIC
159	Rate/1000 bed days	MHMDS. HSCIC
160	Number bed days spent on adult ward	Monthly MHMDS reports